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HFMA 2020 Annual Institute

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MISSISSIPPI DIVISION OF MEDICAID

Mississippi Division of Medicaid

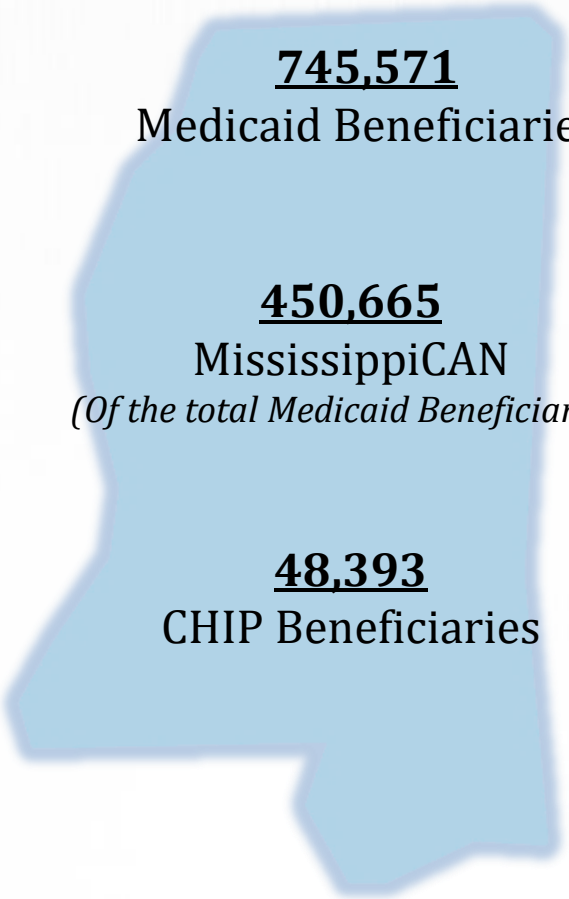
The Mississippi Division of Medicaid (DOM) has 976 employees, about 31,000 enrolled providers, 745,571 beneficiaries, 3 managed care company partners, 2 programs – Medicaid and CHIP, and $6.2 billion in annual expenditures, encompassing approximately 20% of the state's budgeted funds.

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



745,571
Medicaid Beneficiaries

450,665
MississippiCAN
(Of the total Medicaid Beneficiaries)

48,393
CHIP Beneficiaries

(As of June 2020)

What is Mississippi Hospital Access Program (MHAP)?

- DOM received a legislative mandate to implement the Mississippi Hospital Access Program (MHAP) on December 1, 2015, for the purpose of protecting Medicaid beneficiaries' access to care. This program replaced the UPL program that was previously in place under fee-for-service Medicaid.

- Rules and regulations at 42 CFR § 438.6(c), issued May 6, 2016, (known as the Managed Care "Mega Rule") govern supplemental payments in managed care, such as MHAP. Directed and pass-through payments for the purposes of inclusion in managed care rate setting are defined in these regulations.

- In these regulations, the Centers for Medicare & Medicaid Services (CMS) introduced a requirement that federal pass-through payments transition to accountability-based models within 10 years. This includes the Mississippi Hospital Access Program (MHAP).

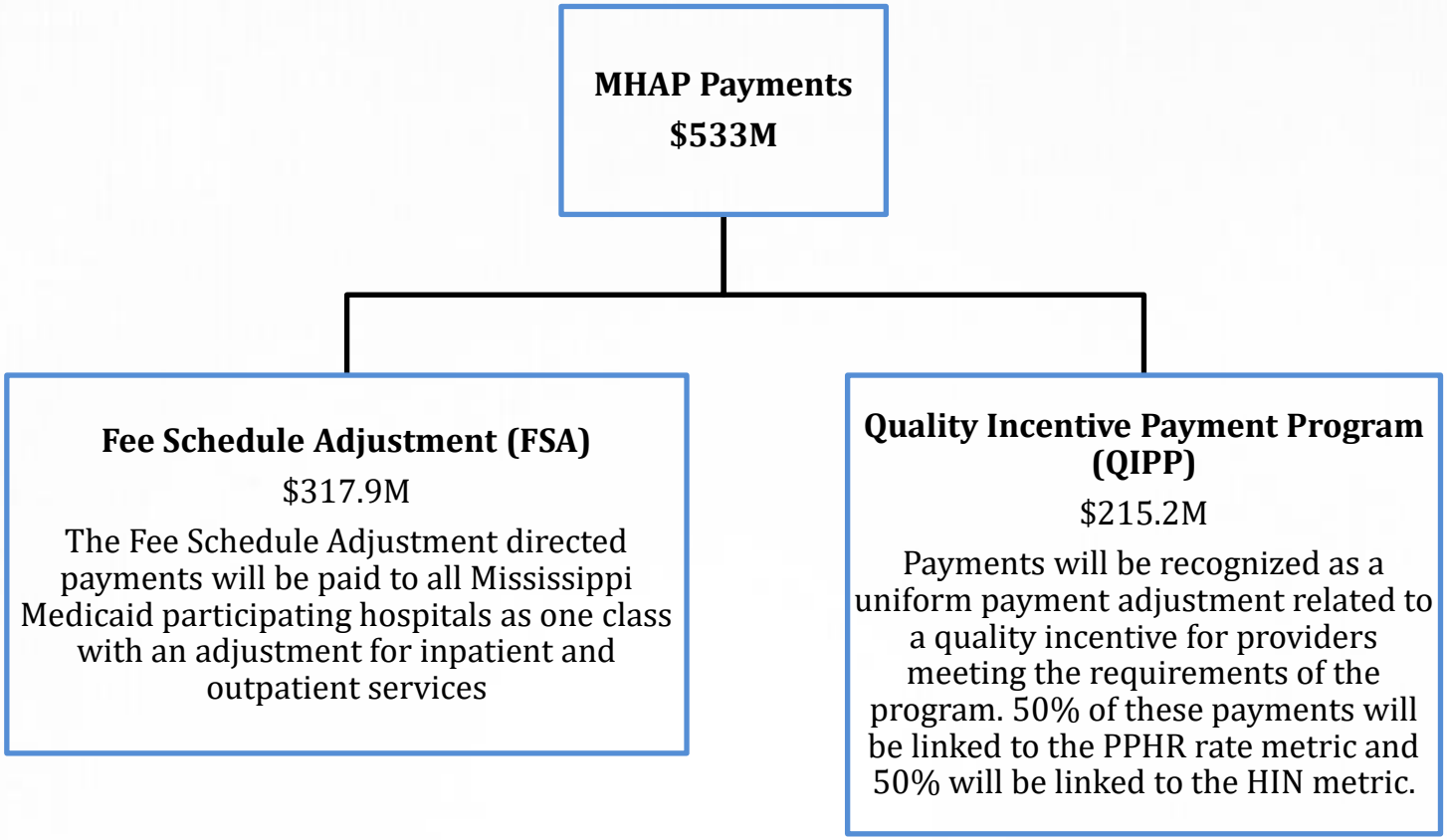
- With CMS's approval, DOM began this transition in SFY 2018 with the Transitional Payment Pool (TPP) and the Fee Schedule Adjustment (FSA) portions of MHAP.

MHAP Payments to Mississippi Hospitals

MHAP Distribution by SFY				
SFY	MHAP-TPP	MHAP-FSA	MHAP-QIPP	Total MHAP
2018	$422,241,632	$110,869,324	$0	$533,110,956
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

- 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 2021 MHAP structure has two components:
  - Fee Schedule Adjustment (FSA)
  - Quality Incentive Payment Program (QIPP)

The Two Components of SFY 2021 MHAP



Future MHAP Plans

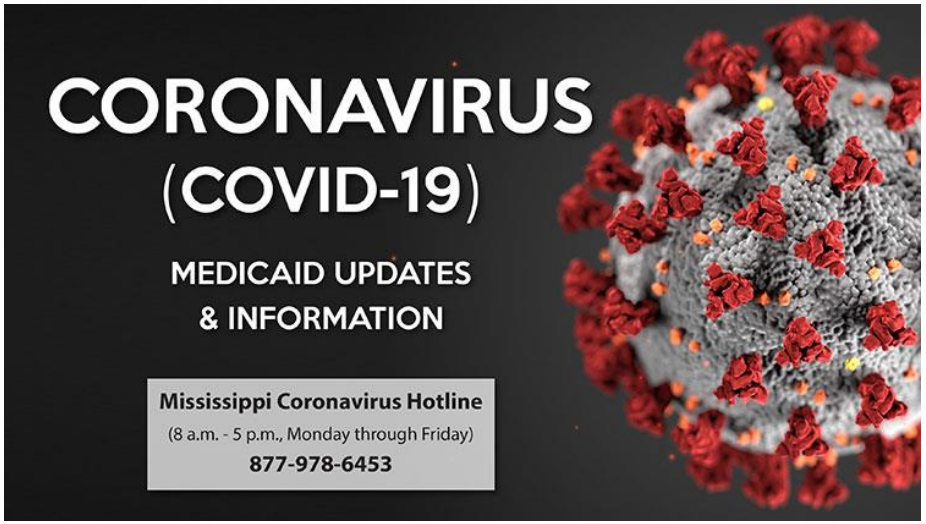
- QIPP is designed to link a portion of MHAP payments to utilization, quality and outcomes. QIPP's goal is to use state and federal funds to improve the quality of care and health status of the Mississippi Medicaid population
  - ❖ The QIPP program currently disburses 40.4% of all MHAP payments
  - ❖ The Division of Medicaid (DOM) will annually evaluate the percentage of MHAP in QIPP to connect more of MHAP to quality metrics
- DOM plans to introduce the quality metric of Potentially Preventable Complications (PPC) into the QIPP reporting structure for SFY 2022.
- 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.
- DOM will continue to collaborate with stakeholders to establish the annual plans.

COVID-19

- Enrollment Impacts:
  - Economic downturn
  - Enrollment limitations in order to accept the additional FMAP (6.2 percentage points)
- Cost of providing COVID-19 testing, treatment and vaccinations
- Cost and timing impact of deferred and foregone services as a result of:
  - Policies limiting non-essential services
  - Individual behavioral changes as a result of social distancing
- Policy changes
- Funding changes

COVID-19 Policy Changes

- Telehealth – coverage of enhanced telehealth services is extended through the end of the PHE
- Appendix K requests for HCBS programs
- 1135 waiver request
- Emergency State Plan Amendments



https://medicaid.ms.gov/coronavirus-updates/

Other Policy Changes

- Ambulance Rates – coordination with Dept. of Health to utilize Trauma Care Funds to enhance reimbursement rates
- FQHC/RHC – for better coordination with Telehealth policy
- Autism Spectrum Disorder – removes annual update to FFS fee schedule
- Private Duty Nursing/Personal Care Services
- Physician Administered Drugs – move from quarterly to annual fee schedule updates
- APR-DRG – Annual Updates

Inpatient APR-DRG Update

APR-DRG changes for SFY 2021

- The following APR-DRG parameters will be updated:
  - Base Payment – will change from $6,574 to $6,590
  - Pediatric mental health policy adjustor – will change from 2.00 to 1.95
  - Adult mental health policy adjustor – will change from 1.60 to 1.50
  - DRG Cost Outlier Threshold – will change from $47,000 to $53,500

- DOM estimates the overall impact of the above changes will be a savings of $2,846,599 in state and federal funds, which DOM intends to invest in community-based mental health services. This savings represents less than 0.5% of the DOM hospital inpatient budget.

- Due to significant changes in the clinical logic and relative weights from version 35 to version 37 of the 3M APR-DRG grouper, DOM did not update to version 37 on July 1, 2020.

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, 2020 end to the enhanced FMAP for current budget projections.

Medicaid Spending

As of June 30, 2020

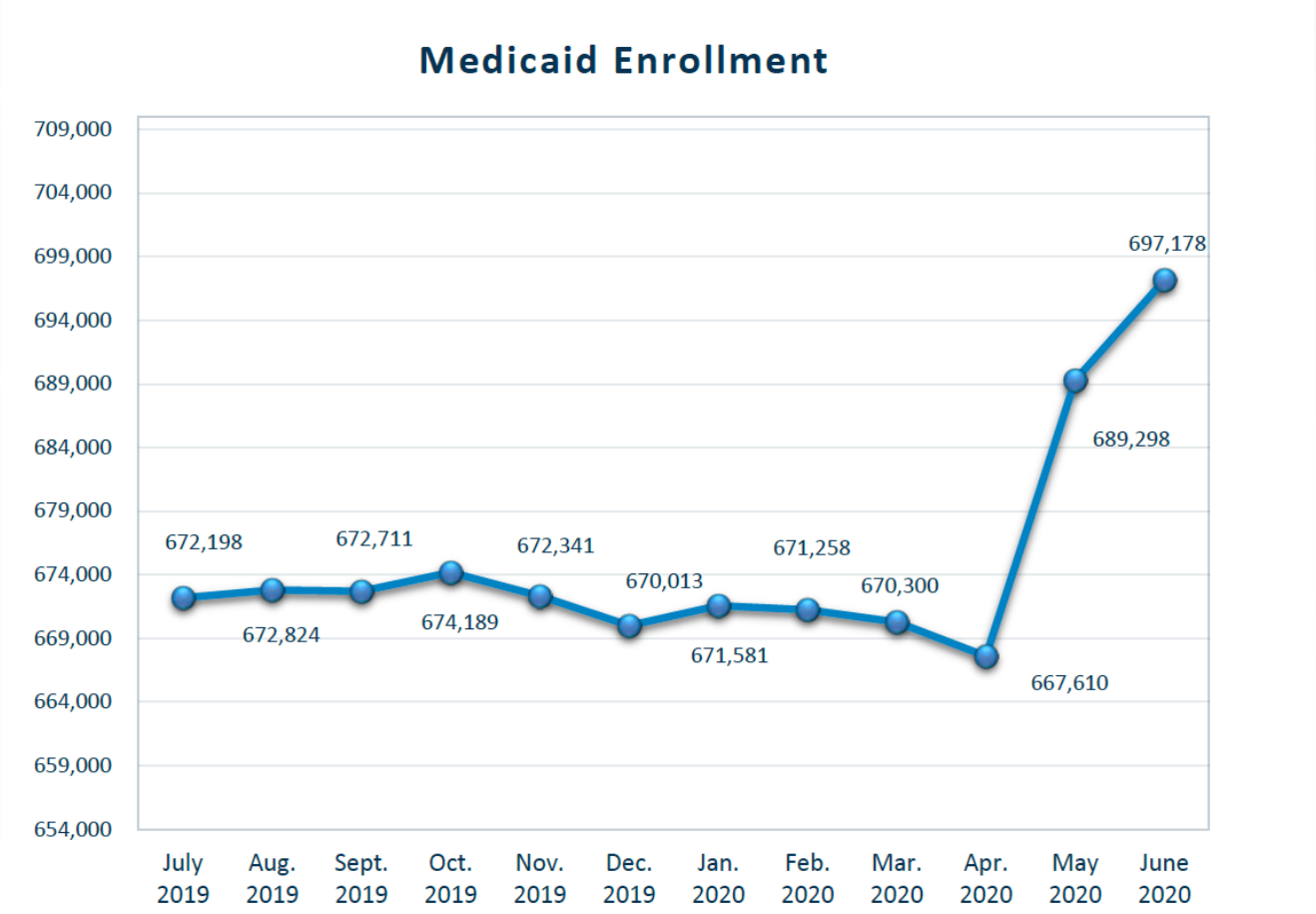
YTD Medicaid Expenditures

FY20: $5,057,974,131

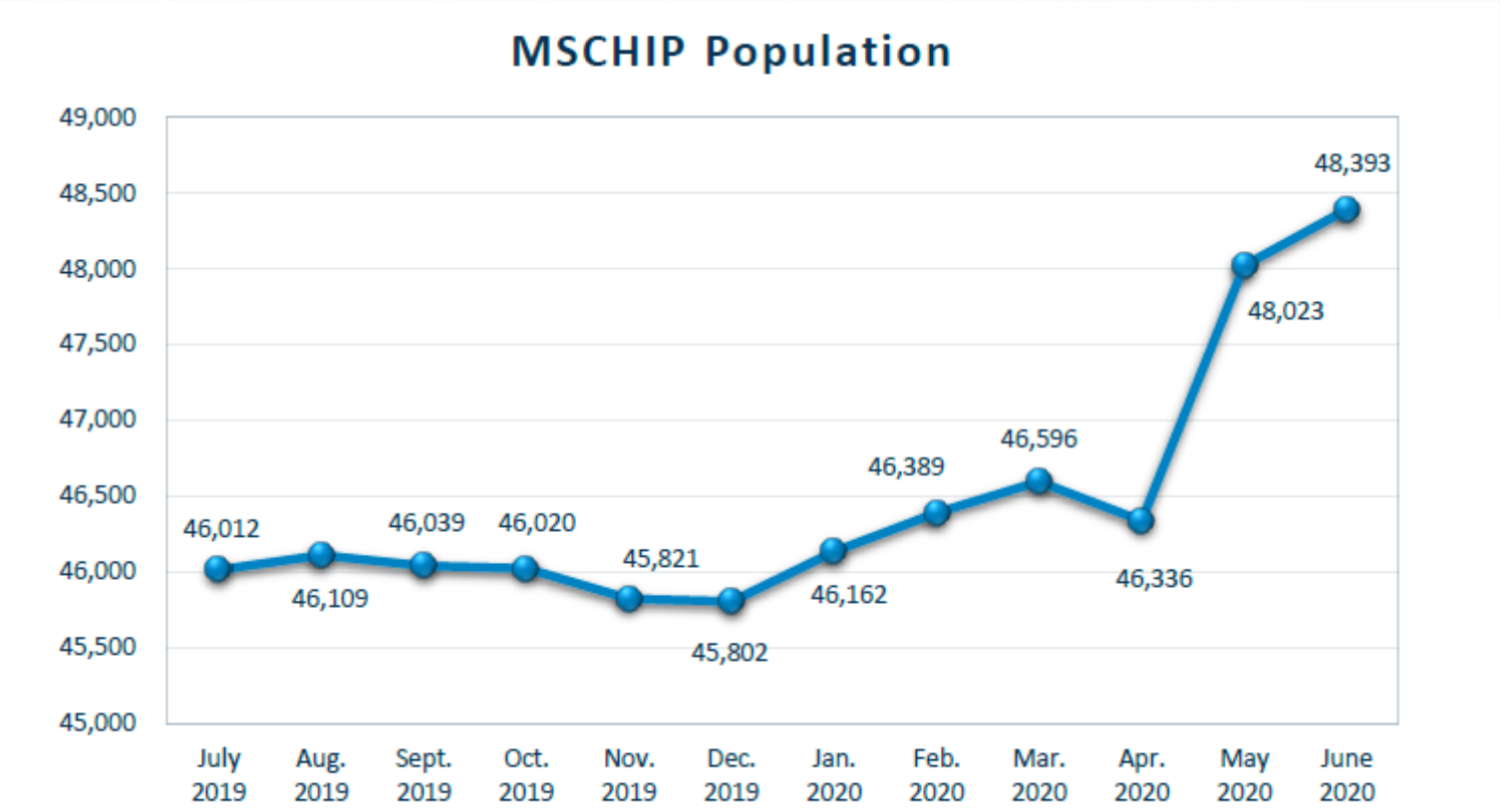
FY19: $4,680,979,204

$376,994,927

Enrollment Increase

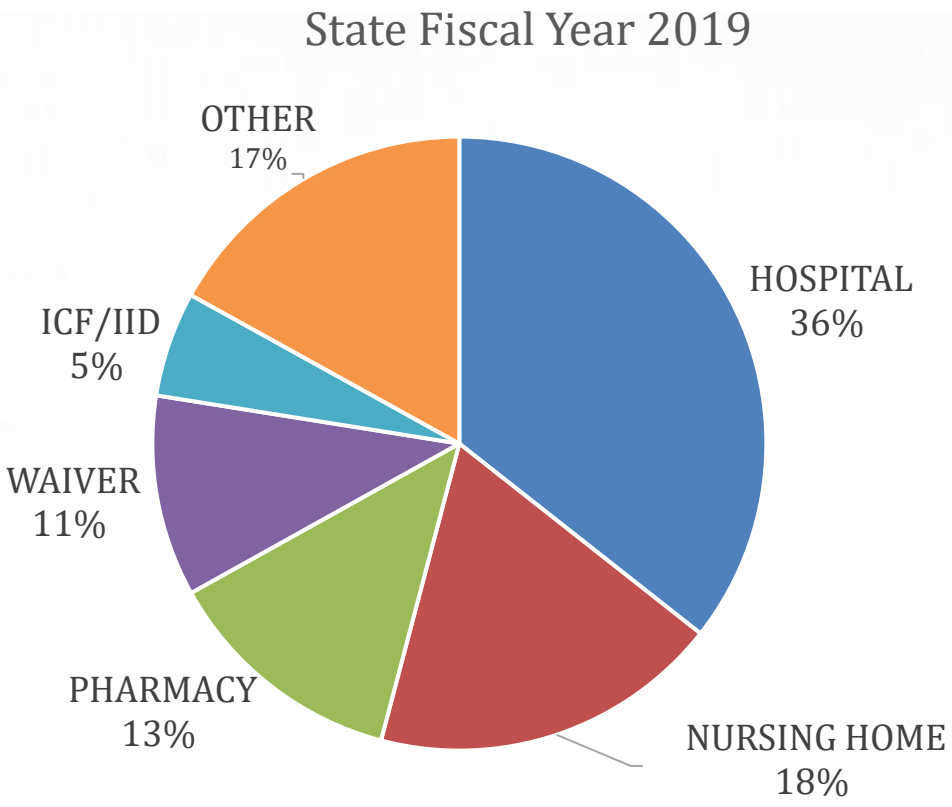


Enrollment Increase

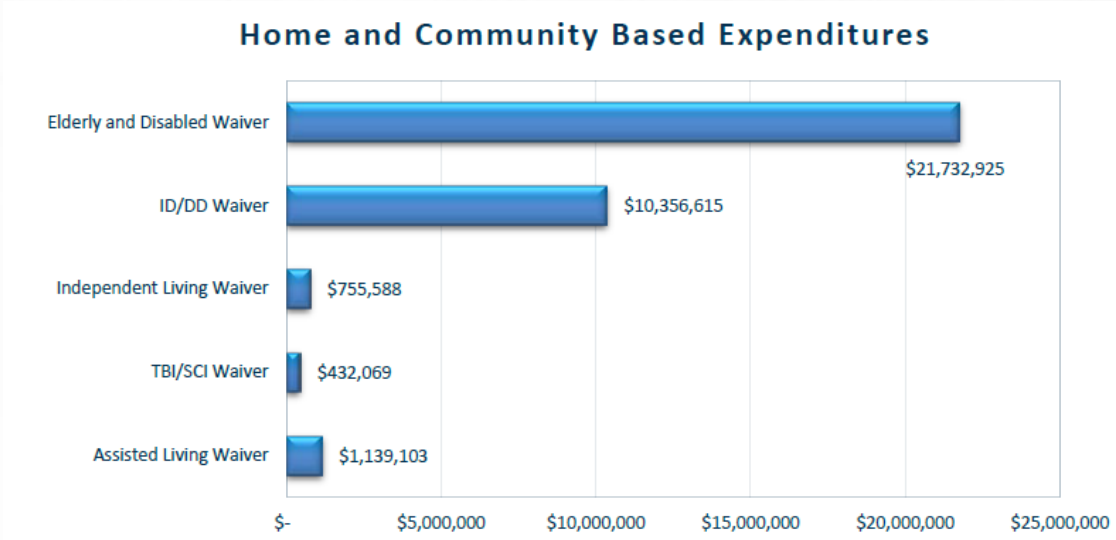


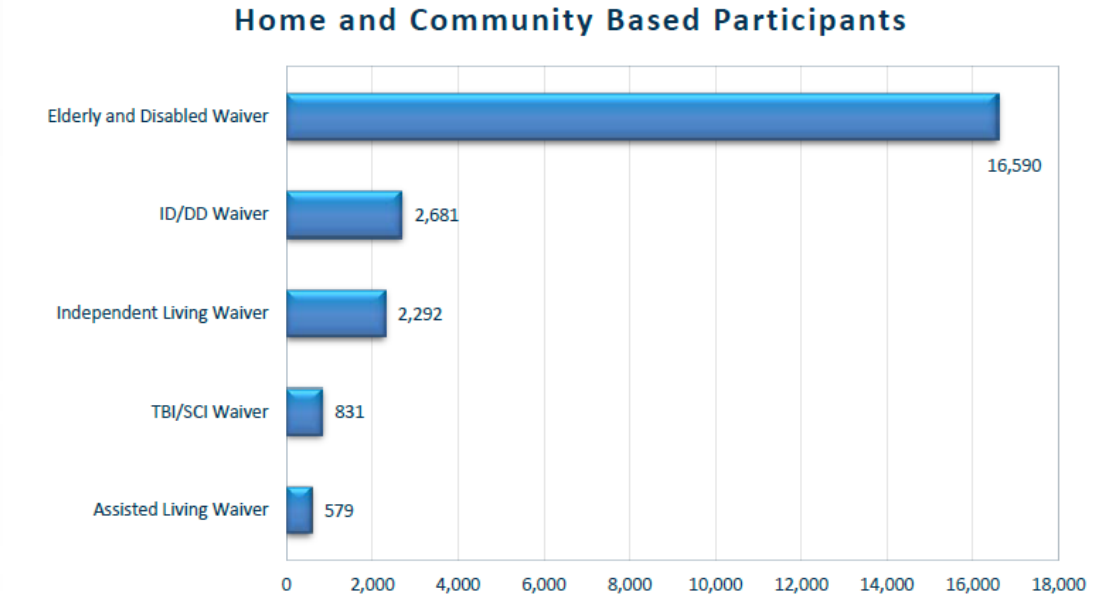
Provider Type Payment Mix

Hospitals receive the highest percentage of Medicaid dollars compared to other provider types

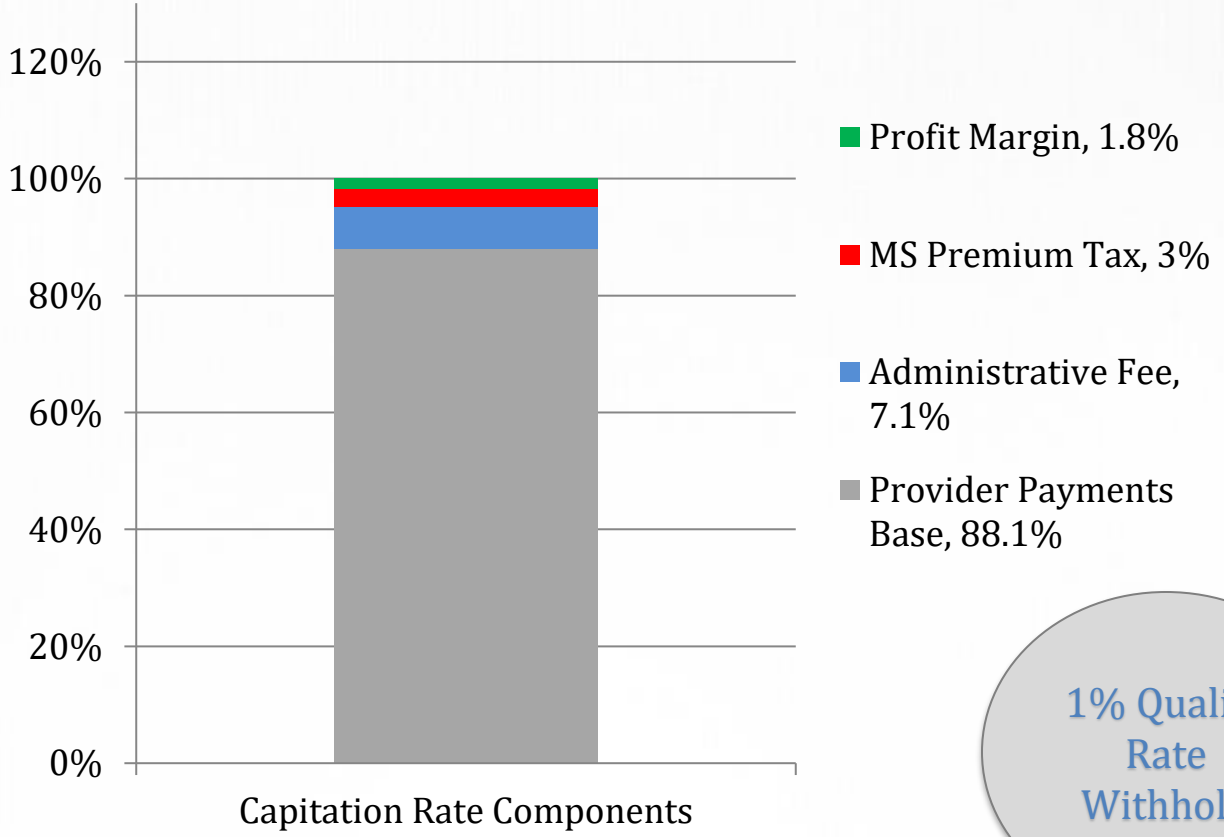


Home and Community Based Services
FY2020





MSCAN Capitation Rate Components



1% Quality Rate Withhold

Note: MHAP is paid directly to hospitals by the CCO's and there is no administrative fee or profit margin adjustment for these payments. Incentive Withhold is deducted from monthly capitation payments.

Capitation Rate – Medical Loss Ratio (MLR)

- The capitation rate paid to the CCOs on a monthly basis provides for a medical payment rate to providers of 88.1%.
- DOM's contract with the CCOs and CMS guidelines require the CCOs to provide a minimum of 85% medical payout.
- DOM regularly monitors the MLR to ensure this medical payout rate is accomplished.
- The current "actual" MLR payout ratio from MSCAN CCOs has exceeded contract requirements.

Capitation Rate – Administrative Expenses

- The capitation rate paid to the CCOs includes an allowance to cover the following administrative expenses:
  - Case management
  - Utilization management
  - Claim processing and other IT functions
  - Customer service
  - Provider contracting and credentialing
  - TPL and program integrity
  - Member grievances and appeals
  - Financial and other program reporting
  - Local overhead costs
  - Corporate overhead and business functions (e.g., legal, executive, human resources)

Provider Payment Timing

- Providers have 180 calendar days to submit claims to the CCOs from the date of service.
- Providers may resubmit denied claims (filed timely) for reconsideration within 90 calendar days from the date of denial.
- CCOs must pay at least 90% of all clean claims for covered services within 30 calendar days of receipt.
- CCOs must pay at least 99% of all clean claims within 90 calendar days of receipt.
- CCOs are subject to liquidated damages (LDs) for non-compliance with contractual requirements.

Provider Payment Timing

- DOM requested a review of the payment timeliness of its three CCOs for the SFY Ended June 30, 2019:

Table 1 – Mississippi CCO Payment Timeliness Totals and Percentages				
Description	Entire Program	Magnolia	Molina	UHC
Net Encounter Total*	16,681,861	8,841,132	792,148	7,048,581
Encounters Paid Within 30 Days	16,578,200	8,766,616	780,602	7,030,982
Percent Paid Within 30 Days	99.38%	99.16%	98.54%	99.75%
Percent Within 30 Days - Contract Requirement	90%			
Encounters Paid Within 90 Days	16,650,915	8,817,858	789,551	7,043,506
Percent Paid Within 90 Days	99.81%	99.74%	99.67%	99.93%
Percent Within 90 Days - Contract Requirement	99%			
Encounters Paid After 90 Days	30,946	23,274	2,597	5,075

Provider Payment Denials

- CCOs are required to send providers written notice and explanation for each claim that is denied.
- If DOM determines that a pattern of inappropriate denials or delay of provider payments exist, it may require a corrective action plan (CAP) or LDs.
- CCOs Average Denials Rate for CY 2019 – 10.4%.
- Top three Denials Categories:
  - Other/Non-classified
  - Duplicate Claims
  - Claims Completion Errors
  - Services Not Covered
  - Timely Filing
- Providers should appeal denied claims to the CCO first. If the denial is upheld by the CCO, providers may request a State Administrative Hearing with DOM.
  - If CCO loses the hearing, it must pay the disputed claim(s) and pay for all associated costs incurred by DOM.

MSCAN 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 2021, the CCOs will be reporting on the following HEDIS measures as a part of their Quality/Incentive risk arrangement:
  - Well Child Visit – First 15 months
  - Anti-Depressant Management – Acute Phase
  - Anti-Depressant management – Continuation Phase
  - Timeliness of Prenatal Care
  - Comprehensive Diabetes Care – HbA1c Testing
- Beginning in SFY 2021, the CCOs will also have the QIPP PPHR reports as a part of their incentive/withhold arrangement with CY 2020 as the Baseline Year.

Contact Information

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