

# MISSISSIPPI MEDICAID REIMBURSEMENT STUDY

Based on Data Ending State Fiscal Year 2017

NAVIGANT

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## Executive Summary

Federal requirements allow each state to determine its own Medicaid rates, but states must comply with the provisions of *42 U.S.C. § 1396a(a)(30)(A)*, which require them to:

*... assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.*

The Mississippi Medical Care Advisory Committee (MCAC), established in *Miss. Code Ann. § 43-13-107(3)(a)*, is required to develop a study and advise the Mississippi Division of Medicaid (DOM) with respect to certain provider reimbursement methodologies and any 5 percent reduction in the rate of reimbursement to all providers. The MCAC is further required to make a report to the Chairmen of the Senate and House Medicaid Committees prior to January 1, 2019, in accordance with *Miss. Code Ann. § 43-13-117(B)*. This section of Code states that:

“... the division shall reduce the rate of reimbursement to providers for any service provided under this section by five percent (5%) of the allowed amount for that service.”<sup>1</sup>

Mississippi Code specifies certain services to which the reduction will and will not apply. The Division of Medicaid is providing technical assistance as needed to enable the MCAC to make effective recommendations to DOM, and engaged Navigant Consulting, Inc. (Navigant) to independently conduct a comprehensive review to estimate the fiscal impact of these recommendations on the State's Medicaid costs and the impact on providers, and to analyze and assess DOM's current reimbursement methodologies and provide recommendations, if appropriate, for changes to rate setting policies. With the assistance of the MCAC Chairman, we prioritized services to include in this study. We conducted the 5 percent fee schedule reduction analysis, as well as the reimbursement methodology analysis. We also compared the Mississippi FFS rates to the FFS rates from three peer states: Alabama, Arkansas, and Louisiana.

Figure 1 on the following page presents a summary of the estimated impact of a reduction of 5 percent in the FFS rate schedules for the selected services. Mississippi's estimated state savings for these select FFS services, is \$1,121,724, represented by applying Mississippi's Medicaid State share to the 5 percent reduction financial impact. Mississippi's Federal Fiscal Year 2017 Federal Medical Assistance Percentage (FMAP) is 74.63 percent.<sup>2</sup>

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<sup>1</sup> Source: <http://www.sos.ms.gov/Education-Publications/Pages/Mississippi-Code.aspx>

<sup>2</sup> Source: <https://www.federalregister.gov/documents/2015/11/25/2015-30050/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for>

**Figure 1: Estimated Impact of Five Percent Reduction Across Select Services (based on SFY 2017 FFS data)**

| Services                                          | SFY 2017 FFS Paid Amount | 5% Reduction Paid Amount | 5% Reduction Financial Impact on Paid Amount | State Savings (FMAP) |
|---------------------------------------------------|--------------------------|--------------------------|----------------------------------------------|----------------------|
| Ambulatory Surgery                                | \$ 1,623,308.33          | \$ 1,542,142.91          | \$ 81,165.42                                 | \$ 20,591.67         |
| Dental                                            | \$ 5,026,899.06          | \$ 4,775,554.11          | \$ 251,344.95                                | \$ 63,766.21         |
| DME                                               | \$ 23,001,880.26         | \$ 21,851,786.25         | \$ 1,150,094.01                              | \$ 291,778.85        |
| Emergency Medical Transportation                  | \$ 4,685,656.07          | \$ 4,451,373.27          | \$ 234,282.80                                | \$ 59,437.55         |
| Laboratory                                        | \$ 6,163,609.89          | \$ 5,855,429.40          | \$ 308,180.49                                | \$ 78,185.39         |
| Mental Health                                     | \$ 46,342,771.75         | \$ 44,025,633.16         | \$ 2,317,138.59                              | \$ 587,858.06        |
| Non-Emergency Medical Transportation <sup>3</sup> | \$ 1,579,822.72          | \$ N/A                   | \$ N/A                                       | \$ N/A               |
| X-Ray <sup>4</sup>                                | \$ 5,254.73              | \$ 4,991.99              | \$ 262.74                                    | \$ 66.66             |
| <i>Total</i>                                      | \$ 88,429,202.81         | \$ 84,007,742.67         | \$ 4,421,460.14                              | \$ 1,121,724.44      |

In addition to reviewing potential impacts and savings, another method to assess payment levels is to compare Mississippi Medicaid FFS rates to other benchmarks, such as comparing Mississippi FFS rates to those of three peer states (Alabama, Arkansas and Louisiana).

To focus the FFS rate comparison, we identified the top 50 Mississippi codes of each identified service, ranked based on payment.<sup>5</sup> Figure 2 on the following page presents a comparison summary of Mississippi Medicaid FFS rates by service type to other peer states' FFS rates, using both the current 2017 rates and the proposed rates (i.e., after a 5 percent reduction). The latter percent represents the Mississippi SFY 2017 FFS rate after a 5 percent reduction is applied, as a percent of the peer states' rates. Additional rate detail for the top 50 Mississippi codes of each identified service and the peer states is available in Appendix A.

<sup>3</sup> Mississippi contracts with a selected vendor to provide Non-Emergency Medical Transportation (NET) services; the majority of NET expense is through the contract with the vendor, and these expenses would not be subject to the 5 percent reduction.

<sup>4</sup> X-Ray expenditures are low because they represent independent radiology only.

<sup>5</sup> Some service types have fewer than 50 distinct procedure codes based on Mississippi FFS paid claims data. These service types include Emergency Medical Transportation, Non-Emergency Medical Transportation and X-Ray Services. For these service areas, we included all the procedure codes for the peer state comparison.

**Figure 2: Summary of Mississippi FFS Reimbursement for Select Services as Compared to FFS Reimbursement in Peer States**

| Service Type                         | Mississippi SFY 2017 Medicaid Rate as a Percent of Peer States' Rates | Mississippi SFY 2017 Medicaid FFS Rate as a Percent of Peer States' Rates after 5% Reduction |
|--------------------------------------|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| Physician Services                   | 127%                                                                  | Not included in rate reduction analysis                                                      |
| • Evaluation and Management Services | 130%                                                                  |                                                                                              |
| • Telehealth                         | 103%                                                                  |                                                                                              |
| Dental Services                      | 149%                                                                  | 142%                                                                                         |
| Laboratory Services                  | 113%                                                                  | 107%                                                                                         |
| Ambulatory Surgical Centers          | 157%                                                                  | 150%                                                                                         |
| DME Purchase                         | 104%                                                                  | 99%                                                                                          |
| Emergency Medical Transportation     | 123%                                                                  | 117%                                                                                         |
| Non-Emergency Medical Transportation | 97%                                                                   | 92%                                                                                          |
| X-Ray Services <sup>6</sup>          | 96%                                                                   | 92%                                                                                          |

Based on the comparison summary of Mississippi Medicaid FFS rates to other peer states' FFS rates, observations include:

- Mississippi Medicaid generally pays higher FFS rates than the average FFS rate of the Medicaid programs in the peer states for the majority of service types reviewed for this study.
- Mississippi Medicaid FFS rates as a percentage of the average of other states' rates range from 96 percent for X-Ray Services (independent radiology only) to 157 percent for Ambulatory Surgical Centers.
- Arkansas' FFS rates are often higher than the rates of all of the peer states and Mississippi.

However, in considering the comparison of FFS rates across states, it is important to also consider characteristics of the general provider and population within each state, as well as indicators of health status within each state and how those affect the delivery and financing of Medicaid. While we do not have a single measure of Medicaid acuity, i.e., how "sick" Medicaid beneficiaries are in Mississippi in comparison to other states, for each state, we considered a number of other population characteristics that create a picture of Mississippi in comparison to these states in terms of beneficiaries, providers, and Medicaid.

<sup>6</sup> X-Ray services represent independent radiology only.

We present select metrics in this report, and note the following:

- Mississippi shows as having the largest uninsured group of the peer states (and so relatively low access to healthcare services).
- Mississippi shows as having the lowest percentage of the population with some kind of private insurance.
- Mississippi has the highest rates of heart disease per 1,000 population and the one of the highest rates of hospital admissions per 1,000 across the peer states.
- All states have shortage areas for both physicians and dentists, with large populations in shortage areas. Mississippi is comparable to Louisiana in the percentage of the population living in a physician shortage area, and has the largest population of the peer states living in a dental shortage area.
  - Physicians per 100,000
    - Mississippi: 218
    - Alabama: 243
    - Arkansas: 234
    - Louisiana: 290
  - Dentists per 100,000
    - Mississippi: 39
    - Alabama: 39
    - Arkansas: 39
    - Louisiana: 47
  - Percent of Population in Primary Care HPSAs
    - Mississippi 59%
    - Alabama: 40%
    - Arkansas: 22%
    - Louisiana: 59%
  - Percent of Population in Dental HPSAs
    - Mississippi: 61%
    - Alabama: 37%
    - Arkansas: 23%
    - Louisiana: 44%
- Mississippi has the lowest number of physicians per 100,000 population of all peer states, and is comparable to Alabama and Arkansas in the number of dentists per 100,000 population.
- Mississippi and Arkansas physicians participated in Medicaid at a higher rate than they did in the other two states in 2016.
- Alabama dentists participated in Medicaid at a higher rate than they did in the other states in 2016.

- Mississippi and Louisiana both cover extensive Medicaid populations through risk-based managed care. Alabama and Arkansas do not use managed care, and so the FFS rates we review in this report are used for a more limited population in Mississippi and Louisiana than in Alabama and Arkansas.
- Louisiana and Arkansas have expanded Medicaid, and so the populations covered by Medicaid will differ for the expansion and non-expansion states.
- In 2016, even without expansion, Mississippi had one of the largest populations as a percent of state population enrolled in Medicaid.
- Selected health risk factors indicate that the general populations across the states are comparable. CMS assigns a risk score (Risk Adjustment Factor) to each Medicare beneficiary which is a relative measure of the probable costs to meet the individual beneficiary's healthcare needs. The RAF helps look at the relative health of a state's population.<sup>7</sup> Mississippi's risk score is comparable to that of Alabama, with Louisiana's score higher than the two and Arkansas' score lower than the two.
- The ACA's risk adjustment program also assigns individual risk scores to each enrollee in individual and small group market plans.<sup>8</sup> The average risk scores are higher for the four peer states than the national average, with Alabama and Arkansas slightly higher than Louisiana and Mississippi, which was the lowest in 2015 (the most recent year available).

We identified other payment models – more specifically, value-based models using alternative payment methodologies – that appear to be more in line with trends in the Mississippi Medicaid program design as well as in other states and among other payers with a goal of improving value in their programs. Since most states are moving away from FFS reimbursement systems, we identified innovative approaches used in the peer states for consideration, recognizing, however, that rate cuts are sometimes needed to balance state budgets and fund other needed state services.

Although this study covers only the FFS rates, it may be the case that the Medicaid capitation rates could also be affected if the 5 percent rate reduction is implemented. Currently, the FFS rates are the “floor” in the fee schedules used by the managed care companies. A reduction, therefore, could result in a decrease in the rates that managed care companies pay their providers. Further, managed care capitation rates are set indirectly using FFS payment rates. It is our experience that Medicaid managed care organizations contract based on Medicaid FFS rates. While we did not study the potential impact of a reduction in rates on managed care, we believe there could be some impact on capitation rates, the rates that managed care companies pay providers, and ultimately the willingness of providers to contract with managed care entities.

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<sup>7</sup> Source: <https://www.aapc.com/risk-adjustment/risk-adjustment-factor.aspx>

<sup>8</sup> KFF analysis of CMS Summary Report on Transitional Reinsurance Payments and Risk Adjustment Transfers for the 2015 Benefit Year, June 30, 2016; source: <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/>

The report that follows provides more detail about these findings and the analysis of payment options, in the following sections:

- A description of the services included in this analysis (Section 1)
- The quantitative impact of an across-the-board reduction in FFS rates for specific services (Section 2)
- A comparison of the Mississippi to three peer southeastern states: Alabama, Arkansas and Louisiana, including FFS rates and methodologies for specific services (Section 3)
- Recommendations for Changes to Reimbursement (Section 4)



## Section 1: Services Selected for Analysis

### Introduction

The Mississippi Medical Care Advisory Committee (MCAC), established in *Miss. Code Ann. § 43-13-107(3)(a)*, is required to develop a study and advise the Mississippi Division of Medicaid (DOM) with respect to certain provider reimbursement methodologies and a 5 percent reduction in the rate of reimbursement to all providers. The MCAC is further required to make a report to the Chairmen of the Senate and House Medicaid Committees prior to January 1, 2019, in accordance with *Miss. Code Ann. § 43-13-117(B)*. This section of Code states that:

“... the division shall reduce the rate of reimbursement to providers for any service provided under this section by five percent (5%) of the allowed amount for that service.”<sup>9</sup>

*Mississippi Code Ann. § 43-13-117(B)* specifies reducing the rate of reimbursement for a number of services. Legislation identifies a specific set of services eligible for a 5 percent reduction. We discussed with the MCAC Chairman which of those services to prioritize for the study and to use to conduct the 5 percent fee schedule reduction analysis, as well as the reimbursement methodology analysis. The services include:

- Ambulatory Surgery Centers (ASCs) – ASCs are distinct entities that operate exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed twenty-four hours following an admission.
- Dental Services – For children under 21, dental services are a necessary component of overall health services; children are eligible for medically necessary dental services, including diagnostic, preventive, therapeutic, emergency, and orthodontic services. For adults, dental services are an adjunct to treatment of an acute medical or surgical condition, including emergency and orthodontic services.
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) – DMEPOS must withstand repeated use; be reusable or removable; are primarily and customarily used to serve a medical purpose; are generally not useful to a person in the absence of a disability, illness, or injury; and are appropriate for use in other than institutional settings.
- Emergency Medical Transportation – There are several components of emergency medical transportation: emergency ground ambulance, emergency air ambulance (helicopter); urgent air ambulance (fixed wing); and non-emergency ground ambulance (transport to another facility when care cannot be provided in the place of residence or medical facility where the patient is an inpatient).

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<sup>9</sup> Source: <http://www.sos.ms.gov/Education-Publications/Pages/Mississippi-Code.aspx>

- Laboratory Services – Performing tests for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment.
- Mental Health Services – Assessment, diagnosis, treatment or counseling in a professional relationship to assist an individual or group in alleviating mental or emotional illness, symptoms, conditions or disorders.
- Non-Emergency Medical Transportation (NEMT) – Services provided through a contract between DOM and Medical Transportation Management (MTM). The State pays a capitated rate for each enrollee (payments are not at-risk). Mississippi contracts with a selected vendor to provide Non-Emergency Medical Transportation (NET) services; the majority of NET expense is through the contract with the vendor, and these expenses would not be subject to the 5 percent reduction.
- X-Ray Services provided by Independent Radiology Providers – Imaging services used to noninvasively and painlessly help to diagnosis disease and monitor therapy; support medical and surgical treatment planning; and guide medical personnel.

In addition to conducting a 5 percent reduction and reimbursement methodology analysis for the services above, Navigant and the MCAC Chairman identified the following additional services to include as part of the reimbursement methodology analysis:

- Nursing Facilities – These services are provided by Medicaid certified nursing homes, which primarily provide three types of services: skilled nursing or medical care and related services; rehabilitation needed due to injury, disability, or illness; long term care, which are health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition).
- Pharmacy – These are services that include retail pharmacies, closed door pharmacies, and institutional pharmacies.
- Physician services, focusing on the Evaluation and Management Services and telehealth – These services refer to the services provided by an individual licensed under state law to practice medicine or osteopathy in an outpatient setting. For the Evaluation and Management services, we conducted additional specific data analyses, since these services are such an integral part of the delivery and financing of primary care services to Medicaid beneficiaries.

Services identified in the *Mississippi Code Ann. § 43-13-117*, as eligible for the rate cut, but excluded from our study, include:

- Chiropractic Services
- Clinic Services
- Early Intervention System Services
- Eyeglasses
- Family Planning Services
- Home and Community Based Services
- Hospice Care Services
- Inpatient Psychiatric Services
- Nurse Practitioner Services
- Pediatric Long-Term Acute Care Hospital Services
- Pediatric Skilled Nursing Services
- Perinatal Risk Management Services

- Periodic Screening and Diagnostic Services
- Physician Assistant Services
- Podiatrist Services
- Targeted Case Management Services

Navigant recognizes that outpatient and inpatient service types account for a large proportion of Mississippi Medicaid expenditures; however, since the legislated 5 percent reduction does not apply to outpatient and inpatient service types, we did not include expenditures for those services in this study.

Before presenting the results for the services included in our study, we believe it is important to put into perspective the relative magnitude of expenditures for these services as a portion of all Medicaid expenditures for these services, as well as the number of beneficiaries receiving those services (unduplicated counts). For our analysis, we relied on State Medicaid paid FFS claims data for State Fiscal Year (SFY) 2017 (July 1, 2016 through June 30, 2017). The total Medicaid expenditure amount for SFY 2017 totaled \$6,169,756,665.<sup>10</sup> As shown in Figure 3 below, payments for the services reviewed for this study represent approximately 1.44 percent of Mississippi’s Total Medicaid Expenditures, paid for approximately 103,000 beneficiaries. The expenditures for the service types listed in Figure 3 are for the select services in the FFS program only; expenditures for other FFS services and managed care are included in the “Other” category (these services are not subject to a 5 percent reduction or are not part of this study).

**Figure 3: Expenditures for Selected Services as a Percent of Total Mississippi Medicaid Expenditures for SFY 2017 and Unduplicated Count of Beneficiaries**

| Service Type                                       | Total State Medicaid Expenditures | Percent of Total State Medicaid Expenditures | Distinct Beneficiary Count | Included/Excluded in Navigant Rate Analysis  |
|----------------------------------------------------|-----------------------------------|----------------------------------------------|----------------------------|----------------------------------------------|
| Mental Health Services                             | \$ 46,342,772                     | 0.75%                                        | 20,547                     | Included in Navigant Rate Reduction Analysis |
| DME                                                | \$ 23,001,880                     | 0.37%                                        | 13,716                     |                                              |
| Laboratory Services                                | \$ 6,163,610                      | 0.10%                                        | 41,207                     |                                              |
| Dental Services                                    | \$ 5,026,899                      | 0.08%                                        | 15,127                     |                                              |
| Emergency Medical Transportation                   | \$ 4,685,656                      | 0.08%                                        | 7,903                      |                                              |
| Ambulatory Surgical Center                         | \$ 1,623,308                      | 0.03%                                        | 2,021                      |                                              |
| Non-Emergency Medical Transportation <sup>11</sup> | \$ 1,579,823                      | 0.03%                                        | 2,365                      |                                              |
| X-Ray Services <sup>12</sup>                       | \$ 5,255                          | 0.00%                                        | 53                         |                                              |
| Total (in 5 percent analysis)                      | \$ 88,429,203                     | 1.44%                                        | 102,939                    |                                              |
| Physician Services                                 | \$ 65,867,541                     | 1.07%                                        | 100,509                    |                                              |
| Nursing Facilities                                 | \$ 756,176,832                    | 12.26%                                       | 17,774                     |                                              |
| Pharmacy                                           | \$ 132,472,423                    | 2.15%                                        | 111,141                    |                                              |
| Other                                              | \$ 5,126,810,667                  | 83.10%                                       | N/A                        |                                              |

<sup>10</sup> Data provided by DOM.

<sup>11</sup> Mississippi contracts with a selected vendor to provide Non-Emergency Medical Transportation (NET) services; the majority of NET expense is through the contract with the vendor, and these expenses would not be subject to the 5 percent reduction.

<sup>12</sup> X-Ray expenditures represent expenditures for independent radiology only.

## Section 2: Rate Reduction Impact Analysis

### Introduction

To determine the impact of a 5 percent reduction in payments for the services described above, we obtained paid FFS claims data from DOM for State Fiscal Year (SFY) 2017 (July 1, 2016, through June 30, 2017). For each of the services, we applied the 5 percent reduction to the paid amounts, assuming that third-party liability and other adjustments to payments would be comparable from SFY 2017 to SFY 2019. Our analysis also assumes that utilization will remain constant, and does not reflect changes in payment that may result from changes in the fee schedules (other than the reductions).<sup>13</sup> While the 5 percent reduction will in practice be applied to Mississippi's fee schedules, Navigant utilized historic paid claims data (SFY 2017) as a predictor for the impact of the reduction on total payments.

**Figure 4: Estimated Impact of Five Percent Reduction Across Select Services (based on Mississippi SFY 2017 FFS data)**

| Services                                           | SFY 2017 Paid Amount | 5% Reduction Paid Amount | 5% Reduction Financial Impact on Paid Amount | State Savings (FMAP) |
|----------------------------------------------------|----------------------|--------------------------|----------------------------------------------|----------------------|
| Ambulatory Surgery                                 | \$ 1,623,308.33      | \$ 1,542,142.91          | \$ 81,165.42                                 | \$ 20,591.67         |
| Dental                                             | \$ 5,026,899.06      | \$ 4,775,554.11          | \$ 251,344.95                                | \$ 63,766.21         |
| DME                                                | \$ 23,001,880.26     | \$ 21,851,786.25         | \$ 1,150,094.01                              | \$ 291,778.85        |
| Emergency Medical Transportation                   | \$ 4,685,656.07      | \$ 4,451,373.27          | \$ 234,282.80                                | \$ 59,437.55         |
| Laboratory                                         | \$ 6,163,609.89      | \$ 5,855,429.40          | \$ 308,180.49                                | \$ 78,185.39         |
| Mental Health                                      | \$ 46,342,771.75     | \$ 44,025,633.16         | \$ 2,317,138.59                              | \$ 587,858.06        |
| Non-Emergency Medical Transportation <sup>14</sup> | \$ 1,579,822.72      | \$ 1,500,831.58          | \$ 78,991.14                                 | \$ 20,040.05         |
| X-Ray <sup>15</sup>                                | \$ 5,254.73          | \$ 4,991.99              | \$ 262.74                                    | \$ 66.66             |
| <i>Total</i>                                       | \$ 88,429,202.81     | \$ 84,007,742.67         | \$ 4,421,460.14                              | \$ 1,121,724.44      |

A 5 percent reduction to the services listed in Figure 4 above is estimated, based on Mississippi FFS claims for SFY 2017, to result in a total savings of \$4,421,460. Navigant estimated

<sup>13</sup> Medicaid enrollment in Mississippi has decreased 4.2% in FY2017, from 708,992 to 678,980; source: <https://medicaid.ms.gov/resources/>

<sup>14</sup> Mississippi contracts with a selected vendor to provide Non-Emergency Medical Transportation services; the majority of net expense is through the contract with the vendor, and these expenses are not considered for the purpose of the study.

<sup>15</sup> X-Ray expenditures represent independent radiology only.

Mississippi's share of the total savings from the proposed 5 percent rate reduction is \$1,121,724 based on the Federal Fiscal Year 2017 Federal Medical Assistance percentage (74.63 percent).

### Considerations Regarding Medicaid Reimbursement

As the MCAC considers the impact of the 5 percent reduction in payment for the services discussed in this report as well as to the additional services identified above, it is important to consider a number of factors, including Federal requirements and the impacts on beneficiaries and providers. In addition, the interrelationship of FFS fee schedules and Medicaid managed care should be considered.

### Federal Requirements

Federal requirements allow each state to determine its own Medicaid rates, but states must comply with the provisions of *42 U.S.C. § 1396a(a)(30)(A)*, which require them to:

*... assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.*

Federal regulations (*42 CFR 447.203*) require states to monitor access to services and determine whether reimbursement is sufficient to assure access, as described in *42 U.S.C. § 1396a(a)(30)(A)*, above. Under these regulations, states must submit to CMS an Access Monitoring Review Plan (AMRP) every three years that assesses access and FFS reimbursement levels for five types of services: primary care, physician specialist, maternity, behavioral health and home health. In addition, states must conduct an access evaluation for any future state plan amendment that reduces provider rates or restructures payments in ways that may reduce access to care for any service type. Access evaluations are expected to address the following:

- The extent to which beneficiary needs are being met
- The availability of care through enrolled providers to beneficiaries by provider type and site of service
- Changes in beneficiary utilization of covered services
- The characteristics of the beneficiary population, including considerations for care, service and payment variations across populations
- Comparison of provider payment levels to other payers, including Medicare and commercial payers

Navigant reviewed Mississippi's 2016 AMRP as part of our analysis, to determine how potential reductions to rates might impact access to services. Mississippi's 2016 AMRP did not specifically identify any access issues for the time period between August 1, 2015, and June 30,

2016. The analysis of the data and information contained in the Mississippi AMRP indicated “Medicaid beneficiaries have access to healthcare that is similar to that of the general population in Mississippi.”<sup>16</sup>

Below are observations from Mississippi’s 2016 Access Monitoring Review Plan, as they relate to the services included in our analysis.

**Figure 5: Observations from Mississippi’s 2016 AMRP for Services Included in Medicaid Reimbursement Study**

| AMRP Service Category                                                                                                                                                   | Service Included in the Medicaid Reimbursement Study                                                                  | Observations                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Primary Care Services – services provided by a physician, federally qualified health center (FQHC), clinic or dentist</li> </ul> | <ul style="list-style-type: none"> <li>Physician Services</li> <li>Dental Services</li> </ul>                         | <ul style="list-style-type: none"> <li>No particular access to care issue</li> <li>78 percent of the beneficiaries identified for the review plan received at least one primary care service</li> </ul> |
| <ul style="list-style-type: none"> <li>Behavioral Health Services – mental health and substance use disorder services</li> </ul>                                        | <ul style="list-style-type: none"> <li>Mental Health Services</li> </ul>                                              | <ul style="list-style-type: none"> <li>26 percent of the beneficiaries identified for the review plan received at least one mental health service</li> </ul>                                            |
| <ul style="list-style-type: none"> <li>Pre- and Post-Natal Obstetric Services – includes labor and delivery services</li> </ul>                                         | <ul style="list-style-type: none"> <li>Maternity Services (Evaluation and Management Procedure Codes only)</li> </ul> | <ul style="list-style-type: none"> <li>No particular access to care issue</li> <li>Approximately 4 percent of the beneficiaries identified for the review plan received a maternity service</li> </ul>  |

Based on federal regulations requiring that states monitor access to services and determine whether reimbursement is sufficient to assure access, states must also conduct an access evaluation for any future state plan amendment that reduces provider rates or restructures payments in ways that may reduce access to care for any service type. CMS may disapprove a proposed state plan amendment affecting payment rates if the state does not include an access evaluation with its submission.<sup>17</sup>

<sup>16</sup> Source: <https://medicaid.ms.gov/wp-content/uploads/2016/09/Access-Monitoring-Review-Plan.pdf>

<sup>17</sup> A Proposed Rule ([https://www.federalregister.gov/documents/2018/03/23/2018-05898/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services-exemptions-for-states-with -Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold](https://www.federalregister.gov/documents/2018/03/23/2018-05898/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services-exemptions-for-states-with-Medicaid-Program-Methods-for-Assuring-Access-to-Covered-Medicaid-Services-Exemptions-for-States-With-High-Managed-Care-Penetration-Rates-and-Rate-Reduction-Threshold)) would provide exemptions for the following: states with comprehensive, risk-based Medicaid managed care enrollment rates above 85 percent their Medicaid population; and reductions of four percent or less in overall spending for the service category during a state fiscal year and six percent or less over 2 consecutive SFYs. Additionally, states would only be required to submit to CMS an assurance that its data indicates “current access is consistent requirements of the Social Security Act” instead of an analysis anticipating the effects of a proposed change in

Therefore, if DOM proposes a rate reduction or changes to payment methodologies for the services mentioned above, it is expected to submit an access evaluation document to CMS to address the following:

- The extent to which beneficiary needs are being met
- The availability of care through enrolled providers to beneficiaries by provider type and site of service
- Changes in beneficiary utilization of covered services
- The characteristics of the beneficiary population, including considerations for care, service and payment variations across populations
- Comparison of provider payment levels to other payers, including Medicare and commercial payers

### Relationship Between Medicaid FFS Rates and Medicaid Managed Care (Medicaid Coordinated Care Organizations, or CCOs)

While this study addresses only the FFS program, it is possible that a 5 percent rate reduction could impact Medicaid managed care in Mississippi. There is a relationship between FFS and managed care in that managed care capitation payments to state CCOs are set indirectly using FFS payment rates, as managed care companies generally contract off the Medicaid fee schedule. Capitation rates are generally set using the rates currently paid by managed care organizations, as long as they appear reasonable, attainable, and appropriate. It is Navigant's experience that many managed care organizations contract based off of Medicaid rates (or Medicare occasionally) so when the fee schedule changes, the managed care organization's payment rates change, too. This in turn affects the capitation rates. However, we are also aware that some actuaries assume rates will not change when the fee schedule decreases. It depends on the feedback received from CCOs and how the CCOs contract.

Further, the Mississippi Medicaid CCOs reimburse all network providers at a rate "no less than the amount that DOM reimburses FFS providers."<sup>18</sup> Thus, the Medicaid FFS rates act as a price floor for the reimbursement flowing to provider organizations. Reducing FFS reimbursement by 5 percent will allow the Mississippi's CCOs to reimburse providers at lower rates. While we are not suggesting that the CCOs will make those changes, it is possible that they may.

Additional analysis would be needed to determine the full impact of rate reductions on the CCOs, but consideration should be given that for certain providers, a cut in payments may discourage them from accepting new managed care enrollees or continuing as managed care providers.

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payment rates or structure.

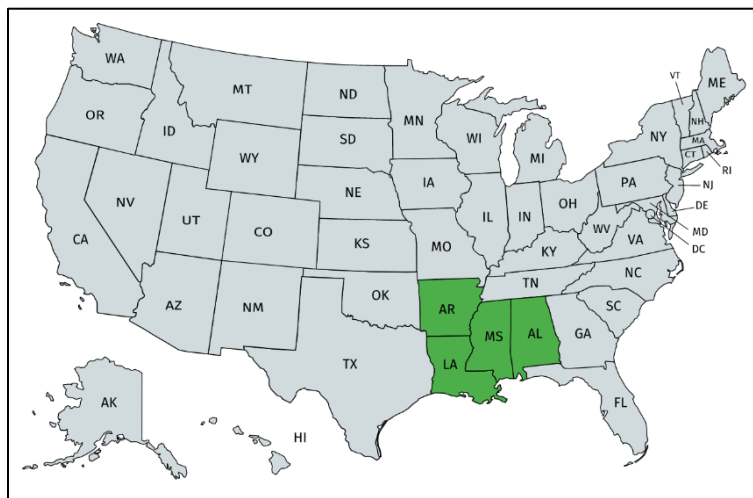
<sup>18</sup> Source: <https://medicaid.ms.gov/wp-content/uploads/2018/07/Managed-Care-Quality-Strategy-submitted-to-CMS-7.23.18.pdf>

## Section 3: Comparison of FFS Rates and Methodologies to Those of Three Peer States

### Introduction

States typically compare their own reimbursement rates and methodologies to those of other relevant states' Medicaid programs, Medicare and commercial payers. Comparisons to other states' Medicaid rates could potentially provide Mississippi Medicaid with relevant benchmarks, but it is important to consider that states have different reimbursement methodologies so direct rate comparisons may be difficult in some situations.

For purposes of this report, we compared Mississippi Medicaid FFS rates to Medicaid FFS rates for the states of Alabama, Arkansas and Louisiana. We also identified these states' reimbursement methodologies to further provide some clarification about rates. DOM requested that any comparison to other states' reimbursement methodologies be to states with "like demographics and provider accessibility. 'Like' information includes patient acuity level, Medicaid population, physician to patient ratio, income levels, and urban vs. rural populations." We reviewed a number of southeastern states to identify peer states and, in collaboration with the Medical Care Advisory Committee Chairman, concluded that Alabama, Arkansas and Louisiana would provide meaningful data for comparison purposes.



### Characteristics of Mississippi and the Peer States

In considering the comparison of FFS rates across states, it is important to also consider characteristics of the general provider and population within each state, as well as indicators of health status within each state and how those affect the delivery and financing of Medicaid. While we do not have a single measure of Medicaid acuity, i.e., how "sick" Medicaid beneficiaries are in Mississippi in comparison to other states, for each state, we considered a



number of other population characteristics that create a picture of Mississippi in comparison to these states in terms of beneficiaries, providers, and Medicaid.

Figure 6 below shows all the population characteristics collected for Mississippi and the peer states and is followed by Figure 7 and Figure 8, showing snapshots of key state characteristics, respectively, for health insurance coverage and provider coverage.

**Figure 6: Mississippi and Peer State Demographic Data**

| Demographic Category                                     | Timeframe         | Mississippi     | Alabama         | Arkansas                                                                                   | Louisiana                                                       |
|----------------------------------------------------------|-------------------|-----------------|-----------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <b>General State and Medicaid Information</b>            |                   |                 |                 |                                                                                            |                                                                 |
| State Population <sup>19</sup>                           | 2016              | 2,948,100       | 4,834,100       | 2,945,300                                                                                  | 4,578,500                                                       |
| Total Medicaid Spend <sup>20</sup>                       | 2017              | \$5,479,389,523 | \$5,593,422,991 | \$6,422,604,379                                                                            | \$11,038,274,292                                                |
| Total Medicaid Enrollment <sup>21</sup>                  | 2018              | 638,956         | 899,824         | 878,537                                                                                    | 1,449,055                                                       |
| Percentage of Medicaid to State Population <sup>22</sup> | 2016              | 21.67%          | 18.61%          | 29.83%                                                                                     | 31.65%                                                          |
| Medicaid Expansion Date                                  | N/A               | N/A             | N/A             | 4/23/2013                                                                                  | 7/1/2016                                                        |
| Medicaid Expansion Population                            | N/A               | N/A             | N/A             | Up to 138 percent of the Federal Poverty Level, with requirements to work <sup>23,24</sup> | Up to 138 percent of the Federal Poverty Level <sup>25,26</sup> |
| Total MCO Spend <sup>27</sup>                            | 2016              | \$2,519,670,607 | N/A             | N/A                                                                                        | \$3,920,822,599                                                 |
| Total MCO Enrollment <sup>28</sup>                       | 2018              | 457,903         | N/A             | N/A                                                                                        | 1,479,366                                                       |
| Percentage of MCO Enrollment to State Population         | N/A <sup>29</sup> | 16%             | N/A             | N/A                                                                                        | 32%                                                             |

<sup>19</sup> Source: Kaiser Family Foundation <https://www.kff.org/other/state-indicator/total-residents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7Dn>

<sup>20</sup> Source: <https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>21</sup> Source: <https://www.medicaid.gov/state-overviews/index.html>

<sup>22</sup> Source: Calculated field provided by DOM (based on State Population and Total Enrollment data in the table)

<sup>23</sup> <http://www.modernhealthcare.com/article/20180305/NEWS/180309952>

<sup>24</sup> <https://www.advisory.com/daily-briefing/resources/primers/medicaidmap>

<sup>25</sup> <https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-1>

<sup>26</sup> <http://ldh.la.gov/assets/medicaid/AnnualReports/MedicaidAnnualReport2017.pdf>

<sup>27</sup> Source: <https://www.kff.org/other/state-indicator/total-medicaid-mco-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>28</sup> Source: <https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/>

<sup>29</sup> These ratios are calculated using data from two timeframes: Total MCO Enrollment (2018) is divided by State Population (2016)

| Demographic Category                                                        | Timeframe         | Mississippi | Alabama   | Arkansas | Louisiana |
|-----------------------------------------------------------------------------|-------------------|-------------|-----------|----------|-----------|
| <b>Provider Supply</b>                                                      |                   |             |           |          |           |
| <b>Physicians</b>                                                           |                   |             |           |          |           |
| Total Physicians <sup>30</sup>                                              | 2018              | 6,424       | 11,755    | 6,932    | 13,275    |
| Physicians per 100,000                                                      | N/A <sup>31</sup> | 218         | 243       | 234      | 290       |
| Primary Care <sup>32</sup>                                                  | 2018              | 3,145       | 5,777     | 3,419    | 6,177     |
| Specialists <sup>33</sup>                                                   | 2018              | 3,279       | 5,978     | 3,513    | 7,098     |
| Medicaid to Medicare Fee Index <sup>34</sup>                                | 2016              | 89%         | 75%       | 80%      | 70%       |
| Medicaid Physician Fee Index <sup>35</sup>                                  | 2016              | 1.17        | 0.95      | 0.98     | 0.97      |
| Percentage of Physicians that Participate in Medicaid or CHIP <sup>36</sup> | 2013              | 83.20%      | 67.50%    | 89.90%   | 56.80%    |
| Total Primary Care HPSA Designations <sup>37,38</sup>                       | 2017              | 117         | 99        | 103      | 144       |
| Population of Designated Primary Care HPSAs <sup>39</sup>                   | 2017              | 1,747,991   | 1,919,497 | 656,572  | 2,719,568 |
| Population in Primary Care                                                  | N/A <sup>40</sup> | 59%         | 40%       | 22%      | 59%       |

<sup>30</sup> Source: <https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&selectedDistributions=total&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>31</sup> These ratios are calculated using data from two timeframes: Total Physicians (March 2018) is divided by State Population (2016), then multiplied by 100,000

<sup>32</sup> Source: <https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>33</sup> Source: <https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&selectedDistributions=specialist-physicians&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>34</sup> Medicaid-to-Medicare fee index measures each state's physician fees relative to Medicare fees in each state. Source: <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>35</sup> The Medicaid Physician Fee Index measures each state's physician fees relative to national average Medicaid fees.

Source: <https://www.kff.org/medicaid/state-indicator/medicaid-fee-index/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>36</sup> Source: <https://www.cdc.gov/nchs/data/databriefs/db195.pdf>

<sup>37</sup> Health Professional Shortage Area (HPSA) designations are used to identify areas and population groups experiencing a shortage of health professionals. For primary medical care, the population to provider ratio must be at least 3,500 to 1;

source: <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>38</sup> Source: <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>39</sup> Source: <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>40</sup> These ratios are calculated using data from two timeframes: Population in Primary Care HPSAs (2017) is divided by State Population (2016)

| Demographic Category                                                      | Timeframe         | Mississippi | Alabama   | Arkansas | Louisiana |
|---------------------------------------------------------------------------|-------------------|-------------|-----------|----------|-----------|
| HPSA / Total Population                                                   |                   |             |           |          |           |
| Percent of Primary Care Need Met <sup>41</sup>                            | 2017              | 41.16%      | 57.58%    | 62.60%   | 68.19%    |
| <b>Dentists</b>                                                           |                   |             |           |          |           |
| Dentists <sup>42</sup>                                                    | 2018              | 1,159       | 1,893     | 1,157    | 2,146     |
| Dentists per 100,000                                                      | N/A <sup>43</sup> | 39          | 39        | 39       | 47        |
| Orthodontists <sup>44</sup>                                               | 2018              | 52          | 116       | 56       | 115       |
| Orthodontists per 100,000                                                 | N/A <sup>45</sup> | 2           | 2         | 2        | 3         |
| Pedodontists <sup>46</sup>                                                | 2018              | 52          | 81        | 46       | 80        |
| Percentage of Dentists that Participate in Medicaid or CHIP <sup>47</sup> | 2016              | 64.80%      | 74.20%    | 63.90%   | 41.30%    |
| Total Dental Care HPSA Designations <sup>48,49</sup>                      | 2017              | 110         | 64        | 84       | 117       |
| Population of Designated Dental Care HPSAs <sup>50</sup>                  | 2017              | 1,798,158   | 1,792,743 | 673,677  | 2,006,437 |
| Population in Dental HPSA / Total Population                              | N/A <sup>51</sup> | 61%         | 37%       | 23%      | 44%       |
| Percent of Dental Need Met <sup>52</sup>                                  | 2017              | 46.17%      | 20.37%    | 38.46%   | 54.26%    |

<sup>41</sup> Source: <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>42</sup> Source: <https://www.kff.org/other/state-indicator/total-dentists/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>43</sup> These ratios are calculated using data from two timeframes: Dentists (2018) is divided by State Population (2016), then multiplied by 100,000

<sup>44</sup> Source: <https://www.kff.org/other/state-indicator/dentists-by-specialty-field/?currentTimeframe=0&selectedDistributions=orthodontist&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>45</sup> These ratios are calculated using data from two timeframes: Orthodontists (2018) is divided by State Population (2016), then multiplied by 100,000

<sup>46</sup> Source: <https://www.kff.org/other/state-indicator/dentists-by-specialty-field/?currentTimeframe=0&selectedDistributions=pedodontist&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>47</sup> Source: [https://www.ada.org/-/media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic\\_0217\\_1.pdf?la=en](https://www.ada.org/-/media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic_0217_1.pdf?la=en)

<sup>48</sup> Health Professional Shortage Area (HPSA) designations are used to identify areas and population groups experiencing a shortage of health professionals. For dental care, the population to provider ratio must be at least 5,000 to 1;

source: <https://www.kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>49</sup> Source: <https://www.kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>50</sup> Source: <https://www.kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>51</sup> These ratios are calculated using data from two timeframes: Population in Dental HPSAs (2017) is divided by State Population (2016)

<sup>52</sup> Source: <https://www.kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

| Demographic Category                                               | Timeframe | Mississippi | Alabama | Arkansas | Louisiana |
|--------------------------------------------------------------------|-----------|-------------|---------|----------|-----------|
| <b>Health Insurance Coverage of the Population<sup>53</sup></b>    |           |             |         |          |           |
| Medicaid                                                           | 2016      | 24%         | 21%     | 21%      | 25%       |
| Medicare                                                           | 2016      | 14%         | 16%     | 17%      | 14%       |
| Uninsured                                                          | 2016      | 12%         | 9%      | 8%       | 11%       |
| Other                                                              |           |             |         |          |           |
| Employer                                                           | 2016      | 42%         | 47%     | 44%      | 42%       |
| Non-Group                                                          | 2016      | 5%          | 5%      | 9%       | 6%        |
| Other Public                                                       | 2016      | 3%          | 3%      | 2%       | N/A       |
| <b>Selected Health Status and Risk Factors (all population)</b>    |           |             |         |          |           |
| Heart Disease Death Rate per 100,000 <sup>54</sup>                 | 2016      | 233.1       | 222.5   | 223.7    | 213.1     |
| Hospital Admission Rates per 1,000 <sup>55</sup>                   | 2016      | 127         | 130     | 118      | 117       |
| National Rank for Hospital Admission Rates per 1,000 <sup>56</sup> | 2016      | 4           | 3       | 12       | 13        |
| Medicare Average Risk Score <sup>57</sup>                          | 2016      | 0.975       | 0.973   | 0.951    | 1.028     |
| Average Individual Market Plan Liability Risk Score <sup>58</sup>  | 2015      | 1.076       | 1.150   | 1.250    | 1.094     |

It is not the purpose of this report to examine each of the metrics presented above across all the states, however, for purposes of our rate review, we highlight the following but provide an additional snapshot of insurance coverage and provider coverage in Figures 7 and 8 below.

- Mississippi and Arkansas physicians participated in Medicaid at a higher rate than they did in the other two states in 2016.
- Alabama dentists participated in Medicaid at a higher rate than they did in the other states in 2016.

[hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D](https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D)

<sup>53</sup> Source: <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>54</sup> Source: <https://www.kff.org/other/state-indicator/number-of-deaths-due-to-diseases-of-the-heart-per-100000-population/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>55</sup> Source: <https://www.kff.org/other/state-indicator/admissions-by-ownership/?currentTimeframe=0&selectedDistributions=total&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>56</sup> Source: <https://www.kff.org/other/state-indicator/admissions-by-ownership/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Total%22,%22sort%22:%22desc%22%7D>

<sup>57</sup> <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data-Items/2019Rates.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descendin>

<sup>58</sup> KFF analysis of CMS Summary Report on Transitional Reinsurance Payments and Risk Adjustment Transfers for the 2015 Benefit Year, June 30, 2016; source: <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/>

- Selected health risk factors indicate that the general populations across the states are comparable. CMS assigns a risk score (Risk Adjustment Factor) to each Medicare beneficiary which is a relative measure of the probable costs to meet the individual beneficiary’s healthcare needs. The RAF helps look at the relative health of a state’s population.<sup>59</sup> Mississippi’s risk score is comparable to that of Alabama, with Louisiana’s score higher than the two and Arkansas’ score lower than the two.
- The ACA’s risk adjustment program also assigns individual risk scores to each enrollee in individual and small group market plans.<sup>60</sup> The average risk scores are higher for the four peer states than the national average, with Alabama and Arkansas slightly higher than Louisiana and Mississippi, which was the lowest in 2015 (the most recent year available).
- Mississippi and Louisiana both cover extensive Medicaid populations through risk-based managed care. Alabama and Arkansas do not use managed care, and so the FFS rates we review in this report are used for a more limited population in Mississippi and Louisiana than in Alabama and Arkansas.
- Louisiana and Arkansas have expanded Medicaid, and so the populations covered by Medicaid will differ for the expansion and non-expansion states.
- In 2016, even without expansion, Mississippi had one of the largest populations as a percent of state population enrolled in Medicaid.

Health Insurance Coverage Snapshot

Figure 7: Health Insurance Coverage of the Population

| Demographic Category                                            | Timeframe | Mississippi | Alabama | Arkansas | Louisiana |
|-----------------------------------------------------------------|-----------|-------------|---------|----------|-----------|
| <b>Health Insurance Coverage of the Population<sup>61</sup></b> |           |             |         |          |           |
| Medicaid                                                        | 2016      | 24%         | 21%     | 21%      | 25%       |
| Medicare                                                        | 2016      | 14%         | 16%     | 17%      | 14%       |
| Uninsured                                                       | 2016      | 12%         | 9%      | 8%       | 11%       |
| Other                                                           |           |             |         |          |           |
| Employer                                                        | 2016      | 42%         | 47%     | 44%      | 42%       |
| Non-Group                                                       | 2016      | 5%          | 5%      | 9%       | 6%        |
| Other Public                                                    | 2016      | 3%          | 3%      | 2%       | N/A       |

- Mississippi shows as having the largest uninsured group of the peer states (and so relatively low access to healthcare services).

<sup>59</sup> Source: <https://www.aapc.com/risk-adjustment/risk-adjustment-factor.aspx>

<sup>60</sup> KFF analysis of CMS Summary Report on Transitional Reinsurance Payments and Risk Adjustment Transfers for the 2015 Benefit Year, June 30, 2016; source: <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/>

<sup>61</sup> Source: <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

- Mississippi shows as having the lowest percentage of the population with some kind of private insurance.

Provider Coverage Snapshot

Figure 8: Provider Coverage of the Population

| Demographic Category                                               | Timeframe         | Mississippi | Alabama   | Arkansas  | Louisiana |
|--------------------------------------------------------------------|-------------------|-------------|-----------|-----------|-----------|
| <b>Population</b>                                                  |                   |             |           |           |           |
| State Population <sup>62</sup>                                     | 2016              | 2,948,100   | 4,834,100 | 2,945,300 | 4,578,500 |
| Heart Disease Death Rate per 100,000 <sup>63</sup>                 | 2016              | 233.1       | 222.5     | 223.7     | 213.1     |
| Hospital Admission Rates per 1,000 <sup>64</sup>                   | 2016              | 127         | 130       | 118       | 117       |
| National Rank for Hospital Admission Rates per 1,000 <sup>65</sup> | 2016              | 4           | 3         | 12        | 13        |
| <b>Physicians</b>                                                  |                   |             |           |           |           |
| Total Physicians <sup>66</sup>                                     | 2018              | 6,424       | 11,755    | 6,932     | 13,275    |
| Physicians per 100,000                                             | N/A <sup>67</sup> | 218         | 243       | 234       | 290       |
| Primary Care <sup>68</sup>                                         | 2018              | 3,145       | 5,777     | 3,419     | 6,177     |
| Specialists <sup>69</sup>                                          | 2018              | 3,279       | 5,978     | 3,513     | 7,098     |

<sup>62</sup> Source: Kaiser Family Foundation <https://www.kff.org/other/state-indicator/total-residents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>63</sup> Source: <https://www.kff.org/other/state-indicator/number-of-deaths-due-to-diseases-of-the-heart-per-100000-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>64</sup> Data is for community hospitals (i.e. all nonfederal, short-term general, and specialty hospitals whose facilities and services are available to the public). Federal hospitals, long term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals are not included. source:

<https://www.kff.org/other/state-indicator/admissions-by-ownership/?currentTimeframe=0&selectedDistributions=total&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>65</sup> Source: <https://www.kff.org/other/state-indicator/admissions-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%22,%22sort%22:%22desc%22%7D>

<sup>66</sup> Source: <https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&selectedDistributions=total&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>67</sup> These ratios are calculated using data from two timeframes: Total Physicians (March 2018) is divided by State Population (2016), then multiplied by 100,000

<sup>68</sup> Source: <https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>69</sup> Source: <https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&selectedDistributions=specialist-physicians&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

| Demographic Category                                      | Timeframe         | Mississippi | Alabama   | Arkansas | Louisiana |
|-----------------------------------------------------------|-------------------|-------------|-----------|----------|-----------|
| Total Primary Care HPSA Designations <sup>70,71</sup>     | 2017              | 117         | 99        | 103      | 144       |
| Population of Designated Primary Care HPSAs <sup>72</sup> | 2017              | 1,747,991   | 1,919,497 | 656,572  | 2,719,568 |
| Population in Primary Care HPSA / Total Population        | N/A <sup>73</sup> | 59%         | 40%       | 22%      | 59%       |
| Percent of Primary Care Need Met <sup>74</sup>            | 2017              | 41.16%      | 57.58%    | 62.60%   | 68.19%    |
| <b>Dentists</b>                                           |                   |             |           |          |           |
| Dentists <sup>75</sup>                                    | 2018              | 1,159       | 1,893     | 1,157    | 2,146     |
| Dentists per 100,000                                      | N/A <sup>76</sup> | 39          | 39        | 39       | 47        |
| Orthodontists <sup>77</sup>                               | 2018              | 52          | 116       | 56       | 115       |
| Orthodontists per 100,000                                 | N/A <sup>78</sup> | 2           | 2         | 2        | 3         |
| Total Dental Care HPSA Designations <sup>79,80</sup>      | 2017              | 110         | 64        | 84       | 117       |
| Population of Designated Dental Care HPSAs <sup>81</sup>  | 2017              | 1,798,158   | 1,792,743 | 673,677  | 2,006,437 |

<sup>70</sup> Health Professional Shortage Area (HPSA) designations are used to identify areas and population groups experiencing a shortage of health professionals. For primary medical care, the population to provider ratio must be at least 3,500 to 1; source: <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>71</sup> Source: <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>72</sup> Source: <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>73</sup> These ratios are calculated using data from two timeframes: Population in Primary Care HPSAs (2017) is divided by State Population (2016)

<sup>74</sup> Source: <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>75</sup> Source: <https://www.kff.org/other/state-indicator/total-dentists/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>76</sup> These ratios are calculated using data from two timeframes: Dentists (2018) is divided by State Population (2016), then multiplied by 100,000

<sup>77</sup> Source: <https://www.kff.org/other/state-indicator/dentists-by-specialty-field/?currentTimeframe=0&selectedDistributions=orthodontist&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>78</sup> These ratios are calculated using data from two timeframes: Orthodontists (2018) is divided by State Population (2016), then multiplied by 100,000

<sup>79</sup> Health Professional Shortage Area (HPSA) designations are used to identify areas and population groups experiencing a shortage of health professionals. For dental care, the population to provider ratio must be at least 5,000 to 1; source: <https://www.kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>80</sup> Source: <https://www.kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>81</sup> Source: <https://www.kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

| Demographic Category                         | Timeframe         | Mississippi | Alabama | Arkansas | Louisiana |
|----------------------------------------------|-------------------|-------------|---------|----------|-----------|
| Population in Dental HPSA / Total Population | N/A <sup>82</sup> | 61%         | 37%     | 23%      | 44%       |
| Percent of Dental Need Met <sup>83</sup>     | 2017              | 46.17%      | 20.37%  | 38.46%   | 54.26%    |

- Mississippi has the highest rates of heart disease per 1,000 population and the one of the highest rates of hospital admissions per 1,000 across the peer states.
- All states have shortage areas for both physicians and dentists, with large populations in shortage areas. Mississippi is comparable to Louisiana in the percentage of the population living in a physician shortage area, and has the largest population of the peer states living in a dental shortage area.
  - Physicians per 100,000
    - Mississippi: 218
    - Alabama: 243
    - Arkansas: 234
    - Louisiana: 290
  - Dentists per 100,000
    - Mississippi: 39
    - Alabama: 39
    - Arkansas: 39
    - Louisiana: 47
  - Percent of Population in Primary Care HPSAs
    - Mississippi 59%
    - Alabama: 40%
    - Arkansas: 22%
    - Louisiana: 59%
  - Percent of Population in Dental HPSAs
    - Mississippi: 61%
    - Alabama: 37%
    - Arkansas: 23%
    - Louisiana: 44%
- Mississippi has the lowest number of physicians per 100,000 population of all peer states, and is comparable to Alabama and Arkansas in the number of dentists per 100,000 population.

<sup>82</sup> These ratios are calculated using data from two timeframes: Population in Dental HPSAs (2017) is divided by State Population (2016)

<sup>83</sup> Source: <https://www.kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>



Based on the snapshots and data above, Mississippi has fewer physicians for its population, serving a greater number of sicker patients.

### Methodology for Comparing FFS Rates for Each Service Area

To develop the FFS rate comparison for each service area reviewed within this study, we took the following steps:

1. Reviewed Mississippi's Medicaid FFS SFY 2017 claims data and determined the top 50 procedure codes with the highest total expenditures for each service type<sup>84</sup>
2. Identified the FFS fee schedule amount for each of the 50 codes for Mississippi and the three peer states
3. Calculated an all-peer state average rate for each procedure code
4. Calculated Mississippi's rate as a percentage of the all-peer state average rate for each procedure code
5. Averaged the proportion of Mississippi's FFS reimbursement rates to the peer states' FFS rates across the top procedure codes to arrive at the Mississippi Rate as Percent of Peer State Average value

### Summary of Comparisons of Mississippi FFS Rates to Rates of Peer FFS States

We present a summary of the results of our analyses in Figure 9 for each of the service areas. We provide in Appendix A the tables that show the top 50 procedures, and the comparisons to the peer states. Appendix B shows the top 50 procedure codes, including the procedure code description and total expenditures by code. Below, we summarize for each service the Mississippi rate in comparison the average of the three peer states' rates. We also show the impact on the comparison if the rates are reduced 5 percent.

We include information for physician services, even though those services are not included in the 5 percent rate reduction. We did not, however, provide this same information for nursing home rates (peer states did not provide that information) or pharmacy with the exception of dispensing fees (comparisons are difficult given the variety and types of services).

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<sup>84</sup> Some service types have fewer than 50 distinct procedure codes based on Mississippi FFS paid claims data. These service types include Emergency Medical Transportation, Non-Emergency Medical Transportation and X-Ray Services. For these service areas, we included all the procedure codes for the peer state comparison.

**Figure 9: Summary Comparison of Mississippi SFY 2017 Medicaid FFS Rates to Peer States' FFS Rates, by Service Type**

| Service Type                         | Mississippi SFY 2017 Medicaid Rate as a Percent of Peer States' Rates | Mississippi SFY 2017 Medicaid Rate as a Percent of Peer States' Rates after 5% Reduction |
|--------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| Physician Services                   | 127%                                                                  | No rate reduction                                                                        |
| • Evaluation and Management Services | 130%                                                                  |                                                                                          |
| • Telehealth                         | 103%                                                                  |                                                                                          |
| Dental Services                      | 149%                                                                  | 142%                                                                                     |
| Laboratory Services                  | 113%                                                                  | 107%                                                                                     |
| Ambulatory Surgical Centers          | 157%                                                                  | 150%                                                                                     |
| DME Purchase                         | 104%                                                                  | 99%                                                                                      |
| Emergency Medical Transportation     | 123%                                                                  | 117%                                                                                     |
| Non-Emergency Medical Transportation | 97%                                                                   | 92%                                                                                      |
| X-Ray Services <sup>85</sup>         | 96%                                                                   | 92%                                                                                      |

Below are observations regarding the FFS rate comparisons for each of the service types.

#### Physician Services

Mississippi's FFS physician services reimbursement rates are on average 127 percent of the reimbursement rates of the peer states. In general, Mississippi's rates are higher than all the peer states' rates. In general, Mississippi's rates for physician services are higher than the rates of the peer states.

#### Dental Services

Mississippi's FFS dental services reimbursement rates are on average 149 percent of the reimbursement rates of the peer states. Given the proposed 5 percent reduction, Mississippi's reduced FFS dental services reimbursement rates would be on average 142 percent of the reimbursement rates of the peer states. In general, Arkansas' dental rates are higher than Mississippi's and the rates of other two states.

In addition to the comparison of Mississippi dental rates to the rates of peer states, DOM also requested that we compare Mississippi FFS rates to rates paid by managed care organizations. We were unable to obtain dental rates paid by managed care companies for either Louisiana or Mississippi, however.

Instead, we compared Mississippi Medicaid FFS rates to commercial rates for Mississippi and the peer states. This may be helpful as there are no Medicare rates for comparison purposes or

<sup>85</sup> X-Ray services represent independent radiology only.

for benchmarking rate data and we find that states nationally often benchmark their Medicaid dental rates to rates paid by commercial insurers.

The American Dental Association publishes a survey of dental fees for general practitioners. The ADA 2016 Survey of Dental Fees breaks out states into regions. Mississippi and the peer states are grouped into the following regions for the ADA Survey:

- East South Central (Alabama, Kentucky, Mississippi, Tennessee)
- West South Central (Arkansas, Louisiana, Oklahoma, Texas)

We compared the rates of the top 50 Mississippi dental FFS procedures to the average payment rate for these procedure codes for each of these two regions.

Compared to the East South Central Region Average Rate, Mississippi's dental FFS rates were 61 percent of the region average. Only one of the fees for the Mississippi procedure codes in comparison to the East South Central region was above 100 percent of the regional average rate:

- D7286 – Incisional Biopsy of Oral Tissue - Soft (123 percent of regional average rate)

Mississippi's dental FFS rates were 59 percent of the West South Central Region Average Rate. Only two of the procedure codes in its comparison to the East South Central region were above 100 percent of the regional average rate:

- D7286 – Incisional Biopsy of Oral Tissue - Soft (120 percent of regional average rate)
- D7410 – Excision of Benign Lesion up to 1.25 CM (113 percent of regional average rate)

### Evaluation and Management Services

We conducted an analysis of certain Evaluation and Management service procedure codes. These procedure codes were also included in the analysis because of the importance of these services to Medicaid patients. The Evaluation and Management services are the core services delivered by family practices, which are critical to the Medicaid population. For a detailed breakout of Evaluation and Management codes by procedure code type, refer to Appendix A.

Mississippi's FFS Evaluation and Management reimbursement rates are on average 130 percent of the reimbursement rates of the peer states, and in general are higher than the other states' rates. For additional detail regarding E/M procedure codes, refer to Appendix A.

### Telehealth

Part of the Evaluation and Management procedure codes reviewed include Telemedicine. In addition to E/M Telemedicine procedures codes, DOM reimburses the originating site a telehealth originating site facility fee for telehealth services per completed transmission (procedure code Q3014). Mississippi's rate for this procedure code is the same as Alabama's rate and rates for Arkansas and Louisiana were not available for SFY 2017. Effective August 1,

2018, Arkansas Medicaid will cover the originating site facility fee for dates of service on or after April 10, 2018.<sup>86</sup>

### Laboratory Services

Mississippi's FFS laboratory reimbursement rates are on average 113 percent of the reimbursement rates of the peer states. Given the proposed 5 percent reduction, Mississippi's reduced FFS laboratory reimbursement rates would be on average 107 percent of the reimbursement rates of the peer states. In general, Arkansas' rates for laboratory services are higher than the rates of the peer states.

### Ambulatory Surgical Centers

Mississippi's FFS Ambulatory Surgical Center reimbursement rates are on average 157 percent of the reimbursement rates of the peer states. Given the proposed 5 percent reduction, Mississippi's reduced FFS Ambulatory Surgical Center reimbursement rates would be on average 150 percent of the reimbursement rates of the peer states. In general, Arkansas' ASC rates are higher than Mississippi's and the other two states.

### DME Purchase and Rental

Mississippi's FFS DME purchase reimbursement rates are on average 104 percent of the reimbursement rates of the peer states. Given the proposed 5 percent reduction, Mississippi's reduced FFS DME purchase reimbursement rates would be on average 99 percent of the reimbursement rates of the peer states.

Mississippi's FFS DME rental reimbursement rates are on average 71 percent of the reimbursement rates of the peer states. Given the proposed 5 percent reduction, Mississippi's reduced FFS DME rental reimbursement rates would be on average 68% percent of the reimbursement rates of the peer states. However, these averages are based on only one procedure code (E1390), since the majority of Mississippi's top 50 procedure codes by expenditures are DME purchase codes or some procedure codes did not have a full range of peer state rates.

### Emergency Medical Transportation

Mississippi's FFS emergency medical transportation reimbursement rates are on average 123 percent of the reimbursement rates of the peer states. Given the proposed 5 percent reduction, Mississippi's reduced FFS emergency medical transportation reimbursement rates would be on average 117 percent of the reimbursement rates of the peer states. In general, the Arkansas and Louisiana reimbursement rates are higher than the Mississippi and Alabama rates.

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<sup>86</sup> Source: <http://www.arkleg.state.ar.us/assembly/2017/Meeting%20Attachments/430/509/Exhibit%20I%20-DHS-Telemedicine.pdf>

### Non-Emergency Medical Transportation

Mississippi's FFS non-emergency transportation reimbursement rates are on average 97 percent of the reimbursement rates of the peer states. Given the proposed 5 percent reduction, Mississippi's reduced FFS non-emergency transportation reimbursement rates would be on average 92 percent of the reimbursement rates of the peer states. Mississippi contracts with a selected vendor to provide Non-Emergency Medical Transportation (NET) services; the majority of NET expense is through the contract with the vendor, and these expenses would not be subject to the 5 percent reduction.

### X-Ray Services (Independent Laboratory)

Mississippi's FFS X-ray reimbursement rates are on average 96 percent of the reimbursement rates of the peer states. Given the proposed 5 percent reduction, Mississippi's reduced FFS X-ray reimbursement rates would be on average 92 percent of the reimbursement rates of the peer states. In general, Arkansas' rates for x-ray services are higher than the rates of the peer states.

### Pharmacy

While there are limitations to direct comparisons for Pharmacy, below are the dispensing fees for Mississippi and the three peer states.

**Figure 10: Pharmacy Dispensing Fees for Mississippi and Peer States**

|                | Mississippi | Alabama | Arkansas                                | Louisiana |
|----------------|-------------|---------|-----------------------------------------|-----------|
| Dispensing Fee | \$11.29     | \$10.64 | \$9.00 – Brand and non-preferred brands | \$11.29   |

### Other States' Reimbursement Methodology

It is important to consider states' reimbursement methodologies. In reviewing the state reimbursement methodologies for Mississippi and the peer states, for the services of this study, many of the methodologies follow the Medicare program, paying a percentage of the associated Medicare fee schedule. In general, states pay the lower of the fee schedule or billed charges for services. Alabama has more of a customized approach within their reimbursement methodology. For additional information on reimbursement methodologies refer to Appendix C.

## Section 4: Recommendations for Changes to Reimbursement

As part of our study, DOM requested that we examine other reimbursement methodology options, including the fiscal impact of these recommendations and why they would be more appropriate.

Before considering whether any reimbursement methodology options might have specific programmatic features that could be applied in Mississippi, it will be necessary to establish the objectives of any future changes in reimbursement or delivery system change. State policymakers may consider, for example, goals such as:

- Reduction in total cost of care for each beneficiary and overall
- Budgetary goals
- Creation of provider networks that assure access to quality services for Medicaid beneficiaries
- Improved outcomes
- More appropriate utilization, i.e., utilization of services in the most appropriate settings of care
- Value
- Provider and beneficiary satisfaction

States often differ in terms of how they define their goals, and rank them as their priorities in terms of the Medicaid program. Whatever the states' priorities are in relation to this list, they should consider the potential unintended consequences of changes. For example, as we presented in Section 3, physician and dentist shortages exist; changes to methodologies should consider their impacts on supply of providers. The peer state findings demonstrate the differences in current state reimbursement policies and rates. We have not, for this study, evaluated the specific Mississippi Medicaid goals and objectives for the Medicaid program; our work is specific to the scope specified in the RFP, as we describe in Section 1 of this report.

### Health Service Models

Below, we describe models for health services financing that may be more in line with current Mississippi initiatives focused on value, including those used by the peer states. The discussion that follows is not intended to be inclusive of every innovative approach or alternative payment methodology used by the peer states. Nor do we suggest that any or all of these can be easily implemented in Mississippi. We provide these examples to illustrate the types of value-based programs the peer states are implementing or considering, to evolve their fee-for-service systems. Specific elements of these programs might be valuable for Mississippi consideration.

### Risk-Based Managed Care

States have implemented risk-based managed care for their Medicaid programs, with the goal of controlling costs, improving beneficiary health, and providing a more accountable and

coordinated system of care that emphasizes preventive services. As of July 2017, 39 states, including Mississippi, have a form of risk-based managed care in their Medicaid programs.

- **Mississippi** Medicaid has implemented risk-based managed care for the SSI, Working Disabled (ages 19-65), Disabled Child Living at Home, Foster Care Children with IV-E and CWS, Foster Care Children with Adoption Assistance, TANF, Pregnant Women, Newborn, Children and Quasi-CHIP (ages 6-19) population. Beginning in October 2018, the 1915(i) Intellectual/Developmental Disabilities Community Support Program (IDD CSP), Psychiatric Residential Treatment Facilities (PRTF) and Mississippi Youth Programs Around the Clock (MYPAC) program are also included in MississippiCAN. Beneficiaries not eligible to participate in the MississippiCAN program include: nursing home residents or residents of an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID); beneficiaries institutionalized in a facility that is not a Psychiatric Residential Treatment Facility; beneficiaries enrolled in a waiver program; Medicare-eligible beneficiaries; and beneficiaries with hemophilia.

As of 2018, MississippiCAN covered approximately 68 percent of Medicaid beneficiaries and accounted for 47 percent of Medicaid expenditures.<sup>87,88</sup>

- **Louisiana** has a risk-based managed care program. During SFY 2017, approximately 93 percent of unduplicated eligible individuals were enrolled in Medicaid managed care and accounted for 45.4 percent of Medicaid expenditures.<sup>89,90</sup> Louisiana's Medicaid Managed Care program includes physical health, basic and behavioral health services, as well as pharmacy, dental, hospice, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Personal Care services.<sup>91</sup>

Louisiana also provides managed care through the Louisiana Behavioral Health Partnership (LBHP) and the Dental Benefits Program. The managed care programs can have overlapping enrollment, and some managed care enrollees may receive services through FFS. Medicaid populations excluded from in SFY 2017 individuals receiving limited Medicaid benefits or single service only; over age 21 residing in an ICF/DD; enrolled in the Program for All-Inclusive Care for the Elderly (PACE); Medicare dual eligibles with incomes between 75 percent and 135 percent of the FPL for whom Medicaid paid only the Medicare Part B monthly premium, and enrollees below 100 percent FPL with limited Medicare crossover payments as the secondary payer; individuals with a limited period of eligibility; and populations within specified programs

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<sup>87</sup> Source: <https://medicaid.ms.gov/wp-content/uploads/2018/07/Managed-Care-Quality-Strategy-submitted-to-CMS-7.23.18.pdf>

<sup>88</sup> Source: <https://www.kff.org/other/state-indicator/total-medicaid-mco-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>89</sup> Source: <http://ldh.la.gov/assets/medicaid/AnnualReports/MedicaidAnnualReport2017.pdf>

<sup>90</sup> Source: <https://www.kff.org/other/state-indicator/total-medicaid-mco-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>91</sup> Source: <http://ldh.la.gov/assets/docs/BayouHealth/2017Act212/2017TR20180629.pdf>

including: Refugee Cash Assistance, Refugee Medical Assistance, Long-Term Care Co-Insurance and Qualified Disabled Working Individuals.<sup>92</sup>

Louisiana 's managed behavioral health services program has a carve-out program administered by a managed care contractor called the Coordinated System of Care (CSoC), designed to create a coordinated network of services and supports for children and youth with behavioral health challenges and their families. This program's goal is to ensure that young people in or at risk of out-of-home placement with significant behavioral health challenges are able to receive the supports and services they need.

- **Arkansas** has implemented a managed care program for dental services for Medicaid, effective January 1, 2018. Two dental vendors provide the same dental services that are covered under the current Medicaid FFS program. The vendors will serve all members who receive dental services through Medicaid except for those residing in Human Development Centers, individuals enrolled in the Program for All Inclusive Care for the Elderly (PACE), members who reside in a nursing home setting, and individuals who are eligible for Medicaid only after incurring medical expenses that cause them to "spend down" to Medicaid eligibility levels.<sup>93</sup>

### Patient Centered Medical Homes and Health Homes

The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the most simple to the most complex conditions. Health Homes provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions.

States are implementing PCMHs both within and outside of managed care plans. PCMHs and Medical Homes may incorporate risk, quality bonuses and shared savings. For example, the State may withhold the PMPM payment if establish cost or quality thresholds are not met. Or, the PCMH or medical home can receive a shared savings payment if cost and possibly quality thresholds are met or exceeded.

According to a 2017 Survey by the Kaiser Family Foundation and the National Association of Medicaid Directors, 30 states have a PCMH program in place, and another 12 programs are in the planning phase.<sup>94</sup> Twenty-one states have a Health Home program and another 7 programs are in the planning phase.

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<sup>92</sup> Source: <http://ldh.la.gov/assets/medicaid/AnnualReports/MedicaidAnnualReport2017.pdf>

<sup>93</sup> Source: <https://medicaid.mmis.arkansas.gov/general/Programs/dntmgdcare.aspx>

<sup>94</sup> Source: Kaiser Family Foundation, Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018, October 2017



To date, many states have implemented PCMHs and over time, the outcomes as reported by health policy researchers have been mixed. More recently, however, research is pointing to better outcomes for PCMHs, particularly those that achieve NCQA recognition. Implementation of PCMHs comes with significant costs for medical practices, however, and it is important to consider how those costs might be funded in the design of new programs, as well as the attributes of successful PCMH programs.<sup>95</sup>

A 2018 evaluation of the first 13 programs in 11 states (includes Alabama) by the U.S. Department of Health and Social Services suggests these programs have "...the potential for improvements in care management and care coordination, care transitions, the integration and physical and behavioral health, access to nonclinical services, patient engagement, and the use of health information technology (HIT). In addition, quantitative results highlight the potential for improved utilization patterns, cost, and quality as a result of the health home programs."<sup>96</sup>

- **Alabama** – The Alabama Medicaid Agency (AMA) has operated a statewide Primary Care Case Management (PCCM) program for the State’s Medicaid beneficiaries since January 1, 1997, to provide Medicaid beneficiaries a medical home. Alabama’s PCCM program is branded as Patient 1<sup>st</sup>.<sup>97</sup> To be eligible for a Health Home, beneficiaries must have two chronic conditions, one chronic condition and the risk of developing another, or specific behavioral health conditions.
  - Approximately 250,000 beneficiaries are served by Health Homes; however, Health Homes actively manage only about 1 percent of the population. Each Health Home receives \$9.50 per member per month (PMPM) for an annual cost of approximately \$25 million. Each PMP contracting with a Health Home and participating in AMA’s medical home program receives \$8.50 PMPM for managing a member enrolled into a Health Home, for an annual cost of approximately \$22.5 million. Each PMP receives \$1.50 PMPM for all other assigned individuals, approximately 500,000 non-chronic members are assigned to medical homes. All services provided to members are reimbursed on a fee-for-service (FFS) basis.
  - The Health Home is responsible for providing coordination with Primary Medical Providers (PMPs) to ensure that best practices are being followed for management of chronic conditions; transitional care to support beneficiaries when discharged from an inpatient or residential setting; and care coordination, including developing a care plan, facilitating care between PMPs and behavioral health providers, conducting risk assessments, identifying any necessary community and social support resources, and educating beneficiaries on health literacy and outcomes; and medication reconciliation.

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<sup>95</sup> Source: <https://www.healthaffairs.org/doi/10.1377/hblog20180905.807827/full/>

<sup>96</sup> Source: <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/medicaidhomehealthstateplanoptionrtc.pdf>

<sup>97</sup> Health Homes are authorized by Section 2703 of the Affordable Care Act.

- The PMP is responsible for providing medical care and participating in the Multidisciplinary Care Team, reviewing utilization data on beneficiaries each month to help achieve Health Home goals and quality improvement initiatives and participating in the medication reconciliation process
- **Alabama** will be implementing a new Health Home Program, called the Alabama Coordinated Health Network (ACHN), likely in the Spring of 2019. This will replace the current health home and additional other programs. The AMA designed the ACHN program to address several concerns about the existing Health Home program, including that Health Homes are not managing enough members or that they are managing the wrong members (e.g., individuals with lower dollar medical spend or members that would not benefit from additional care coordination).
  - AMA will pay Network Entities (NE) a lower per member per month (PMPM) fee (\$1.50 PMPM) than the current Health Home program. AMA will also pay NEs for specific Case Management (CM) activities. The CM activity payments will be based upon CM audit information; higher levels of case management (e.g., face-to-face) will pay higher rates than lower levels of case management (e.g., a phone call). The program will annually cap the total amount paid to an individual NE. NEs can be paid up to, but not more than, the cap.
  - Physicians will no longer receive a PMPM, and AMA will continue to pay for all services through FFS payments. Primary care physicians choosing to participate with the ACHN will be eligible for increased reimbursement for select Evaluation and Management codes. Participating primary care physicians will also be eligible for incentive payments, which will be a yearly Equality Bonus payment based upon NEs achieving quality measures at sufficient levels. Medicaid will make these annual payments to each NE, and then each NE pays its qualifying providers quarterly. These payments will be based on: quality (50 percent), cost-effectiveness (45 percent) and PCMH status (5 percent).
- **Arkansas** created the Arkansas Patient-Centered Medical Home Program as one component of the Arkansas Health Care Payment Improvement Initiative, which was designed to derive value for the dollars it spends on Medicaid, and specifically, to prevent drastic cuts in payments to providers. The PCMH program rewards team-based care and promotes early intervention to reduce complications and associated health care costs. The program rewards providers enrolled in the PCMH program who meet defined metrics of care coordination and general practice investment, and who practice transformation.
  - The care coordination payment is risk adjusted (e.g., ranging from \$1 to \$30 per attributed beneficiary per month) based on factors including demographics (age, sex), diagnoses and utilization. After each quarter, DMS may pay, recover, or offset the care coordination payments to ensure that a practice did not receive a care

- coordination payment for any beneficiary who died or lost eligibility if the practice lost eligibility during the quarter.
- To receive these monthly PMPMs, practices must demonstrate that they have implemented and are performing numerous activities integral to building a medical home structure. These activities include providing 24/7 live voice access to a health professional, identification of and formulation of care plans for high-risk patients, flexible same-day scheduling, installment of meaningful use certified electronic health records, assessment of operations and opportunities for improvement, and other practice enhancements related to a PCMH framework.

### Episodic or Bundled Payments

Under this payment approach, payments revolve around a patient's specific condition or procedure (e.g., joint replacement, surgery, or pregnancy). Bundled payments can reflect a set of services provided by the same provider or by a team of providers. After the payment for the episode is determined, providers are held to the episodic rate regardless of their actual costs of delivering the care. This model gives providers an incentive to coordinate care to control costs.

- **Arkansas** has implemented a bundled payment approach as another component of the Arkansas Health Care Payment Improvement Initiative. Arkansas's Episodes of Care model is designed for conditions that require care coordination and intensive use of resources. In an Episode of Care, payers identify a principal accountable provider (PAP) to manage the quality and minimize treatment variations. Through identified opportunities to improve quality and reduce complications for the entire episode, pre-established performance expectations enable PAPs to benefit from system efficiencies. Quarterly reports detail individual performance metrics for each PAP. Providers are eligible to share in any savings that occur if they achieve quality targets. PAPs with average costs above an acceptable threshold are subject to share risks and excess costs.

According to a 2017 Survey by the Kaiser Family Foundation and the National Association of Medicaid Directors, 6 states have a bundled payment program in place, and another 7 states are in the planning phase.<sup>98</sup>

Arkansas and Tennessee have both preliminarily reported savings. Arkansas has achieved savings from 2 to 39 percent per bundle in its first year, while Tennessee has saved \$14.5M in its first year (2016).<sup>99,100</sup>

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<sup>98</sup> Source: Kaiser Family Foundation, Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018, October 2017.

<sup>99</sup> Timeframe: 2014; source: [http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD\\_Bailit-Health\\_Value-Based-Purchasing-in-Medicaid.pdf](http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf)

<sup>100</sup> Source: TennCare, 2016 TennCare Episode of Care Results, 2017.

### Accountable Care Organizations (ACOs)

ACOs are formally structured groups of healthcare providers who are collectively held responsible for the health needs of Medicaid patients assigned to the ACO. Medicaid pays an ACO as one entity, sometimes with a global, population-based payment, and it is the ACO's responsibility to distribute payment to the participating providers and organizations. While Medicaid ACOs are in use in more than 15 states, they are not in use in the study states.

According to a 2017 Survey by the Kaiser Family Foundation and the National Association of Medicaid Directors, 13 states have an ACO program in place, and another 6 states are in the planning phase for ACO development.<sup>101</sup> Given the relative “newness” of the programs, there are limited results available, but programs in Colorado and Oregon, for example, have achieved cost savings and improved outcomes:

- **Colorado** uses an Accountable Care Collaborative (ACC) model to expand medical home services for the adult and pediatric Medicaid population. To receive monthly PMPMs, practices must demonstrate that they have implemented and are performing numerous activities integral to building a medical home structure. These activities include providing 24/7 live voice access to a health professional, identification of and formulation of care plans for high-risk patients, and flexible same-day scheduling. The program has resulted in an average cost reduction of \$60 PMPM for adults and \$20 PMPM for children.<sup>102</sup> In addition to \$77 million in net savings for Colorado Medicaid, the program has demonstrated lower rates of emergency department visits, high-cost imaging and hospital readmissions for adults enrolled for six months or more.<sup>103</sup>
- **Oregon** uses a coordinated care model where the coordinated care organizations (CCOs) provide physical health care, addictions and mental health care and dental care to Medicaid patients. Its CCOs have demonstrated improved quality measures and reduced growth in Medicaid spending.<sup>104</sup>

### Dual Integration models

These delivery and financing models integrate Medicare and Medicaid services for the dually eligible beneficiaries. CMS has awarded design contracts to 15 states to develop and test new integrated delivery system models for dually eligible individuals. None of the study states is involved in these models.

### Other Coordinated Care Models

In addition to the above models, the peer states in our study have implemented a number of other initiatives designed to achieve value.

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<sup>101</sup> Source: Kaiser Family Foundation, Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018, October 2017.

<sup>102</sup> Source: <https://www.colorado.gov/pacific/sites/default/files/ACC%20Evaluation%20Full%20Report.pdf>

<sup>103</sup> Source: <https://www.chcs.org/media/ACO-Fact-Sheet-02-27-2018-1.pdf>

<sup>104</sup> Source: <https://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/CCO-Metrics-2016-Final-Report.pdf>

- **Alabama** is implementing an Integrated Care Network (ICN) program, a Primary Care Case Management program designed to provide more community options for Medicaid long-term care beneficiaries. With the ICN program, the State will implement a system with managed care components, including a strong emphasis on case management, outreach, and adjusting the long-term services and supports program (LTSS) balance of institutional versus home and community-based services (HCBS) utilization. The ICN program is for Medicaid beneficiaries who live in a nursing facility or receive services in their homes through Medicaid's Elderly and Disabled waiver or the Alabama Community Transition waiver. The ICN will complement and enhance the current system by introducing tools to better manage the medical and LTSS needs of beneficiaries, educating beneficiaries and other stakeholders about the full array of LTSS options, and working with participants to promote LTSS use in the least restrictive setting.

The ICN program primarily pays for activities, with a portion of that payment withheld based on quality outcomes. The ICN will receive a per member, per month payment (PMPM) that will cover the enhanced case management, education, and outreach activities that are not delivered currently. The PMPM will also cover HCBS case management activities. The ICN will be required to contract with local Area Agencies on Aging (AAAs) to deliver HCBS case management services for the first two years of the program. The ICN must reimburse the AAAs for HCBS case management services at a minimum rate equal to the prevailing Medicaid FFS payment schedule, unless otherwise jointly agreed to by a AAA and the ICN. The ICN will be held accountable for increasing the percentage of members living in HCBS settings compared to a baseline. To hold the ICN accountable, the Agency will withhold ten percent of the ICN's PMPM payments to fund a withhold pool. The Agency will distribute withhold pool funds to the ICN if the ICN is successful in improving the mix of members residing in HCBS settings (as opposed to nursing facilities) compared to a target set by the Agency.

- **Arkansas** has implemented PASSE (Provider-Led Arkansas Shared Savings Entity), (October 2017) to address the needs of individuals who have intensive behavioral health and intellectual and developmental disabilities service needs. The PASSE program is designed to help people not only connect to services from their doctors but also services in the community that those members might need. The goal is for the PASSE to help improve people's health and let them take a more active role in their treatment. Through care coordination, the PASSE will help connect primary care physicians with specialty behavioral health providers and developmental disabilities services providers to create a complete plan of care for each member. The care coordinator will also work with the members, their families and guardians, and people in the community to support the members to keep them healthy and safe. Each member will have an opportunity to create goals for treatment, and the care coordinator will work with the member's family to help each member achieve those goals.<sup>105</sup>

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<sup>105</sup> Source: <https://humanservices.arkansas.gov/about-dhs/dms/passe>

## Fee-for-Service Changes

In the past, Medicaid reimbursement methodology changes were often focused on ways to improve provider efficiency through refining fee schedules. More recently, healthcare payers – public and private – have been moving providers away from the more traditional FFS payment systems, which reward volume, to value-based purchasing activity, broadly defined as any activity that a state Medicaid program is undertaking to hold a provider or a contracted managed care organization accountable for the costs and quality of the care they provide or pay for in the case of a managed care organization. Alternative Payment Models build on a foundation of FFS or managed care systems, or a mix of both. These approaches generally leverage incentives to improve cost efficiency, coordination, and quality.

In general, the FFS methodologies used by Mississippi are comparable to those of the peer states. While fee schedule amounts may be higher in some cases, we would not recommend rate across-the-board cuts as a reimbursement methodology option, at least not without further delineation of the goals of Medicaid, and specifically the value the State wants to derive from the Medicaid program. In addition, as we have pointed out throughout the report, even though we have selected peer states for comparison purposes, there are still significant differences across these states that should be considered in evaluating the results of one-to-one comparisons.

Many of the states that have recently made changes in their FFS methodologies have focused on services in addition to those included in our study, for example, inpatient and outpatient hospital reimbursement.

- States continue to move to APR-DRG systems to pay hospitals, as has Mississippi.
- States are moving to Enhanced Ambulatory Patient Groupings (EAPGs) that bundles payment into groups for classification, payment and risk adjustment. EAPGs apply to outpatient hospital services, ASC services and other outpatient settings. States continue to move to systems for ASCs that increase equity in payment levels for services, while still recognizing the service settings create differences in costs.
- States are developing approaches to pay for “true emergencies” in emergency departments, and to create payment differentials for non-emergency services provided in the Emergency Department. While diagnosis cannot be used solely as the determinant of whether an emergency exists, CMS allows state to:

“...establish a reasonable, clinically-based method to distinguish emergency from non-emergency visits. The application of this method must occur after a hospital has fulfilled its Emergency Medical Treatment and Labor Act (EMTALA) obligations...but before any further evaluation or treatment is provided....”<sup>106</sup>

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<sup>106</sup> CMS Center for Medicaid & CHIP Services, CMCS Informational Bulletin, *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care Settings* (January 16, 2014), p. 6.; source: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-16-14.pdf>

States, and their managed care companies, continue to adopt policies that implement provisions for more efficient use of the Emergency Department.

### Other Considerations

As we describe in Section 3, Mississippi experiences shortages of both physicians and dentists for the general population; provider participation rates are a concern for Medicaid programs nationally. However, more frequently, states are moving to ensure that their provider networks that are in place are comprised of providers that demonstrate the quality standards that the state endorses. States have implemented new quality standards through their managed care organizations and in FFS programs through some of the Value-Based Programs identified above (e.g., PCMH, Health Home, bundled payment initiatives, ACOs).

As we describe above, it is important that the State develop its priorities for reimbursement methodology change as it considers alternatives. Should Mississippi implement a 5 percent reduction in fee schedule rates for the services identified above (and the additional services not included in our data analysis), the reduction in expenditures will be immediate. However, the change in reimbursement does not address any new priorities or goals the state might seek to achieve.