MISSISSIPPI DIVISION OF
MEDICAID

Report of Cost–Containment Measures and Initiatives

Updated

December 2017

The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians.

The Mississippi Division of Medicaid (DOM) is pleased to present this report of cost savings measures it has undertaken along with initiatives both within DOM and with the Coordinated Care Organizations (CCO) through the managed care program MississippiCAN. DOM appreciates the opportunity to share how the agency has been working to provide health care for Medicaid beneficiaries and obtain cost savings at the same time.

Health Initiatives

DOM is committed to finding savings while continuing to improve health outcomes in Mississippi. The unique health challenges the state faces are well-documented and are amplified in the Medicaid population. The following examples have been provided to illustrate this point.

Mississippi has one of the highest rates of pre-term deliveries in the nation. It is widely proven that pre-term births and low birth-weight babies result in higher hospital costs. The national average for pre-term deliveries stands at 9.6 percent, while the Mississippi average is 13.6 percent. By comparison, the average pre-term delivery rate among Mississippi Medicaid beneficiaries is 17.1 percent (7.5 percentage points higher than the national rate).

However, DOM's managed care program, MississippiCAN, has shown positive outcomes in reducing this trend. For instance, by encouraging the use of the drug Makena, a weekly injection designed to help pregnant women carry their babies to full term. In a pilot study conducted in 2016, 101 beneficiaries with high-risk pregnancies enrolled in Magnolia Health who received Makena before delivering their babies. Of those, 73 babies were born healthy and sent home with their mothers, avoiding lengthy hospital stays. Furthermore, Magnolia has shown that its average pre-term delivery rate has decreased by 6.04 percent, from 20 percent in 2014 to 13.96 percent in 2016.

Mississippi also ranks first in the nation for incidence of sickle cell disease per capita, leading to 448 hospitalizations related to the condition during state fiscal year (SFY) 2015. By increasing the usage of the drug Hydroxyurea for qualified candidates, the goal is to decrease emergency room and inpatient admissions. Since MississippiCAN was established in 2011, DOM has been tracking a gradual but steady reduction in sickle cell-related emergency room visits.

According to the most recent data, Mississippi has one of the highest adult obesity rates in the nation at 37.3 percent, and leads the nation in overall diabetes prevalence, at more than 14.7 percent of the adult population. Consequently, screening to monitor and treat type 2

diabetes early on is a key focus. According to Healthcare Effectiveness Data and Information Set (HEDIS) measures for the past five years, there has been a sharp increase in each category of Comprehensive Diabetes Care Screening between 2012 and 2017 in both the CCOs, which is a critical preventive tool to curtail diabetes progression.

And as a final example, efforts to increase primary care physician (PCP) visits through case management and reduce emergency room (ER) visits have proven successful. For instance, through its ER Diversion Program, Magnolia Health data has shown that between 2013 and 2015, PCP visits have steadily increased while ER utilization has declined. A reduction in inappropriate ER utilization translates to a real cost savings.

Each of these health initiatives discussed above highlight where DOM is focusing its efforts to both address health improvements while also containing costs. These initiatives are not available to DOM outside of the managed care setting.

Inflation Comparison

DOM has provided all appropriately needed health services to beneficiaries over the past five fiscal years while doing so at overall cost increases that were below the Centers for Medicare and Medicaid Services (CMS) rates of inflation showing that DOM's costs were lower by $198 million. The state share of this cost equates to $54 million.

Managed Care Financial Benefit

While addressing "cost savings", DOM would also like to present efforts that have produced "financial benefit" for the state of Mississippi. Since its inception in 2011, the MississippiCAN program has saved and/or provided to the state of Mississippi total financial benefit of $285.3 million through SFY 2017. This financial benefit was produced by:

- $97.1 million in direct program savings, and
- $188.2 million in Net Premium Tax paid to the state of Mississippi.

Although the 3 percent Mississippi Premium Tax is assessed and paid by the CCOs as a part of DOM's budget, this tax goes to the Mississippi Insurance Department and becomes a part of the General Fund. The $188.2 million shown is in net Federal funds.

DOM regularly requests its independent actuaries Milliman, a national actuarial firm, to review and certify the savings.

Of the entire Medicaid budget, 95 percent goes to reimburse providers for health services. Medicaid covers approximately 65 percent of all births in the state of Mississippi, and children up to age one.

Some additional specific costs savings measures DOM has accomplished have been as follows:

Provider Payment Initiatives

- On Oct. 1, 2012, DOM switched to a DRG-based payment of inpatient reimbursement. Since this time, the rate amendments related to this reimbursement have been "budget-neutral". This change for ensuing rate years has saved the state approximately $27 million. Also meaningful data resulting from the DRG-based payment is providing information to develop cost saving measures that improve health outcomes.

- In April 2016, DOM implemented the Pharmacy pricing change based on National Average Drug Acquisition Cost (NADAC) that resulted in annual state savings of $3.5 million.

- On January 1, 2013, DOM implemented Outpatient Prospective Payment System (OPPS) Phase 1a resulting in overall savings of $35.6 million and state share savings of $9.2 million for the first six months. This change continues to generate savings.

- During SFY 2016, DOM implemented OPPS Phase II resulting in overall savings of $1,683,616 and state share savings of $435,520. This change continues to generate savings, depending on changes in volume and mix of services.

- Bridge to Independence, Mississippi's Money Follows the Person Demonstration Project is a five year demonstration project designed to assist qualified individuals residing in facilities such as nursing facilities and intermediate care facilities to transition into home and community-based settings. The project to date has assisted with the transition of 528 individuals. Since 2012, the State of Mississippi has increased the percentage of home and community based services to total long term care expenditures from 29.40 percent to 33.83 percent as of December 31, 2016. Bridge to Independence is a program built around the core principles of consumer choice and empowerment to assist individuals in facilities in identifying potential community living options. Bridge to Independence is for persons of any age with physical, mental, developmental, or

intellectual disabilities and adults age 65 and older. On aggregate, it is estimated that two individuals can be served in a home and community-based setting for every one individual that can be served in an institution, with an average savings of $36,000 for each individual.

- For SFY2017 and SFY2018, the estimated state savings due to the new pharmacy reimbursement methodology effective April 1, 2017 is $4.4 million with a state share of $1.1 million.

- Through the Family Planning Waiver over the last five years, DOM has had a reduction in total expenditures of $613,350, an average yearly savings of $122,670. DOM expects the waiver to be extended and to continue to provide this level of savings.

- The Healthier MS waiver provides health coverage to aged, blind and disabled individuals who do not qualify for Medicare or Medicaid state plan benefits. Without health coverage these individuals would likely be admitted to a nursing facility and become eligible for Medicaid state plan benefits. DOM saves $58,167 per year for every waiver participant not admitted to a nursing facility.

- Effective November 1, 2013, DOM began enhanced reimbursement for after-hours office services. The payment change is intended to reduce avoidable emergency department use for non-emergency services. The average emergency department visit cost is $1,200.

- DOM implemented the National Correct Coding Initiative in FY 2011. Cost savings since 2011 are $9,656,219.

Operational Efficiencies

Over the past three years, DOM has worked diligently to ensure that the overall operational costs of the CCOs (including taxes) are in line with or below national averages. This is tracked by the Administrative Expense Ratio – This ratio includes payment to the CCOs for the following expenses:

- Case Management
- Utilization management / Prior Authorization
- Claim processing and other information technology (IT) functions
- Customer service / Call Center
- Provider contracting and credentialing

- Third Party Liability (TPL) / Identifying and Preventing Fraud
- Member grievances and appeals
- Financial and other program reporting
- Local overhead costs
- Corporate overhead and business functions (e.g. legal, executive, human resources)

Mississippi Combined CCO Admin. Ratio – 2016 = **11.2 percent**

(This includes 6.4 percent General Admin. Expense, 1.9 percent ACA – Health Insurance Providers Fee and 3 percent Mississippi Premium Tax)

CMS Region 4 (Southeast) Rate – 2016 = **12.2 percent**

The MississippiCAN CCOs' total administrative costs were a full 1 percent less than the average for the region.

The SFY 2018 and 2019 budgets include increases due to Contractual Services increasing in SFY 2018 (and carrying over to SFY 2019) by $136.8 million most of which is federally funded. The largest increases were contracts related to the following projects:

Project	FY 2018 Increase	State Share	State %
MES Replacement	$62.8M	$6.3M	10.0%
Eligibility Enhancement/DHS	$35.5M	$3.9M	10.9%
MMIS	$22.0M	$6.2M	28.4%
iTech General	$11.9M	$5.9M	50.0%
HIT Implementation	$11.2M	$1.1M	10.0%

The Medicaid Enterprise System (MES) Replacement project is mandated by CMS to replace one of the oldest systems in the nation. The Health Information Technology (HIT) Implementation project is a required CMS project where professionals and hospitals are paid an incentive for implementing and using certified electronic health records technology. The state has distributed over $200 million for an administrative cost of $2 million in state funds for this project. CMS funds 100 percent of the distributions and 90 percent of the administrative costs. The Eligibility Enhancement project is a state Legislative approved project. The Medicaid Management Information System (MMIS) and iTECH general projects are necessary improvements to the current systems.

Also, DOM requested from a number of its contractors a reduction in the contracted rates by 5 percent during fiscal years 2017 and 2018. The resulting savings of contracts in 2017 total $455,059, and a state share savings of $148,457. The efforts to reduce contractual spending for FY 2018 are ongoing. To date, DOM has achieved a reduction to projected contractual spending of $3,818,382. The state share of the savings is $842,061.

Investments with a Positive Return

DOM has worked through a number of its own internal departments and outside contractors to bring about positive return of investment (ROI) from the services they perform. Some examples are highlighted below:

- Through the managed care financial oversight contract with Myers & Stauffer, LC, DOM implemented a robust encounter reconciliation process. This is a new requirement of CMS for states to maintain their FFP (Federal Funds Participation) matching funds under the Managed Care Rule issued by CMS in May 2016. Additionally Myers & Stauffer has assisted DOM with audits of Medical Loss Ratio (MLR) reporting with the CCOs which have benefited the state through reductions to reported CCO administrative expense (as noted above). Through their automated review of enrollees, Myers & Stauffer has assisted DOM with reducing the incidence of duplicate members to avoid unnecessary capitation payments. This is an issue faced by all Medicaid programs nationally. Through this effort, DOM has avoided the payment of $6.5 million over the course of the review.

- Through the contract with HMS, DOM continues to identify other third party insurers which should have paid Medicaid claims and to seek recovery from these other sources. Over the past five years $79 million has been recovered. This equates to $20.4 million in state share dollars recovered.

- Through the contract with Cornerstone Healthcare Financial Consulting, LC, DOM has been able to implement a number of managed care reporting enhancements including the implementation of the MLR Report. The rebates received from this reporting in the past two fiscal years have exceeded $6 million. The additional financial benefits over two years from the partnership with this contractor exceed $4 million.

- By transferring to providers the burden of delivering records for audit to DOM, the Performance and Financial Review department reduced its annual travel expenses by $35,000. This department was responsible for the collection of $4.8 million in provider overpayments during FY 2017.

- The Program Integrity department has reduced FY 2018 expenditures by $22,000 through changing the way it handles appeals and processes files for hearings thus reducing their expenses for supplies and travel. During FY 2017, this department was responsible for $1.6 million in recoveries. Additionally,

seven improper billing case cases valued at $3.1 million were referred to the Medicaid Fraud Control Unit in the attorney general's office. This department also continues to work hundreds of cases to identify fraud, waste and abuse.

- The Reimbursement department annually calculates and applies desk audit adjustments to cost reports prior to setting facility rates. Adjustments made in FY 2017 totaled $12.5 million with an estimated savings to the Medicaid program of $8.5 million and a state share savings of over $2 million.

- Through the Utilization Management/Quality Improvement Organization contracts with eQHealth Solutions, cost savings for FY 2014 were $21,412,813 and for FY 15 were $7,644,140. Cost savings continue and are expected to continue for the next five years. Additionally, the services for advanced imaging began in FY 17 and savings were $184,998. These savings are expected to continue for the next three years.

- In September 2016, LTC requested and received the Centers for Medicare and Medicaid Services (CMS) approval to review less than 100% of recertification for the Elderly and Disabled (E&D) waiver. The Long Term Services and Support (LTSS) system supported implementation of this change which helped reduce the backload of waiver applications and enabled better utilization of personnel resources. Two contract registered nurse positions were eliminated at a total savings of approximately $100,000, with a state savings of $25,370.

- CMS-required waiver home visits and statewide transition plan provider site visits are now being conducted by full-time staff instead of contract staff. One contract nurse position was eliminated. Travel costs decreased greatly because the contract nurse was not eligible to use a DOM vehicle unlike full-time staff members who are. Total savings approximated $50,000 with state savings of $12,685 annually.

- In the case-mix division of the Office of Long Term Care, the following changes decreased administrative costs:
    - Effective July 1, 2016 districts assigned to nurses were adjusted so that travel destinations were closer to their home base to decrease travel costs,
    - Nurse vacancies were filled with applicants who lived in the travel region to minimize travel costs,

- When the Southern district was vacated by a nurse for an extended time, that district was assigned to the nurse on staff who lived closest to minimize travel costs,
- When the Central district was vacated by a nurse, the other nurses shared this load and coordinated their trips in conjunction with scheduled monthly trips to the Jackson central office,
- The Medicaid Program nurse assigned to the office was cross-trained in case mix duties, which allowed her to transition to a case mix nurse position without the need for additional staff time and training, and
- The contract registered nurse position was eliminated on June 30, 2015.

- Implementation of the Complex Pharmacy Care Unit on October 1, 2016 has achieved savings of $3,501,152 for the period of October 1, 2016 through March 2017 and estimated savings of $1,854,088 just through May, 2017.

- DOM utilized Balancing Incentive Program federal grant funds to implement the Electronic Visit Verification system. The system is used to ensure beneficiaries in the community receive services needed to maintain their quality of life. The system also monitors the delivery of services. The system will be required by the 21st Century CURES Act and the implementation will ensure no reduction to the state's FMAP January 1, 2019 of .25 percentage points per quarter.

- DOM was awarded the Bridge to Independence federal grant to transition individuals from institutional long term care settings to home and community based settings. The total grant award was $21,517,819.

CCO Partnerships

DOM is partnering with the CCOs on the following proposed savings initiatives:

- ER Overutilization/Coding review – While improvements have been made, as noted above, with PCP utilization, the utilization of the Emergency Department continues to be a high cost area where DOM and the CCOs are focusing attention for cost savings especially in the review of the coding for ER visits at higher reimbursement levels than seen historically.

- Neonatal usage reduction – DOM is working collaboratively with the CCOs to increase the prenatal visit rates and ultimately reduce the pre-term delivery rate. This initiative is directed at one of the highest costs areas, which is the high rate of neonatal admissions. The NICU cost of a low birth weight baby can average $33,600.

One avenue to address this is through the use of the drug Makena which works to help prevent pre-term labor.

- Oversight of managed care has gotten more robust. Through efforts internally such as those of DOM's Health Services department, staff is working to reduce overutilization of services by increased oversight of care management activities. In the new CCO contracts, the requirements for CCO reporting have increased to achieve higher levels of quality reporting. For example, DOM has a CCO Reporting Manual that covers all aspects of the operations of the managed care program which contains over 200 required reports requiring the CCOs to report on a periodic basis.

DOM diligently works to provide for the healthcare needs of Medicaid beneficiaries, maintain access for needed services, and improve the quality of the care provided to them, all while also working within the federal and state regulatory guidelines to reduce costs and to provide financial benefits to the state of Mississippi.

Division of Medicaid
Measurable Financial Savings Summary
Updated December, 2017

Savings Initiatives	Initiative Results - State Savings, in millions						
Managed Care Financial Benefit	Total	SFY 2018	SFY 2017	SFY 2016	SFY 2015	SFY 2014	SFY 2013
Managed Care Financial Benefit	$235.1		$74.7	$72.4	$31.6	$36.3	$20.1
Provider Payment Initiatives							
DRG-based Inpatient Hospital reimbursement	$27						
Pharmacy pricing change to NADAC	$7.9	$3.5	$3.5	$0.9			
Pharmacy Methodology Effective 4-1-17	$1.1						
APC-based Outpatient Hospital Reimbur	$101.2	$18.4	$18.4	$18.4	$18.4	$18.4	$9.2
APC-based Outpatient Hospital Reimbur	$1.2	$0.4	$0.4	$0.4			
Transition of Long-term care residents to home/community based settings (MFP grant)	$9.60	$4.8	$4.8				
Utilization Management/Quality Improvement Organization (UM/QIO)	$7.8				$2.0	$5.8	
UM/QIO Advanced Imaging	$0.1		$0.1				
Family Planning Waiver	$0.2						
NET Contract & Transportation Management	$0.8						
Administrative Investments with Positive ROI							
Duplicate Enrollee Avoidance Efforts	$6.5						
Third party insurance recoveries (FY13-FY16)	$20.4		$5.0	$3.5	$3.4	$3.8	$4.7
Managed Care financial oversight	$10.0						
Performance and Financial Review efforts	$4.8		$4.8				
Program integrity recoveries	$3.4		$1.2	$1.7	$0.5		
Cost reviews preceding rate setting	$12.0	$2.0	$2.0	$2.0	$2.0	$2.0	$2.0
Administrative Efficiencies							
Governor's contract reduction initiative	$0.9	$0.8	$0.1				
DOM administrative cost containment initiative FY18 projected	$0.3	$0.3					

Total **$450.3**

Note: Some DOM projects included in the associated report were undertaken by DOM to improve beneficiary health. Although these projects have reduced Medicaid costs, the related savings are not easily quantifiable and are not reflected here.