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HFMA Summer Virtual Event

June 18, 2021

MISSISSIPPI DIVISION OF MEDICAID

Mississippi Division of Medicaid

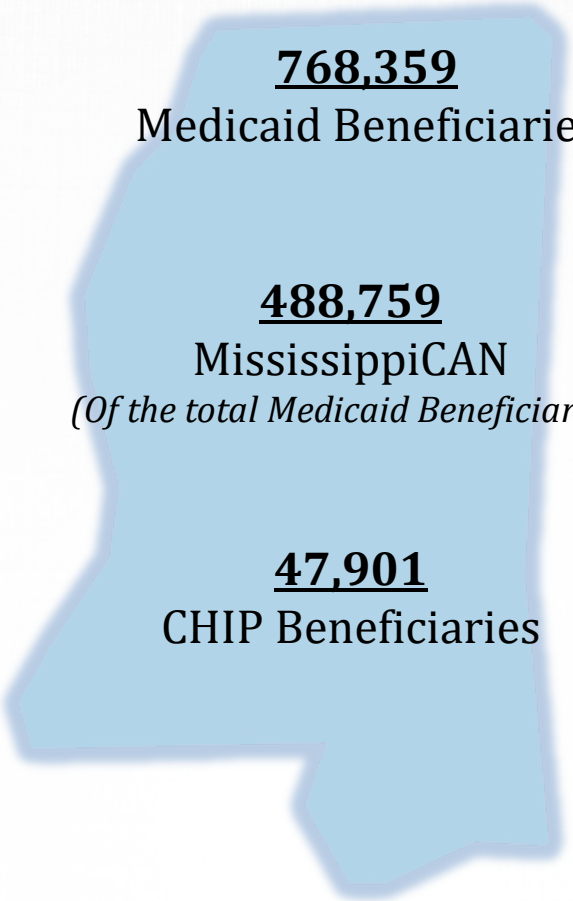
864 employees, 30 Regional Offices and 75 Outstations	33,486 enrolled providers	816,260 beneficiaries
3 managed care company partners – Medicaid and CHIP	$6.6 billion in annual expenditures	21% of the state's budgeted funds

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

Values: *We are committed to accomplishing our mission by conducting operations with…*

*Accountability * Consistency * Respect*

Medicaid Enrollment Statistics



768,359
Medicaid Beneficiaries

488,759
MississippiCAN
(Of the total Medicaid Beneficiaries)

47,901
CHIP Beneficiaries

(As of May 2021)

Topics

- Mississippi Hospital Access Program (MHAP)
- APR-DRG Update
- Rural Hospital Outpatient Reimbursement
- Disproportional Share Hospital (DSH) Update
- Hospital Tax Model Changes
- Senate Bill 2799
- Other DOM Updates
- FMAP
- MSCAN Quality Initiatives

SFY 2022 Changes to MHAP

- **Potentially Preventable Hospital Returns (PPHR)**
  - This is the third year of PPHR being included in the QIPP portion of MHAP.
  - Hospitals will be required to review and attest to the quarterly PPHR reports.
  - Those hospitals with an a/e ratio >= to the statewide threshold of 1.07 on the July 2021 report will be required to submit a CAP by Sept. 1, 2021.

- **Potentially Preventable Complications (PPC)**
  - This new quality metric will be introduced during this state fiscal year.
  - For this state fiscal year, hospitals will be required to review and attest to the receipt of the quarterly PPC reports.

- **Health Information Network (HIN)**
  - Hospitals will be required to attest to their continued participation in the statewide HIN via a quarterly certification.
  - Hospitals will also be expected to submit the data supported by the HIN to include admission, discharge and transfer information for Medicaid beneficiaries.

MHAP Payments to MS Hospitals

MHAP Distribution by SFY				
SFY	MHAP-TPP	MHAP-FSA	MHAP-QIPP	Total MHAP
2019	$380,017,469	$153,093,487	$0	$533,110,956
2020	$215,886,793	$275,000,000	$42,224,163	$533,110,956
2021	$0	$317,886,793	$215,224,163	$533,110,956
2022	$0	$285,603,168	$247,507,788	$533,110,956

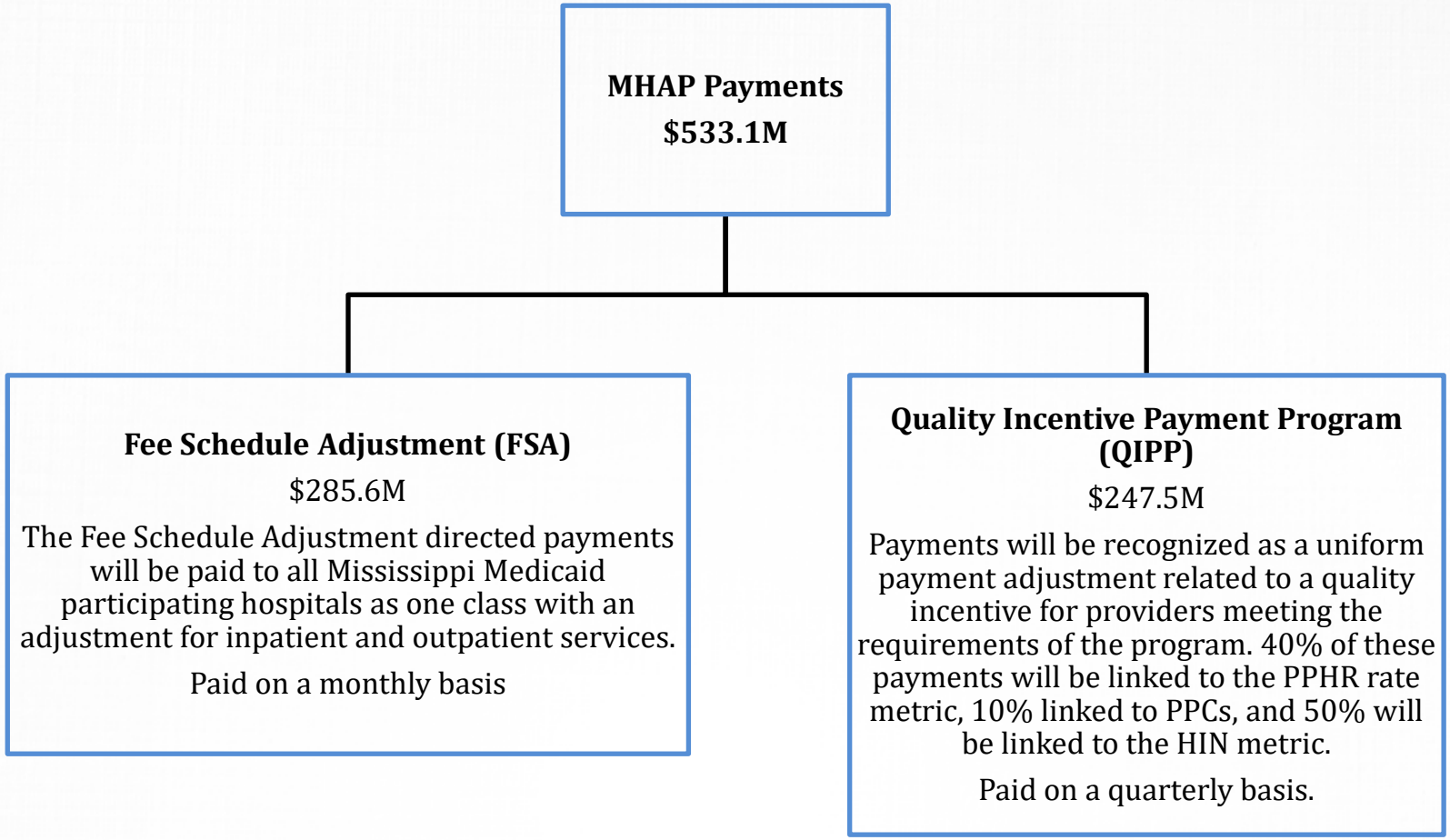
- CMS requires that a preprint be submitted annually to request approval for the total amount of MHAP, each component and the structure for how the payments will be tied to utilization, quality and outcomes.

- The annual CMS-approved MHAP payment is distributed in full to participating hospitals by the Coordinated Care Organizations (CCO).

- The CCO's do not deduct any administrative fee in making this payment.

- The SFY 2022 MHAP structure has two components:
  - Fee Schedule Adjustment (FSA)
  - Quality Incentive Payment Program (QIPP)

Two Components of SFY 2022 MHAP



MHAP Requirements

- QIPP is designed to link a portion of MHAP payments to utilization, quality and outcomes. QIPP's goal is to use state and federal funds to improve the quality of care and health status of the Mississippi Medicaid population
  - ❖ The QIPP program currently disburses 46.4% of all MHAP payments
  - ❖ The Division of Medicaid (DOM) will annually evaluate the percentage of MHAP in QIPP to connect more of MHAP to quality metrics
- MHAP payments must be fully transitioned to payments tied to utilization, quality and/or outcomes by SFY 2027.
- DOM will submit the "Section 438.6(c) preprint" to CMS annually to comply with the transition requirements.
- CMS will only approve a plan for one year at a time. **MHAP payments cannot be made until CMS approves the SFY 2022 preprint.**
- DOM will continue to collaborate with stakeholders to establish the annual plans.

MHAP Dates of Interest

July 7, 2021:	Quarterly PPHR and PPC reports distributed to hospitals Hospitals required to submit a PPHR corrective action plan for cycle two identified
August 6, 2021:	Hospital deadline to attest receipt and review of the quarterly reports
September 1, 2021:	PPHR Corrective action plan (cycle two) deadline
October 5, 2021:	Quarterly PPHR and PPC reports distributed to hospitals
November 4, 2021:	Hospital deadline to attest receipt and review of the quarterly reports
January 10, 2022:	Quarterly PPHR and PPC reports distributed to hospitals **Performance incentives for PPHR cycle one allocated**
February 7, 2022:	Hospital deadline to attest receipt and review of the quarterly reports
April 5, 2022:	Quarterly PPHR and PPC reports distributed to hospitals
May 5, 2022:	Hospital deadline to attest receipt and review of the quarterly report

MHAP Future Plans

- Health Information Exchanges - DOM expects to increase the use of data from the HIEs in quality reporting each year

- For copies of QIPP documents (including the PPHR and PPC methodology supplements and this presentation) email QIPP@medicaid.ms.gov, or go to the QIPP website: https://medicaid.ms.gov/value-based-incentives/

- DOM plans to begin posting statewide and hospital-specific data for the reporting period of calendar year 2019 on its website, including:
  - PPR percentages
  - PPED percentages
  - Actual-to-expected ratios

Inpatient APR-DRG Update

APR-DRG changes for SFY 2022

- The following APR-DRG parameters will be updated:
  - Adopt V.38 of the 3M APR-DRG grouper and HSRV weights
  - Re-center V.38 HSRV weights
  - Base Payment – will change from $6,590 to $5,350
  - Pediatric mental health policy adjustor – will change from 1.95 to 1.90
  - Adult mental health policy adjustor – will change from 1.50 to 1.45
  - Obstetrics policy adjustor – will change from 1.50 to 1.40
  - Normal Newborn policy adjustor – will change from 1.50 to 1.45
  - DRG Cost Outlier Threshold – will change from $53,500 to $60,000
  - DRG Cost Outlier Marginal Percentage – will change from 60% to 50%

- DOM estimates the overall impact of the above changes will be a savings of $210,588 in state and federal funds, which is budget neutral to SFY 2021.

Inpatient APR-DRG Update

Recentering the HSRV Weights

- V.38 of the APR-DRG HSRV weights are substantially lower on average for Medicaid inpatient stays relative to V.35 so DOM has opted to implement a process to re-center the APR-DRG relative weights to a population average of 1.0 each year to avoid substantial changes in the base price from year-to-year.
- The relative weights will still be based on the values published by 3M but will be adjusted so that the average weight across Mississippi Medicaid inpatient stays is 1.0.
  - This new process will mean that the average APR-DRG relative weight will not change from year-to-year, which will reduce the need to adjust the base price each year.
- However, because this process will significantly increase the average weight in SFY 2022 relative to SFY 2021, the Division will need to make a one-time significant decrease in the base price to maintain budget neutrality.

Inpatient APR-DRG Update

Future Plans

- Post-implementation monitoring and review
  - DOM will continue to monitor utilization due to COVID-19 and its effects on the inpatient program
- Monitor legislation
- DOM implements APR-DRG V.38 mapper and HAC utility on 10/1/2021
- No additional policy or grouper changes expected until 7/1/2024
- The outlier threshold will increase 5% per year each year until 7/1/2024 to account for increasing charges over time
  - This will allow DOM to maintain the payment levels in effect as of July 1, 2021, as required by Senate Bill 2799

Rural Hospital OP Reimbursement

- Senate Bill (SB) 2799 requires DOM to give rural hospitals that have 50 or fewer licensed beds the option to opt out of the APC reimbursement methodology
  - A hospital is considered rural if:
    - It is a critical access hospital (CAH), or
    - A small hospital (50 licensed beds or less) located in a rural core-based statistical area (CBSA) or in a designated area as determined by HRSA/HPSA (Health Resources and Services Administration/Health Professional Shortage Area).

- Hospital opting out of APC reimbursement will be reimbursed at one hundred one percent (101%) of costs and shall remain under cost-based reimbursement for a two-year period before they are able to revert back to the APC methodology.

- DOM will calculate the difference in cost as part of the cost/payment analysis.
  - Providers should continue to complete cost reports

Rural Hospital OP Reimbursement

Cost/Payment Analysis

- Interim Payments – outpatient fees published on the Outpatient Prospective Payment System (OPPS) fee schedule effective July 1, 2021

- Cost/payment analysis will utilize the following:
  - Final Medicare CCR calculated using the first issued Medicare final settled cost report that spans state fiscal year
  - Charges and Payments from FFS and MCO PS&R reports
  - Outpatient portion of the fee schedule adjustment (FSA) payments made as part of the Mississippi Hospital Access Program

- 101% of cost threshold cost settlement
  - If the cost settlement results in DOM paying below 101% of cost, a payout will be made to meet 101% of cost threshold.
  - If the cost settlement results in DOM paying above 101% of cost, DOM will recoup the amount in excess of the 101% of cost threshold.

DSH Update

- Due to the American Rescue Plan Act (ARPA) the FY-20 DSH total payments will increase $11,511,598.53 from $220,150,038.26 to $231,661,636.79
- The increased FY-20 DSH payments will be made June 21, 2021 if the additional assessments are received by DOM
- Total FY-21 DSH payments will increase from $215,376,121.96 to $223,633,182.47
- The 3rd final FY-21 DSH installment payments will include the increased DSH due to ARPA
- The 3rd FY-21 DSH installment will be made June 21, 2021 if hospital assessments are received by DOM

Hospital Tax Model Update

- The FY-20 hospital taxes to fund the increased ARPA DSH payments are $2,114,681
- FY-20 provider taxes were due to DOM June 15, 2021, to ensure timely payment of the FY-20 additional ARPA DSH payments
- The FY-21 hospital tax total will increase to $196,452,968 from $195,548,519 to fund the increase in total FY-21 DSH payments
- FY-21 provider taxes were due to DOM June 15, 2021, to ensure timely payment of the 3rd final DSH installment payments

Senate Bill 2799

http://billstatus.ls.state.ms.us/documents/2021/dt/SB/2700-2799/SB2799SG.pdf

- Rate Changes – SB 2799 – 43-13-117 (D)
- Hospital Tax Changes – SB 2799 – 43-13-145
- Dental Rate Increases 2022-2024
- Prior Authorization Alignment
- Managed Care Reporting
- Credentialing Requirements

Other DOM Updates

- PPRB approval for a managed care procurement RFQ; MSCAN/CHIP to be combined
- Nursing Home Add-on Payment
- New Quality Strategy – Effective July 2021
- ARPA included some enhanced funding for HCBS services; spending plan must be submitted to CMS
- Consolidated Appropriations Act – OBRA limit calculation for DSH

FMAP

- Due to the enhanced FMAP provided by Section 6008 of the Families First Coronavirus Relief Act, there is a 6.2 percentage point increase in the federal portion of Medicaid expenditures from January 1, 2020 until the end of the quarter when the Public Health Emergency (PHE) ends.
- What it means to providers:
  - Intergovernmental transfers for UPL payments or other state share contributions is reduced.
  - Hospitals see a decrease in their assessments.
- DOM has assumed a Dec 31, 2021 end to the enhanced FMAP for current budget projections.

MSCAN SFY 2020 Quality Results

MSCAN CCO HEDIS Measures Incentive/Withhold Program				
Quality Measure	Sub Measure	MS Medicaid Baseline	Benchmark	Average CCO Results
Well-Child First 15 months (W15)	6 or more visits	40.2%	40.6%	53.1%
Anti-Depressant Mgt-Acute (AMM-AD)	Effective Acute Phase Treatment	37.2%	37.5%	51.8%
	Effective Continuation Phase Treatment	22.0%	22.2%	39.0%
Comprehensive Diabetes Care	HbA1c Testing	85.7%	86.6%	86.8%
	Nephropathy Screening	92.3%	93.2%	91.7%
Prenatal and Postpartum Care (PPC-AD)	Timeliness of Prenatal Care	88.3%	89.2%	95.9%

MSCAN SFY 2022 Quality Initiatives

- DOM has expanded the quality reporting of the three CCOs. One percent of the CCOs monthly capitation rate is tied to incentive/quality withhold reporting.

- For SFY 2022, the CCOs will be reporting on the following HEDIS measures as a part of their Quality/Incentive risk arrangement:
  - -Well Child Visit – First 30 months / First 15 months
  - - Immunization for Adolescents (IMA) – Combo 2: (Meningococcal, Tdap, HPV)
  - - Anti-Depressant Management - Effective Acute Phase Treatment
  - - Anti-Depressant Management - Effective Continuation Phase Treatment
  - - Timeliness of Prenatal Care
  - - Comprehensive Diabetes Care - HbA1c Testing
  - - Comprehensive Diabetes Care – Patients with Diabetes – Received Statin Therapy
  - - Adult & Children Asthma Control – Ages 5-64
  - - Adults Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid

- The CCOs will also have the QIPP PPHR reports as a part of their incentive/withhold arrangement with CY 2020 as the Baseline Year.

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