#555

Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER)

Report to
the Mississippi Legislature

An Evaluability Assessment of the Mississippi Coordinated Access Network

Managed care encompasses a variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care, primarily through increased care coordination. In the Second Extraordinary Session of 2009, the Legislature authorized the Division of Medicaid (DOM) to implement a managed care program on or after January 1, 2010. The legislation also required the PEER Committee to conduct a comprehensive performance evaluation of the program by December 15, 2011.

The DOM selected Magnolia and UnitedHealthcare to implement the Mississippi Coordinated Access Network (MSCAN) managed care program. The DOM implemented MSCAN on January 1, 2011, with the goals of improving access to and quality of care and reducing state expenditures for Medicaid. Because MSCAN is still not fully operational in terms of a functioning performance accountability structure, PEER refocused this review from an evaluation of actual performance to an evaluability assessment of whether the DOM is collecting adequate information to allow a comprehensive performance evaluation in the future.

PEER determined the following with regard to MSCAN's evaluability in the three areas of cost savings, quality of care, and access to care:

- Due to limited program data availability, MSCAN's actual cost savings cannot be calculated until completion of the actuarial consultant's capitation rate and inpatient cost targets analysis. This analysis will occur once the first program year has been completed.
- Operational definitions of the MSCAN quality requirements are in place based on the sources of general measures that the Division of Medicaid will utilize in monitoring the quality of program providers' service structures. However, the program does not have clearly defined outcome measures and performance targets for quality of care.
- Both Magnolia and UnitedHealthcare produce maps that may be utilized to measure access in terms of distance and time of travel for MSCAN enrollees, but these maps do not necessarily reflect enrollees' actual utilization of active providers. Further, no other extensive access measures are readily available on how MSCAN might improve enrollees' access to care in comparison to those eligible beneficiaries who did not enroll in MSCAN.

This report lists specific suggested steps to ensure future evaluability of MSCAN and includes additional recommendations regarding the managed care program.

November 15, 2011

PEER: The Mississippi Legislature's Oversight Agency

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A joint committee, the PEER Committee is composed of seven members of the House of Representatives appointed by the Speaker and seven members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms, with one Senator and one Representative appointed from each of the U. S. Congressional Districts and three at-large members appointed from each house. Committee officers are elected by the membership, with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of four Representatives and four Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues that may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, special investigations, briefings to individual legislators, testimony, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, and the agency examined.

The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

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November 15, 2011

Honorable Haley Barbour, Governor
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Honorable Billy McCoy, Speaker of the House
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On November 15, 2011, the PEER Committee authorized release of the report entitled **An Evaluability Assessment of the Mississippi Coordinated Access Network.**

Harvey Moss

Representative Harvey Moss, Chair

This report does not recommend increased funding or additional staff.

Table of Contents

Table of Contents (continued)

List of Exhibits

An Evaluability Assessment of the Mississippi Coordinated Access Network

Executive Summary

Introduction

Statutory Mandate

During its 2009 Second Extraordinary Session, the Mississippi Legislature passed House Bill 71 (now codified as MISS. CODE ANN. Section 43-13-117 [1972]), which contained several provisions designed to control Medicaid costs, including a provision authorizing the Division of Medicaid (DOM) to implement a managed care program on or after January 1, 2010. The bill included a mandate for the PEER Committee to conduct a comprehensive performance evaluation of the program by December 15, 2011.

Problem Statement

For PEER to conduct a comprehensive performance evaluation of the Mississippi Coordinated Access Network (MSCAN) program by the legislatively mandated deadline, the following information would need to be available to serve as the basis for the evaluation:

- *operational (i. e., measurable) definitions of the key components* of the evaluation, as established in state law--i. e., quality of care to the beneficiaries, access to care by the beneficiaries, and cost savings to the Division of Medicaid;
- *program performance goals and objectives* for each of the key program evaluation components, both long-term and short-term; and,
- *comprehensive, valid, accurate and reliable performance data* (including benchmark data) collected over a period of at least one year from full implementation of the program, measuring the program's success in achieving its goals and objectives, and ideally measuring the success of the Medicaid managed care program relative to the Medicaid fee-for-service program.

Early in this review, PEER determined that while the Division of Medicaid was statutorily authorized to implement managed care on or after January 1, 2010,

MSCAN was not implemented until January 1, 2011, and is still not fully operational in terms of a functioning performance accountability structure.

As a result, PEER refocused this review from an evaluation of actual performance to an evaluability assessment of whether the Division of Medicaid is collecting adequate information to allow a comprehensive performance evaluation by a date certain in the future. PEER cautions that such a performance evaluation should take place before the Legislature considers any changes to the Medicaid managed care program in Mississippi.

Background: Managed Care and Delivery of Medicaid Services

Medicaid has traditionally been provided in a fee-for-service delivery system. Fee-for-service is a method for the administration of the Medicaid program whereby provider participation is open to all providers that meet state requirements. Under a fee-for-service system, providers are reimbursed for each unit of service delivered.

A growing concern is that the traditional fee-for-service system has the potential for Medicaid providers to provide many services as an economic incentive, which may contribute to rising Medicaid costs. As a result of this concern, many states have shifted from the traditional fee-for-service system to a managed care system for their respective Medicaid programs to reduce and stabilize costs and gain greater budget control.

Managed care is a term used to describe a variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care, primarily through increased care coordination. The primary method for paying Medicaid managed care programs is through capitation, whereby the state agency pays a managed care organization a per member per month payment based on program enrollment.

The Division of Medicaid's Implementation of the Mississippi Coordinated Access Network

The Division of Medicaid selected two providers to implement MSCAN and entered into contracts with Magnolia and UnitedHealthcare to provide these services until December 31, 2013. On January 1, 2011, the division implemented MSCAN, with the goals of improving access to and quality of care and reducing state expenditures for Medicaid. As of September 2011, the program had complied with all state-mandated requirements and most federal requirements. According to the division's staff, the

program is in the process of complying with the remaining federal requirements or will have complied upon completion of the first full program year.

The contracts between the Division of Medicaid and the managed care organizations established reporting requirements, including periodic reporting of financial, quality, and access data. As of September 2011, both managed care organizations (MCOs) had complied with all contractual reporting requirements to date. However, the MCOs cannot fulfill some of the contractual reporting requirements until completion of the first MSCAN program year.

MSCAN's Cost Savings: Performance Measures, Impact, and Evaluability

The Division of Medicaid considers its capitation rates (which are designed to ensure a ten percent net savings to the state) and savings guarantee program (a financial incentive to the MCOs to save at least ten percent on inpatient hospital services) to be its cost savings performance measures.

PEER could not calculate documented cost savings of MSCAN to date because of delays in financial reporting by the managed care organizations. This was compounded by delays in submitting encounter and claims data to the DOM data system because of coding errors. However, Milliman (the actuarial firm that DOM retained to calculate capitation rates to be paid to the MCOs) is scheduled to review actual MSCAN expenditures in comparison to capitation rates and inpatient hospital cost targets upon completion of the first complete program year of MSCAN.

MSCAN's actuarially sound capitation rate was calculated taking into account a ten percent net savings to the state for MSCAN enrollees. However, due to limited program data during its implementation, actual cost savings to date cannot be calculated until completion of the Milliman capitation rate and inpatient cost targets analysis. This analysis will occur once the first MSCAN program year has been completed.

MSCAN's Quality of Care: Performance Measures, Impact, and Evaluability

According to the Division of Medicaid, it will utilize the primary quality tools (such as the Healthcare Effectiveness Data and Information Set [HEDIS] measures) commonly used by other states that have entered into a comprehensive MCO arrangement for Medicaid managed care. However, the DOM did not establish clearly defined objectives with associated timeframes or target levels of performance for the program prior to its implementation.

Also, the State Quality Assessment and Improvement Strategy, required by federal regulation, should incorporate goals and objectives for MSCAN and the state standards for quality measurement and improvement.

The Division of Medicaid has not completed the State Quality Assessment and Improvement Strategy, which should contain outcome measures for quality. Also, although both Magnolia and UnitedHealthcare have general measures that they plan to use to assess quality of care for MSCAN's enrollees, neither has data regarding whether the program has improved the quality of care for MSCAN enrollees to date compared to the quality of care received by those eligible populations who did not enroll in MSCAN.

Operational definitions of the MSCAN quality requirements are in place based on the sources of general measures that the Division of Medicaid will utilize in monitoring the quality of program providers' service structures. However, PEER cannot perform a comprehensive review of how MSCAN has impacted quality due to a lack of clearly defined outcome measures and performance targets.

MSCAN's Access to Care: Performance Measures, Impact, and Evaluability

The Division of Medicaid has several operational definitions for and performance goals for MSCAN access measures. The division noted that the primary access measure that will be utilized for MSCAN is to ensure that enrollees travel no more than sixty minutes or sixty miles in rural regions and thirty minutes or thirty miles in urban regions for access to primary care. The division also established timeframe requirements for MSCAN enrollees to receive services for urgent care, routine care, and wellness care. Both Magnolia and UnitedHealthcare measure access through the number and types of network providers and the ratio of providers by type to enrollees.

Both managed care organizations produce GeoAccess maps that may be utilized to measure access in terms of distance and time of travel for their respective MSCAN enrollees, but these maps do not necessarily reflect enrollees' actual utilization of active providers in the program. Furthermore, no other extensive access measures are readily available on how MSCAN might improve access to care in comparison to those eligible beneficiaries who did not enroll in MSCAN. Therefore, PEER cannot conduct a comprehensive review of how MSCAN has impacted access to date.

PEER determined that operational definitions, access standards, and service requirements for a managed care program are in place for MSCAN. However, adequate performance data is missing on these and other indicators

to allow evaluators to draw conclusions on whether managed care has improved enrollees' access beyond the access available to those in the fee-for-service Medicaid system.

Steps to Ensure Future Evaluability of MSCAN

Mississippi should take the lessons learned from implementation of MSCAN and focus on the steps needed next to prepare the program for future evaluability.

As noted in this report, several key reports and a full year of MSCAN program data should be available in early 2012. At that point, the Division of Medicaid should ensure that it takes the actions listed on pages 52-53 of the report to facilitate future evaluability of MSCAN's cost savings, quality of care, and access to care.

Recommendations

1. The Legislature should require the PEER Committee to monitor and evaluate the continued implementation of MSCAN by using a tiered evaluation approach.

   a. At the midpoint of the 2012 MSCAN program year, PEER should evaluate the State Quality Assessment and Improvement Strategy that DOM will provide to CMS in early 2012 to ensure that operational definitions as well as performance goals, objectives, and outcome measures are in place.

      This review should include, but not be limited to, a review of specific outcome measures developed by the DOM such as specific HEDIS measure targets, a review of the Milliman follow-up capitation rate and inpatient cost target analysis, and a review of the analysis performed by the External Quality Review Organization upon its completion.

      PEER should also compare these measures to those of other states who have similar Medicaid managed care structures and target populations.

   b. At the midpoint of the 2013 MSCAN program year, PEER should perform a follow-up evaluation of MSCAN. This evaluation should compare how MSCAN performed during its second full program year in comparison to the baseline data established in the initial program implementation year regarding specific quality and access outcome measures, as well as documented cost savings.

2. The Division of Medicaid should amend the initial MSCAN contracts with Magnolia and UnitedHealthcare

through the addition of a renewal option for one additional year (through December 31, 2014) instead of utilizing another request for proposals process in 2013. This would allow PEER to perform a more comprehensive evaluation for MSCAN (see Recommendation 1) while ensuring that the Legislature has sufficient time to review the findings and allow a decision to continue or repeal the managed care program during the 2014 regular legislative session. Also, this one-year renewal option would allow for a more continuous system of care and would be less likely to disrupt or require transition for a new contracting process.

3. The Division of Medicaid should analyze its data collection and reporting systems to identify potential data elements that could be utilized to compare quality and access of services of MSCAN enrollees with those same eligibility categories in the FFS system, as long as program enrollment is voluntary. Potential measures could include, but would not be limited to, the use of enhanced benefits of MSCAN, such as unlimited office visits, the number of preventable inpatient hospitalizations and hospital readmissions, EPSDT (Early and Periodic Screening, Diagnosis and Treatment) screenings, and the number of active specialists participating in MSCAN versus fee-for-service Medicaid.

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An Evaluability Assessment of the Mississippi Coordinated Access Network

Introduction

Authority

PEER conducted the review pursuant to the authority granted by MISS. CODE ANN. Section 5-3-51 et seq. (1972). Furthermore, PEER conducted this review pursuant to the mandate in MISS. CODE ANN. Section 43-13-117 (1972).

Statutory Mandate for Review

During its 2009 Second Extraordinary Session, the Mississippi Legislature passed House Bill 71 (now codified as MISS. CODE ANN. Section 43-13-117 [1972]), which contained several provisions designed to control Medicaid costs, including a provision authorizing the Division of Medicaid (DOM) to implement a managed care program on or after January 1, 2010.

The Legislature included in the bill the following mandate for the PEER Committee to conduct a comprehensive performance evaluation of the program:

> *After a managed care program or coordinated care program is implemented by the division under this section, the PEER Committee shall conduct a comprehensive performance evaluation of the managed care program or coordinated care program, which shall include, but not be limited to, a* ***determination of any cost savings to the division, quality of care to the beneficiaries, and access to care by the beneficiaries.*** *The PEER Committee shall provide regular reports on the status of the managed care program or coordinated care program to the members of the Senate Public Health and Welfare Committee and the House Medicaid Committee, and shall complete the performance evaluation and provide it to members of those committees not later than December 15, 2011.*
>
> **[PEER emphasis added]**

Problem Statement

For PEER to conduct a comprehensive performance evaluation of the Mississippi Coordinated Access Network (MSCAN) program by the legislatively mandated deadline, the following information would need to be available to serve as the basis for the evaluation:

- operational (i. e., measurable) definitions of the key components of the evaluation, as established in state law--i. e., quality of care to the beneficiaries, access to care by the beneficiaries, and cost savings to the Division of Medicaid;
- program performance goals and objectives for each of the key program evaluation components, both long-term and short-term; and,
- comprehensive, valid, accurate and reliable performance data (including benchmark data) collected over a period of at least one year from full implementation of the program, measuring the program's success in achieving its goals and objectives, and ideally measuring the success of the Medicaid managed care program relative to the Medicaid fee-for-service program.

Early in this review, PEER determined that while MISS. CODE ANN. Section 43-13-117 (1972) authorized the Division of Medicaid to implement a managed care program on or after January 1, 2010, MSCAN was not implemented until January 1, 2011, and is still not fully operational in terms of a functioning performance accountability structure.

As a result, PEER refocused this review from an evaluation of actual performance to an evaluability assessment of whether the Division of Medicaid is collecting adequate information, as enumerated above, to allow a comprehensive performance evaluation by a date certain in the future. PEER cautions that such a performance evaluation should take place before the Legislature considers any changes to the Medicaid managed care program in Mississippi.

Scope and Purpose

In light of the managed care program implementation issues discussed in the previous section, PEER sought to address the following objectives during the course of this evaluability assessment:

- describe the Mississippi Division of Medicaid's implementation of MSCAN and its compliance with applicable state and federal laws;
- for the required evaluation components of cost savings, quality of care, and access to care, determine:
    - whether MSCAN has performance measures in place;
    - the impact MSCAN has had to date;
    - the evaluability of the performance measures; and,
- determine what is needed to ensure the future evaluability of MSCAN.

Method

In conducting this review, PEER:

- reviewed applicable state and federal laws;
- interviewed personnel and examined records of the Office of the Governor, Division of Medicaid;
- reviewed organizational charts and records from Magnolia and UnitedHealthcare,[1] including monthly management reports, Healthcare Effectiveness and Information Data Set measures, and GeoAccess maps;
- reviewed reports of comparisons of state Medicaid managed care programs; and,
- reviewed reports and statistics on the evolution of Medicaid managed care from the Centers for Medicare and Medicaid Services (CMS).

[1] The Division of Medicaid selected two providers to implement its managed care program, the Mississippi Coordinated Access Network program (MSCAN), and entered into contracts with Magnolia and UnitedHealthcare to provide these services until December 31, 2013.

Background: Managed Care and Delivery of Medicaid Services

Medicaid has traditionally been provided in a fee-for-service (FFS) delivery system. FFS is a method for the administration of the Medicaid program whereby provider participation is open to all providers that meet state requirements. Under a FFS system, providers are reimbursed for each unit of service delivered.

A growing concern is that the traditional fee-for-service system has the potential for Medicaid providers to provide many services as an economic incentive, which may contribute to rising Medicaid costs. As a result of this concern, many states have shifted from the traditional FFS system to a managed care system for their respective Medicaid programs with the goals to reduce and stabilize costs and gain greater budget control.

This chapter will address the following questions:

- What is managed care?
- How do states pay for Medicaid managed care?
- What is the potential impact of the Patient Protection and Affordable Care Act on Medicaid managed care?

What is managed care?

Managed care **is a term used to describe a variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care, primarily through increased care coordination.**

According to the National Conference of State Legislatures:

> *. . .managed care is a term used to describe a variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care for organizations that use those techniques or provide them as services to other organizations.*

The broad goals behind an effective managed care program include:

- promote care management and care coordination;
- provide greater control and predictability over state spending; and,
- improve program accountability for performance, access, and quality.

In 2009, almost seventy-two percent of the total Medicaid beneficiaries in the United States received Medicaid benefits through some form of managed care, compared to approximately fifty-six percent in 2000.

Medicaid managed care programs typically focus primarily on low-income children and families. However, an increasing number of states are now using managed care for populations with more extensive medical needs, such as Medicaid beneficiaries with disabilities and the elderly. This trend will likely continue as states seek to control costs and better coordinate care for high-need, high-cost populations that have a disproportionately high average annual benefit expenditures but a low representation in total enrollment.

In most states, Medicaid programs have contracted out the delivery of health care services to publicly traded, for-profit health plans that are focused on managing the care of Medicaid beneficiaries. The owner or provider of the managed care program supervises the financing of medical care delivered to enrollees. These programs strive to reduce costs through several means, such as buying services in bulk in order to obtain lower prices from doctors and hospitals. Managed care organizations may also reduce costs by limiting choice and controlling the delivery system for their enrollees, such as managing who provides the health care, where it is provided, and the different types of physician specialties in the system or network.

Medicaid managed care is delivered primarily through three types of arrangements: a comprehensive risk-based contract through a managed care organization (MCO); primary care case management (PCCM); or, a prepaid health plan (PHP). Mississippi's Medicaid managed care program is a comprehensive risk-based plan. Comprehensive risk-based plans are the type of managed care most commonly used by the states. A comprehensive at-risk contract places the financial risk with the managed care organization.

How do states pay for Medicaid managed care?

The primary method for paying Medicaid managed care programs is through capitation, whereby the state agency pays a managed care organization a per member per month (PMPM) payment based on program enrollment.

Medicaid managed care payments vary depending on the populations served, benefit packages provided, and whether the plans are at risk for the costs of services. States typically pay a per member per month (PMPM) capitation rate, especially for comprehensive risk-based (MCO) and PCCM plans.

A *capitation* is a payment a state agency makes periodically to a managed care organization on behalf of each participant enrolled under the managed care plan. The state agency pays the capitation regardless of whether every participant receives services during the period covered by the payment. The goals of paying on the basis of capitation rates are to provide a more accountable, coordinated system of care for participants, with an emphasis on preventive and primary care services. This is especially true for at-risk contracts, in which the managed care organization has the financial risk and relies on Medicaid managed care programs to be profitable.

States may use a variety of approaches for setting capitation rates, such as risk adjustment and risk sharing methodologies. As a result of the Federal Balanced Budget Act of 1997, CMS requires that state capitation rates be actuarially sound, meaning they must be developed in accordance with generally accepted actuarial principles and certified by qualified actuaries. Many states have begun to use risk adjustment to adjust rates based on enrollee health status. This allows rates to reflect more accurately the mix of enrollees in each plan and to predict expenditures more accurately, especially with the increasing number of plans that target high-cost, high-need eligibles such as the aged and disabled.

What is the potential impact of the Patient Protection and Affordable Care Act on Medicaid managed care?

In Federal Fiscal Year 2014, the Patient Protection and Affordable Care Act will expand Medicaid eligibility requirements, resulting in increased Medicaid expenditures.

With continuing budget concerns and the implementation of the federal Patient Protection and Affordable Care Act (PPACA) of 2010 that will expand Medicaid eligibility, managed care usage as a means to control Medicaid costs is expected to increase in the years to come. According to CMS's *2010 Actuarial Report on the Financial Outlook for Medicaid*, Medicaid eligibility expansion as a result of PPACA is expected to add approximately 11.6 million people to enrollment in Federal Fiscal Year 2014 and almost twenty million people by Federal Fiscal Year 2019. This eligibility expansion is projected to increase Medicaid expenditures by a total of approximately $428 billion from Federal FY 2014 through Federal FY 2019.

The Division of Medicaid's Implementation of the Mississippi Coordinated Access Network

This chapter will address the following questions regarding creation of MSCAN:

- What has been Mississippi's experience with Medicaid managed care?
- Why was MSCAN created?
- What requirements did state law establish for MSCAN?
- What are the federal authority and requirements for implementing a managed care program?
- Does MSCAN comply with state and federal requirements?

Regarding the contracts for MSCAN between the Division of Medicaid and the managed care organizations, this chapter will address:

- What are the reporting requirements in the managed care contracts?
- Have both managed care organizations complied with the reporting requirements?

Regarding key elements of MSCAN, this chapter will address:

- What are the goals of MSCAN?
- Who is eligible for MSCAN?
- How do MSCAN services compare to fee-for-service Medicaid?
- What incentives does MSCAN provide to enrollees and providers?

Creation of the Mississippi Coordinated Access Network (MSCAN)

The Division of Medicaid implemented Medicaid managed care in selected rural counties in FY 1997, with limited success. On January 1, 2011, the division implemented MSCAN to improve access to and quality of care and to reduce state expenditures for Medicaid. As of September 2011, the program had complied with all state-mandated requirements and most federal requirements. According to the division's staff, the program is in the process of complying with the remaining federal requirements or will have complied upon completion of the first full program year.

MSCAN is not the first managed care system that has been implemented in Mississippi. PEER reviewed past reports

discussing the issues with prior managed care reports to identify whether MSCAN might be faced with these same challenges. PEER also reviewed state law and federal requirements to determine why the program was created and to determine the program's compliance with these laws.

What has been Mississippi's experience with Medicaid managed care?

The Division of Medicaid implemented a capitated managed care program in FY 1997. However, the program was implemented only in selected rural counties and, according to the health maintenance organizations that contracted with the Division of Medicaid at that time, the program was not financially solvent and could not continue to provide services beyond FY 2000.

According to DOM staff, the division attempted to implement a managed care system during the 1990s. However, they noted that the previous managed care program did not have enough participants to sustain the program; thus, the program was not financially viable for the contracted providers.

In 2006, the Mississippi Health Policy Research Center at Mississippi State University issued a report entitled *Medicaid HMOs in Mississippi: A Post Mortem*, which focused on why the managed care attempt in the 1990s was not successful. While this report cited no specific reasons for the program's failure, it did provide a general overview of the timeline of events and general issues that inhibited the success of managed care at the time.

According to that report, during the 1995 regular session, the Legislature mandated the DOM to implement a capitated managed care program in limited areas. During the 1996 regular session, the Legislature specified eleven counties for Medicaid managed care enrollment: Bolivar, Coahoma, Hancock, Harrison, Humphreys, Leflore, Sunflower, Tallahatchie, Warren, Washington, and Yazoo. CMS approved the managed care program and capitation rates in 1996. By FY 1997, four health maintenance organizations (HMOs) had contracted with DOM to provide capitated managed care; in FY 1998, five HMOs contracted with DOM to provide managed care, but none of the original group of HMOs continued their contracts. The report noted continual changes in contract HMOs in the following fiscal year, with only a single HMO contracting with DOM by FY 2000.

The Mississippi Health Policy Research Center's 2006 report highlighted the following as inhibiting the success of the program:

- the program was primarily launched in rural areas;

- enrollment was voluntary as opposed to mandatory; and,
- the program lacked sufficient political support.

The reported noted similar concerns stated by DOM staff. The participating HMOs in the early managed care programs assumed that the program would become statewide and mandatory. However, because the enrollment remained limited to rural areas and was voluntary, the HMOs that contracted with DOM at the time did not have enough enrollees to make the program solvent.

Based on the state's prior experience with Medicaid managed care, DOM created MSCAN to be a statewide program through a three-year contract with only two managed care organizations. The goal of DOM's program design was to ensure that the program covered a large enough area of the state and had enough enrollees per MCO to be financially solvent.

Why was MSCAN created?

The Mississippi Coordinated Access Network was created to control increasing state Medicaid costs associated with targeted beneficiaries defined as being high-cost and high-need.

In other states, managed care target populations focus on beneficiaries that represent a small portion of a state's Medicaid population, but incur a disproportionately high share of total Medicaid expenditures. The theory behind this trend is that these target populations have the potential to result in much higher cost savings in a managed care setting. Similarly, Mississippi has adopted a Medicaid managed care program to control costs for those beneficiaries that are considered high-cost and high-need.

What requirements did state law establish for MSCAN?

House Bill 71, Second Extraordinary Session 2009, established requirements for MSCAN that included a start date for the program, a participation cap of fifteen percent of the total state Medicaid population, and voluntary program participation. The bill prohibited managed care organizations from requiring enrollees to use mail-order pharmacies. The bill also required that PEER conduct a comprehensive performance evaluation and provide a report no later than December 15, 2011.

As noted previously, House Bill 71, Second Extraordinary Session 2009, included a provision authorizing the Division of Medicaid (DOM) to implement a managed care program on or after January 1, 2010.

House Bill 71 also set limits on the total number of participants that could enroll in MSCAN, stating:

> *Any managed care program or coordinated care program implemented by the division* [Mississippi Division of Medicaid] *under this section shall be limited to a* ***maximum of fifteen percent of all Medicaid beneficiaries. . . .***
>
> [PEER emphasis added]

Regarding voluntary participation, the bill required that enrollees in the program be given thirty days each year during which they could withdraw from the program and return to fee-for-service Medicaid. House Bill 71 also specified that the managed care organizations would be paid by the Division of Medicaid on a capitated basis and that enrollees not be required to use any pharmacy that ships, mails, or delivers prescription drugs.

Also, as noted on page 1, House Bill 71 required that PEER conduct a comprehensive evaluation of MSCAN after implementation:

> *. . .the PEER Committee shall conduct a comprehensive performance evaluation of the managed care program or coordinated care program, which shall include, but not be limited to, a determination of any cost savings to the Division, quality of care to the beneficiaries, and access to care by the beneficiaries.*

What are the federal authority and requirements for implementing a Medicaid managed care program?

The Centers for Medicare and Medicaid Services (CMS) administers Medicaid at the federal level and establishes requirements for the state to implement managed care programs. CMS sets requirements for managed care contracts (such as contract type and procurement), program eligibility, and the program enrollment process. CMS also mandates certain performance components, such as an external quality review and a State Quality Assessment and Improvement Strategy.

According to Section 1932(a)(1)(A) of the Social Security Act, the state may enroll Medicaid beneficiaries on a voluntary basis into managed care organizations without the requirement of submitting a waiver request to CMS. Instead, the state can amend the Medicaid state plan that it was required to file with CMS to enroll certain categories of Medicaid beneficiaries in managed care organizations.

The Division of Medicaid submitted its state plan amendment to CMS, which approved it on September 1, 2010, with an effective date of January 1, 2011, pending completion of the actuarially sound capitation rates as required in the federal Social Security Act. The DOM retained Milliman, Inc., of Brookfield, Wisconsin, to

calculate the monthly capitation rates to be paid to the managed care organizations. Milliman provided the capitation rates to DOM on September 13, 2010.

42 C.F.R. Part 434 and 42 C.F.R. Part 438 set forth requirements for states' Medicaid managed care programs regarding:

- contract terms and capitation rates;
- state plan requirements;
- monitoring procedures;
- marketing;
- a State Quality Assessment and Improvement Strategy;
- availability of services;
- assurances of adequate capacity and services;
- an internal quality assurance system;
- an Annual External Quality Review;
- grievances and appeals;
- sanctions; and,
- periodic medical audits.

Appendix A, page 57, summarizes federal requirements for states' Medicaid managed care programs and includes definitions and required components of the above requirements.

Has MSCAN complied with state and federal requirements?

As of September 2011, the Division of Medicaid had complied with all state requirements for MSCAN and had complied with most federal requirements. According to the division's staff, the program is in the process of complying with the remaining federal requirements or will have complied upon completion of the first full program year.

Compliance with State Requirements

Implementation Date

As of September 2011, the Division of Medicaid and MSCAN had complied with the requirements stated in House Bill 71, Second Extraordinary Session 2009. As noted previously, the bill authorized implementation on or after January 1, 2010, and implementation of MSCAN began on January 1, 2011.

Fifteen Percent Cap

Regarding the number of MSCAN participants, the Division of Medicaid used the average annual number of Medicaid

beneficiaries for SFY 2010 (615,497) to determine the maximum number of beneficiaries that could participate in MSCAN (15% of the total number of beneficiaries, or 92,325). As of August 2011, the Division of Medicaid reported a total enrollment of 52,515 in MSCAN.

Voluntary Participation

Regarding enrollees' voluntary participation in the program, House Bill 71 required that MSCAN enrollees have at least thirty days each year during which to opt out of the program without cause. According to the state plan amendment submitted by DOM to CMS, MSCAN enrollees have ninety days upon initial enrollment to the program to opt out and return to fee-for-service Medicaid. Every subsequent year, the enrollee has a ninety-day window (from October and through December annually) during which to opt out and return to fee-for-service Medicaid.

While the program is voluntary, anyone classified within one of the MSCAN eligible populations received an information packet from the Division of Medicaid describing MSCAN and was auto-enrolled into the program if they did not opt out of the program within ninety days.

No Mail-Order Pharmacy Requirement

Regarding the requirement that MSCAN enrollees cannot be required to use pharmacies that ship or mail prescriptions, DOM specified within its contract that the managed care providers could not require the use of such pharmacies.

Compliance with Federal Requirements

The DOM was not required to apply for a state waiver to implement MSCAN (see page 10), but instead submitted the program for approval within a state plan amendment.

Also, the actuarially sound capitation rates were calculated by Milliman, Inc., and submitted to DOM on September 13, 2010. These rates were subsequently submitted to CMS for approval.

The program has complied with all of the federal requirements except:

- implementing a State Quality Assessment and Improvement Strategy;
- undergoing an Annual External Quality Review; and,
- conducting periodic medical audits.

(See Appendix A, page 57, for more information on the components of these federal requirements.)

Because the State Quality Assessment and Improvement Strategy is an essential component of an evaluation framework for a managed care program, this strategy ideally would be in place prior to program implementation in order to allow DOM to monitor MSCAN's performance as it is being implemented. However, developing this strategy after MSCAN's implementation may present challenges in obtaining adequate and comparable data for the period prior to program implementation and data comparing the experiences of MSCAN enrollees to those of fee-for-service Medicaid beneficiaries. According to the Division of Medicaid's staff, it is currently preparing the State Quality Assessment and Improvement Strategy.

Also, the division's staff stated that it is in the process of preparing a request for proposals for the Annual External Quality Review. Both this review and periodic medical audit requirements should be completed after the first MSCAN program year, when a full year of data will be available.

Reporting Requirements in the MSCAN Contracts

The contracts between the Division of Medicaid and the managed care organizations (Magnolia and UnitedHealthcare) established reporting requirements, including periodic reporting of financial, quality, and access data. As of September 2011, both MCOs had complied with all contractual reporting requirements to date. However, the MCOs cannot fulfill some of the contractual reporting requirements until completion of the first MSCAN program year.

The Division of Medicaid's contracts with Magnolia and UnitedHealthcare established the same reporting requirements for both managed care organizations. PEER reviewed the contracts to identify the types and frequency of reporting requirements for the managed care organizations.

What reporting requirements do the contracts contain?

The contracts between DOM and the MCOs specify periodic completion of reports for finances, quality, types of medical services, and claims.

In addition to reporting requirements that are mandated by federal regulation (e. g., medical audits and the Annual External Quality Review), the contracts between DOM and the MCOs require reports to be provided to or performed by the division at specified intervals. These include financial reports, semi-annual quality management internal audits performed by the MCOs, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services audits.

Early and Periodic Screening Diagnosis and Treatment is a required service under the Medicaid state plan to provide

early and periodic screening and diagnosis of eligible Medicaid participants under the age of twenty-one to determine any physical or mental issues and to provide treatment to correct or ameliorate any defects or chronic conditions found. In conjunction with the medical audits required by federal regulations (see Appendix A, page 57), the Division of Medicaid will sample and evaluate complete EPSDT claims data and medical records for each MCO to determine compliance with the provision of EPSDT services to enrollees under age twenty-one. The division also uses EPSDT audits as one of its performance measures for quality of care (see page 34).

The contracts also require the MCOs to furnish to the DOM the following records, documents, reports, or data generated or required in the performance of the contract:

- quarterly reports summarizing formal grievances and informal complaints and resolutions (in service of a federal requirement for a grievance and appeals process; see Appendix A, page 57);

- monthly encounter data for enrollees stating what services were provided to MSCAN enrollees (see page 48);

- quarterly network provider mapping showing the physical locations of all primary care physicians and specialty providers throughout the state for each respective MCO (in service of the division's performance measures for access to care; see page 41);

- enrollees' experience of care survey results showing satisfaction with MSCAN (in service of one of the division's performance measures for quality of care; see page 33); and,

- results of the annual study of clinical guidelines that each MCO's network of providers must adhere to in order to ensure that quality services are provided to MSCAN enrollees.

The contracts also require the MCOs to provide monthly management reports to the Division of Medicaid. This report is the primary tool utilized by the division to summarize the MCOs' output measures in regard to access and quality (see page 43).

Division of Medicaid staff members meet with Magnolia and UnitedHealthcare staff members each month to discuss these monthly management reports and address issues or trends in the reporting requirements that may need action steps established in a corrective action plan. In addition, the DOM's staff conducts quarterly on-site reviews at both provider headquarters to review operations and verify corrective actions.

Have both managed care organizations complied with the contracts' reporting requirements?

As of September 2011, both MCOs had complied with all contractual reporting requirements to date. However, the MCOs cannot fulfill some of the contractual reporting requirements until completion of the first MSCAN program year.

Both Magnolia and UnitedHealthcare have complied with all monthly and quarterly reporting requirements to date. Because program data is not yet available for a full program year, the managed care organizations cannot yet fulfill the reporting requirements that require a year's worth of program data, such as HEDIS and CAHPS (see page 37).

Overview of the MSCAN and Its Key Elements

The Division of Medicaid implemented the Mississippi Coordinated Access Network to improve access to and quality of care received by MSCAN enrollees and to reduce state Medicaid expenditures. MSCAN provides enhanced services to its enrollees in comparison to fee-for-service Medicaid, such as no copayments for office visits and a twenty-four-hour nurse hotline. In addition, MSCAN enrollees and certain providers may participate in incentive programs that promote the utilization of primary care, such as screenings and wellness visits.

The following discussion includes key elements of MSCAN, such as goals of the program, eligibility to participate in the program, services (in comparison to FFS), and incentives for MSCAN enrollees and providers.

What are the goals of MSCAN?

According to the Division of Medicaid, the three primary goals of MSCAN are to improve access to needed medical services, to improve the quality of care received, and to reduce state Medicaid expenditures.

According to the DOM, MSCAN was implemented on January 1, 2011, with three primary goals:

- *improve access to needed medical services*--This includes connecting the targeted beneficiaries with a "medical home," increasing access to providers, and improving use of primary and preventive care services;
- *improve quality of care*--This includes providing systems and supportive services, such as disease management and other programs that will allow beneficiaries to take increased responsibility for their health care; and,
- *improve efficiencies and cost effectiveness*--This includes contracting with coordinated care organizations on a full-risk capitated basis to provide

comprehensive services through an efficient, cost-effective system of care.

Who is eligible for MSCAN?

The Division of Medicaid selected five of its Medicaid categories of eligibility to participate in MSCAN: Supplemental Security Income recipients, disabled children living at home, beneficiaries with breast and cervical cancer who participate in the screening program administered by the Mississippi Department of Health, children in Mississippi Department of Human Services foster care, and the working disabled.

As stated on page 11, the Division of Medicaid used the average annual number of Medicaid beneficiaries for SFY 2010 (615,497) to determine the maximum number of beneficiaries that could participate in MSCAN (15% of the total number of beneficiaries, or 92,325). In determining which beneficiary groups would be eligible for the program, the DOM selected five Medicaid beneficiary groups that were considered high-need and high-cost and whose anticipated enrollment would comply with the requirement for a maximum fifteen percent participation cap based on the total Mississippi Medicaid population.[2] The Medicaid categories of eligibility that DOM selected to participate in MSCAN are:

- *individuals receiving Supplemental Security Income* (SSI)--Administered by the federal Social Security Administration, SSI provides monthly benefits to people with limited income and resources who are disabled, blind, or age sixty-five or older. Blind or disabled children and adults may receive SSI benefits. For the purposes of MSCAN eligibility, the Division of Medicaid has included the SSI Medicaid beneficiaries up to age sixty-five, because after that age the individual would become eligible for Medicare, which is excluded from MSCAN.
- *disabled children living at home*--Medicaid beneficiaries who are disabled and under the age of eighteen based on income under 300% of the SSI limit (excluding parental income and resources) and who meet an institutional level of care requirement.
- *breast and cervical cancer*--female Medicaid beneficiaries under age sixty-five with no other insurance and income under 250% of the federal poverty level who have been screened and diagnosed with breast or cervical cancer and are enrolled in the Centers for Disease Control screening program that is administered through the state Department of Health.

[2] The DOM defines *high-cost beneficiaries* as those individuals that have been determined by claims with an above average per member per month cost.

- *Department of Human Services foster care*--Medicaid beneficiaries up to age twenty-one in the custody of the Mississippi Department of Human Services and in a licensed foster home.
- *working disabled*--Medicaid beneficiaries who are any age and disabled, but work and have earnings under 250% of the federal poverty level.

MSCAN will serve these five eligibility groups in all eighty-two counties.

Exhibit 1, below, presents actual August 2011 MSCAN enrollment by category of eligibility. Exhibit 2, page 18, shows that those Medicaid beneficiaries who would have been eligible for MSCAN in State Fiscal Year 2010 (approximately 15% of the total Mississippi Medicaid population for SFY 2010) represented approximately 23% percent of all Mississippi Medicaid expenditures for that fiscal year because they are high-cost, high-need groups.

MSCAN excludes the following Medicaid beneficiaries regardless of the category of eligibility:

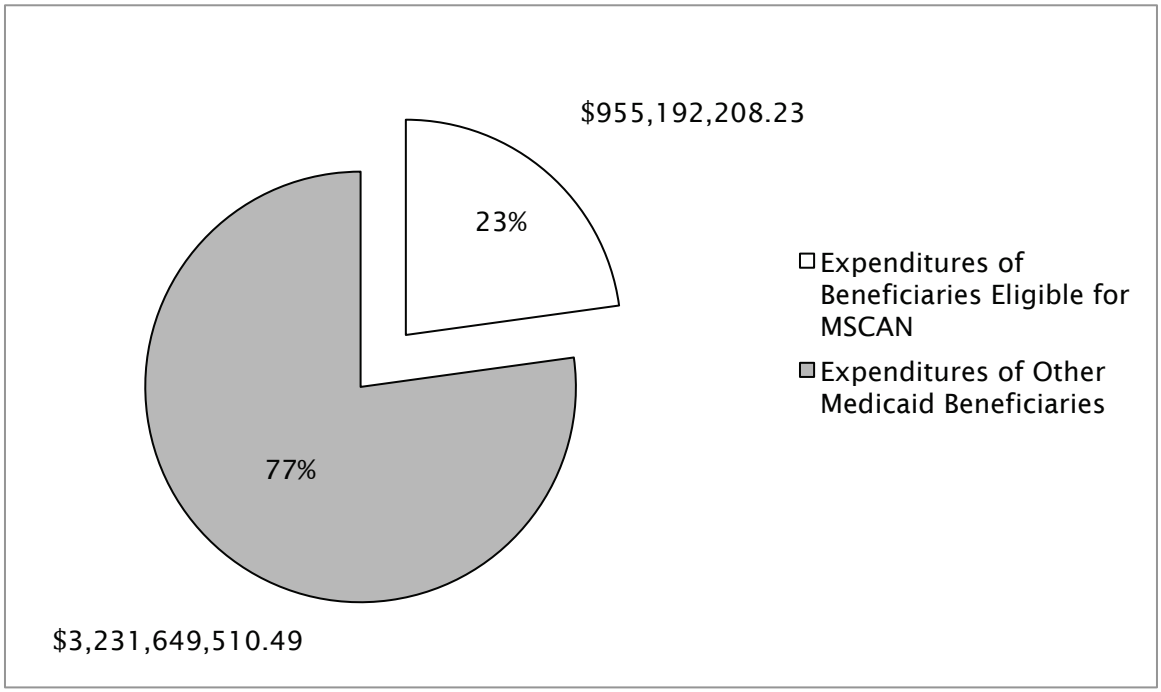
- persons in an institution, such as a nursing facility, intermediate care facility for the mentally retarded (ICFMR), or psychiatric residential treatment facility (PRTF);
- dual eligibles (i. e., eligible for both Medicare and Medicaid); and,
- waiver program participants (i. e., those Medicaid beneficiaries who receive assistance through a separate program such as the home and community-based services waiver program).

Exhibit 1: MSCAN Enrollment by Category of Eligibility as of August 2011

Category of Eligibility	Number of MSCAN Enrollees	Percentage of Enrollees
Supplemental Security Income	51,035	97.2%
Disabled Child Living at Home	325	0.6
Breast and Cervical Cancer	150	0.3
DHS Foster Care	946	1.8
Working Disabled	59	0.1
Total Enrollment	**52,515**	**100%**

SOURCE: Mississippi DOM as of August 2011.

Exhibit 2: State Fiscal Year 2010 Medicaid Expenditures Showing Percentage of Beneficiaries Eligible for MSCAN



NOTE: Although MSCAN was not implemented until January 1, 2011, those Medicaid beneficiaries who would have been eligible for MSCAN in State Fiscal Year 2010 (approximately 15% of the total Mississippi Medicaid population for SFY 2010) represented approximately 23% percent of all Mississippi Medicaid expenditures for that fiscal year.

SOURCE: PEER analysis of state fiscal year 2010 Medicaid expenditures.

How do MSCAN services compare to fee-for-service Medicaid?

Both of the current MSCAN managed care organizations provide some services to MSCAN enrollees that exceed those provided by Medicaid fee-for-service, such as no co-payments for office visits, a higher number of monthly prescription drugs allowed, more frequent adult eyeglass purchases allowed, a twenty-four-hour nurse hotline, and disease management program for chronic diseases.

The DOM compiled a comparison sheet summarizing the major differences in services provided by the current managed care providers, Magnolia and UnitedHealthcare, in comparison to traditional Medicaid FFS (see Exhibit 3 on page 19).

Exhibit 3: Comparison of Medicaid Fee-for-Service, Magnolia, and UnitedHealthcare Plans

Benefits and Services	FFS Medicaid	Magnolia	UnitedHealthcare
Co-Pays	Yes	No	No
Office Visits*	Adults and children – 12 per year	No limits	No limits
Hospital Outpatient Visits (ER Visits)*	Adults and children – 6 per year	Adults and children – 6 per year	Adults and children – 6 per year
Prescription Drugs*	Adults and children – 5 per month	Adults and children – 6 per month	Adults and children – 5 per month
Vision Care	Adults – 1 pair of glasses every 5 years Children – 2 pair of glasses every year	Adults – 1 pair per year and 1 eye exam per year Children – 2 pair per year and 2 eye exams per year	Adults – 1 pair every 36 months and 1 eye exam per fiscal year Children – 1 pair per year and 2 eye exams per fiscal year; plus 1 additional pair under repair/replacement
Dental Care	Adults – 4 limited oral evaluations Children – 2 comprehensive oral evaluations and 4 limited oral evaluations $2,500 annual limit	Adults – 4 limited oral evaluations Children – 2 comprehensive oral evaluations and 4 limited oral evaluations $2,500 Annual Limit	Adults – 4 limited oral evaluations Children – 2 comprehensive oral evaluations and 4 limited oral evaluations $2,500 annual limit
Home Health Services*	Adults and children – 25 per year	Adults and children – 25 per year	Adults and children – 25 per year
Gift Reward Program	No	CentAccount program provides prepaid MasterCard each time enrollee receives select screenings and preventive care	Gift reward program provides rewards for seeing a PCP within 90 days of joining UnitedHealthcare
24-Hour Nurse Advice Line	No	Yes	Yes
Disease/Care Management	No	Start Smart for Your Health programs help members with chronic illnesses, complex conditions, disabilities, weight loss and more, manage and improve their health Start Smart for Your Baby is a program for expecting and new mothers	Access to programs for members who have one of the following problems: Diabetes, Asthma, COPD, Obesity, Hypertension, Heart Disease, or Heart Failure Healthy First Steps Program is a program available for expecting and new mothers.
Tele-Medicine/Tele-Monitoring	No	Eligible members will have access to registered nurses 24/7 who will help monitor blood pressure, pulse, and more through easy to use devices from home	Eligible members will have access to a registered nurse who will be able to connect members to doctor by using a camera
Non-Emergency Transportation	Provide travel to and from medical appointments	Provide travel to and from medical appointments (through FFS)	Provide travel to and from medical appointments (through FFS)

*Children under 21 are eligible for more visits if determined to be medically necessary.
SOURCE: Division of Medicaid.

Major highlights from this comparison of services include:

- unlimited number of office visits for Magnolia and UnitedHealthcare (Medicaid FFS has a limit of twelve office visits per year);
- no co-payment for office visits for either UnitedHealthcare or Magnolia (Medicaid FFS requires co-payments);
- five prescription drugs per month allowed to adults and children by UnitedHealthcare and six allowed per month by Magnolia (Medicaid FFS allows five per month to adults and children);
- one pair of glasses to adults allowed per year by Magnolia and one pair every three years allowed by UnitedHealthcare (Medicaid FFS allows one pair of glasses to adults every five years);
- access to a nurse's advice via twenty-four-hour hotline provided by both Magnolia and UnitedHealthcare (Medicaid FFS does not provide this service); and,
- a disease management program for chronic conditions provided by both Magnolia and UnitedHealthcare (Medicaid FFIS does not provide this service).

Services excluded from MSCAN include inpatient hospital services, mental health services, and non-emergency transportation. The traditional Medicaid FFS system provides inpatient hospital services and mental health services, while non-emergency transportation is provided through a state Prepaid Ambulatory Health Plan.

What incentives does MSCAN provide to enrollees and providers?

Both of the managed care organizations provide financial incentive plans to enrollees to promote utilization of the primary care physicians. Furthermore, one of the providers (Magnolia) also provides additional financial incentives to enrollees for selected well care visits, screenings, and completion of a disease management program. Magnolia also provides selected MSCAN enrollees with access to cellular telephones as well as financial incentives for providers within the network for performing selected services.

Incentive programs are an emerging trend in managed care programs to promote utilization of specific services. In many managed care settings, such programs encourage enrollees to utilize services focusing on prevention and disease maintenance services (e. g., annual mammograms). Both Magnolia and UnitedHealthcare provide incentive plans to MSCAN enrollees.

UnitedHealthcare provides only one financial incentive to enrollees and that is a $15 payment for seeing their respective primary care physicians within ninety days of

enrolling in the program. UnitedHealthcare does not currently offer incentives to health care providers for MSCAN.

The Magnolia plan provides a more extensive benefit incentive plan to enrollees. Enrollees participate in a CentAccount rewards program whereby financial incentives are placed on a pre-paid MasterCard for completing certain services or exhibiting certain behaviors such as the following:

- having a health risk screening;
- visiting a primary care physician within ninety days of enrollment;
- having an annual mammogram;
- having an annual adult well care visit;
- for diabetics, completing all screenings;
- having an annual body mass index assessment; or,
- graduating from a disease management program.

The prepaid card may be utilized for paying prescription costs, other health-related needs, or monthly bills (such as utilities).

In addition to the CentAccount incentives, Magnolia also provides a pre-programmed, limited-use cell phone for those enrollees who are considered high-risk and without reliable phone access. The phone numbers pre-programmed include the enrollee's primary care physician, the nurse hotline, the case manager, pharmacy, home health company, and 911. According to Magnolia staff, approximately eighty of these cell phones had been distributed to enrollees as of September 2011.

Magnolia also provides a physician incentive plan for the providers within its network. These financial incentives are paid to the provider per claim or encounter. The frequency of these payments per enrollee may range from a one-time incentive to a periodic basis, such as once or twice per year on average. Incentive payments may range from one dollar to twenty dollars per service, with the majority ranging from two to five dollars. Similar to incentive plans for managed care enrollees, pay-for-performance programs provide financial incentives to Medicaid managed care providers to promote utilization of specific services. For example, a Magnolia network provider may receive two dollars for administering a childhood immunization for measles, mumps, and rubella and five dollars for administering an annual eye exam for a diabetic.

Components Needed for a Comprehensive Performance Evaluation of MSCAN

As noted previously, the Division of Medicaid and the MSCAN managed care organizations (Magnolia and UnitedHealthcare) are responsible for assuring that Mississippi's Medicaid managed care program fulfills the goals of the program, which are:

- to improve access to needed medical services;
- to improve the quality of care received; and,
- to reduce state Medicaid costs.

Also, as stated on page 1, the Legislature mandated in H.B. 71, Second Extraordinary Session 2009, that PEER:

> *. . .conduct a comprehensive performance evaluation of the managed care program or coordinated care program, which shall include, but not be limited to, a determination of any cost savings to the division, quality of care to the beneficiaries, and access to care by the beneficiaries.*

Thus PEER's task was to evaluate how MSCAN has performed in view of these three primary program goals. To do so, PEER sought to determine what accountability framework to use specific to evaluating a managed care program.

This chapter will address the following questions:

- What are the elements of an accountability framework for evaluating a managed care program?
- What critical elements should the Division of Medicaid have in place and operable in order to conduct a comprehensive performance evaluation of MSCAN?

What are the elements of an accountability framework for evaluating a managed care program?

A 2007 report by the U. S. Department of Health and Human Services provided a suggested accountability framework for monitoring and evaluating managed care programs.

PEER determined that a November 2007 report prepared for the Agency for Healthcare Research and Quality within the U. S. Department of Health and Human Services (DHHS) provided a suggested framework for the monitoring and

evaluation of managed care programs. This report highlighted the importance of establishing a managed care evaluation plan for implementing a managed care program and provided the following elements for an effective accountability framework:

- identification of core program goals and measurable objectives;
- identification of data that is needed and is available;
- establishing an evaluation timeframe;
- determining available resources;
- selecting a reference group for comparison;
- selecting analytic methods;
- identifying and addressing data issues; and,
- translating data and findings to targeted audiences based on the evaluation goals and objectives.

What critical elements should the Division of Medicaid have in place and operable in order to conduct a comprehensive performance evaluation of MSCAN?

PEER identified three critical elements that the Division of Medicaid must have in place and operable in order to conduct a comprehensive performance evaluation of MSCAN: operational definitions of the key variables of interest; performance goals and objectives for access, quality, and cost; and comprehensive, valid, accurate, and reliable performance data.

Relative to PEER's task, the DHHS evaluation framework may be distilled to three critical elements, all three of which should be in place and operable to serve as a basis for the evaluation required by H.B. 71:

- *operational definitions of the key variables of interest* (i.e., access, quality, and cost of care);
- *performance goals and objectives* (both long-term and short-term) for access, quality, and cost; and,
- *comprehensive, valid, accurate, and reliable performance data* (including baseline data) collected over a period of at least one year from full implementation of the program, measuring the program's success in achieving its goals and objectives and ideally measuring the success of the Medicaid managed care program relative to the Medicaid fee-for-service program or other relevant standard.

PEER used these three critical elements to assess MSCAN's evaluability status--i. e., whether MSCAN is positioned to yield a valid comprehensive performance evaluation in the future.

MSCAN's Cost Savings: Performance Measures, Impact, and Evaluability

This chapter addresses the following questions:

- What performance measures for cost savings does the Division of Medicaid have in place for MSCAN?
- What impact has MSCAN had to date on cost savings?
- What is the evaluability status of MSCAN's cost savings measures?

What performance measures for cost savings does the Division of Medicaid have in place for MSCAN?

The Division of Medicaid considers its capitation rates (which are designed to ensure a ten percent net savings to the state) and savings guarantee program (a financial incentive to the MCOs to save at least ten percent on inpatient hospital services) to be its cost saving performance measures.

According to the Division of Medicaid's staff, MSCAN's performance measures for cost savings are:

- the capitation rates; and,
- the savings guarantee program.

Use of Capitation Rates as Performance Measures for Cost Savings

The Division of Medicaid retained an actuarial and consulting firm, MIlliman, Inc., to calculate the capitation rate for MSCAN. The goal of the established capitation rates was to ensure a ten percent net savings to the state.

The Balanced Budget Act of 1997 provided both client protections and increased Medicaid options to allow states to continue expanding managed care to higher risk populations. One major change was the establishment of specific requirements for state rate-setting that ensured all managed care capitation rates would be actuarially sound. This provided assurance that managed care plans receive the funding required to pay for the care needed for people with chronic illnesses and disabilities.

The DOM retained Milliman, Inc.,[3] to calculate the capitation rate for MSCAN. Milliman calculated the MSCAN capitation rates based on eligible population data by geographic region of the state. Milliman also estimated cost savings targets for MSCAN by category of eligibility and service category.

The DOM provided Milliman with Medicaid FFS claims and eligibility data from state Fiscal Year 2008 and state Fiscal Year 2009. Milliman limited its analysis of the claims to the MSCAN target populations: SSI; Disabled Child at Home; Working Disabled; DHS Foster Care; and Breast/Cervical Cancer. Once the enrollment by category was calculated, Milliman then narrowed the claims data further by geographic region of the state. Exhibit 4, below, lists the MSCAN capitation rates calculated by Milliman based on geographic region and eligibility group.

The rates shown in Exhibit 4 are valid from January 1, 2011, through December 31, 2011. Milliman calculated these capitation rates with a goal of a ten percent net savings to the state for those who enroll in MSCAN. Thus the DOM considers these rates to be cost savings measures for MSCAN.

Exhibit 4: MSCAN Capitation Rates (Per Member Per Month) for Calendar Year 2011

Region	SSI/Disabled	Foster Care	Breast/Cervical Cancer
North	$514.14	$211.55	$2,373.98
Central	541.77	222.92	2,501.56
South	574.82	236.52	2,654.16

NOTE 1: Milliman combined the SSI and disabled categories and the breast cancer and cervical cancer categories because claims costs were projected to be similar.

NOTE 2: See Appendix B, page 61, for a list of the counties within each of the DOM's regions.

SOURCE: Milliman Capitation Rate Development Report.

[3] Milliman, Inc., is an independent actuarial and consulting firm with consulting practices in employee benefits, healthcare, investment, life insurance and financial services, and property and casualty insurance.

Use of the Savings Guarantee Program as a Performance Measure for Cost Savings

The Division of Medicaid and Milliman designed a savings guarantee program that will provide a financial incentive (or penalty) to the managed care organizations to reduce hospital inpatient costs. The goal of this program is to save ten percent on inpatient hospital services for MSCAN enrollees in comparison to inpatient hospital service costs for fee-for-service Medicaid patients, even though inpatient hospital services are excluded from the Medicaid managed care program.

Inpatient hospital services constitute a large portion of Medicaid expenditures. According to the Kaiser Foundation, in Fiscal Year 2009, 41.6 percent of all acute care Medicaid spending in Mississippi was for inpatient hospital services.

Even though MSCAN excludes inpatient hospital services, the Division of Medicaid and Milliman designed a savings guarantee program that will provide a financial incentive, or penalty, to the managed care organizations to reduce Medicaid fee-for-service hospital inpatient costs (i. e., reduce the number of hospital admissions). The goal of this program is to save ten percent on inpatient hospital services for those enrolled in MSCAN, because FFS would be responsible for inpatient hospital costs for these enrollees should they become hospitalized (since inpatient hospital services are excluded from MSCAN).

The Division of Medicaid pays each MCO an administrative fee of $10 per member per month to coordinate the hospital inpatient care of MSCAN enrollees. Should the FFS inpatient cost per member per month of a managed care organization's enrollees plus the administrative fee be greater than ninety percent of the inpatient FFS cost target, the managed care organization will pay a penalty equal to the difference so that DOM attains the ten percent savings guarantee. Should the FFS inpatient cost per member per month of a managed care organization's enrollees plus the administrative fee be less than ninety percent of the inpatient FFS cost target (see Exhibit 5, page 28), the MCO will earn an incentive payment equal to twenty percent of the difference. CMS requirements limit this incentive payment to five percent of the non-inpatient capitation rate (see Exhibit 4, page 26).

Exhibit 5: MSCAN Inpatient FFS Targets and Savings Guarantees Per Member Per Month

Rate Cell	FFS Inpatient Cost Target Per Unit of Service	10% Minimum Savings Guarantee
SSI/Disabled		
North	$204.14	$20.41
Central	234.57	23.46
South	227.68	22.77
Foster Care		
North	$101.72	$10.17
Central	116.89	11.69
South	113.46	11.35
Breast/Cervical Cancer		
North	$233.68	$23.37
Central	268.52	26.85
South	260.64	26.06

SOURCE: Milliman Capitation Rate Development for MSCAN Coordinated Care Program Report.

What impact has MSCAN had to date on cost savings?

PEER could not calculate documented cost savings of MSCAN to date due to delays in financial reporting by the managed care organizations. This is compounded by delays in submitting encounter and claims data to the DOM data system because of coding errors. However, Milliman is scheduled to review actual MSCAN expenditures in comparison to capitation rates and inpatient hospital cost targets upon completion of the first complete program year of MSCAN.

As noted on page 1, one of the original objectives of this review was to calculate the documented cost savings of MSCAN to date. However, PEER could not calculate definitive cost savings due to limited program data. Some of these compounding issues include the following.

- *Lag in financial reporting*--During the course of this MSCAN evaluability assessment, only the first quarter of financial reporting was readily available, which was

the initial enrollment period and therefore may not be comprehensive.

- *Lag in encounter and claims data*--As noted on page 48, there were multiple coding issues regarding services provided and claims coding upon program implementation and this data was not correctly reported to DOM until July 2011.

- *No financial audit and analysis until end of MSCAN program year*--While there is a requirement for the financial audits of claims and a Milliman comparison of actual expenditures to capitation rates and cost targets, these functions will not be performed until completion of the first full MSCAN program year.

These compounding issues prevented PEER from calculating any documented savings. However, upon completion of the Milliman capitation rate and inpatient cost targets analysis, a more accurate and comprehensive savings amount should be available.

What is the evaluability status of MSCAN's cost savings measures?

The actuarially sound capitation rate was calculated taking into account a ten percent net savings to the state for MSCAN enrollees. However, due to limited program data during its implementation, actual cost savings to date cannot be calculated until completion of the Milliman capitation rate and inpatient cost targets analysis. This analysis will occur once the first MSCAN program year has been completed.

In assessing the evaluability status of cost measures established for MSCAN, PEER determined that, for its foundation elements, the Division of Medicaid utilized an administrative rate setting method using actuaries to establish the capitation rates for MSCAN. This is the most common method utilized by the states with managed care arrangements and is also in keeping with requirements of the Balanced Budget Act of 1997. Milliman, the actuary selected by the Division of Medicaid, established the MSCAN capitation rates based on claims and eligibility data from two fiscal years and estimated cost savings targets.

Also, the Division of Medicaid and Milliman have designed a savings guarantee program that will provide a financial incentive to the MCOs to reduce FFS hospital inpatient costs. The goal of the savings guarantee is to save ten percent on inpatient hospital services for those enrolled in MSCAN, even though inpatient hospital services are excluded from the Medicaid managed care program.

However, from an accountability perspective, documented cost savings of MSCAN cannot be calculated to date due to the lag in financial reporting by the managed care

organizations. This is compounded by the issue that the encounter and claims data experienced delays in submission to the DOM's data system based on coding errors. However, Milliman is scheduled to review the actual MSCAN expenditures in comparison to the capitation rates and inpatient hospital cost targets upon completion of the first complete program year.

As noted on page 1, one of the original objectives of this review was to calculate the documented cost savings of MSCAN to date. However, at this time no definitive cost savings can be calculated due to limited program data. Upon completion of the Milliman capitation rate and inpatient cost targets analysis, a more accurate and comprehensive savings amount should be available.

Exhibit 6, below, summarizes the evaluability of MSCAN's performance measures for cost savings as of September 2011.

Exhibit 6: Evaluability of MSCAN Cost Measures as of September 2011

Performance Measure	Purpose	Status as of September 2011	Monitoring Frequency	Comments
Capitation Rates	Provides an actuarially sound per member per month payment to the MCOs based on a 10% net savings to the state per MSCAN enrollee.	DOM tracks the total capitation paid to the MCOs to date.	Milliman will review the actual expenditures of the MSCAN enrollees in comparison to the capitated rates upon completion of the first full program year and annually thereafter.	DOM must ensure that this review also compares the capitated rates to the FFS expenditures used in calculating the initial capitation.
Inpatient Hospital Savings Guarantee Program	Provides a 10% net savings guarantee for inpatient hospital services provided to MSCAN enrollees.	DOM and Milliman will review these expenditures and cost savings target upon completion of the first full program year.	Milliman will review the actual inpatient hospital expenditures for MSCAN enrollees in comparison to the inpatient cost savings target per member per month expenditures on an annual basis.	Will ensure a 10% savings to the state because if the MCOs do not meet the guaranteed savings targets, they must pay a penalty to DOM equal to the amount needed to ensure the 10% amount.

SOURCE: PEER analysis of DOM cost saving measures.

MSCAN's Quality of Care: Performance Measures, Impact, and Evaluability

This chapter addresses the following questions:

- What performance measures for quality of care does the Division of Medicaid have in place for MSCAN?
- What impact has MSCAN had to date on quality of care?
- What is the evaluability status of MSCAN's quality measures?

What performance measures for quality of care does the Division of Medicaid have in place for MSCAN?

According to the Division of Medicaid, it will utilize the primary quality tools (such as the Healthcare Effectiveness Data and Information Set [HEDIS] measures) commonly used by other states that have entered into a comprehensive MCO arrangement for Medicaid managed care. However, the DOM did not establish clearly defined objectives with associated timeframes or target levels of performance for the program prior to its implementation. Also, the State Quality Assessment and Improvement Strategy, required by federal regulation, should incorporate goals and objectives for MSCAN and the state standards for quality measurement and improvement.

According to the Division of Medicaid, it plans to utilize the same primary quality measures for MSCAN that other states with comprehensive MCO arrangements for Medicaid managed care use:

- the Healthcare Effectiveness Data and Information Set (HEDIS) measures;
- the Consumer Assessment of Healthcare Providers and Systems (CAHPS) experience of care survey; and,
- the requirement that the managed care organizations comply with Early and Periodic Screening Diagnosis and Treatment (EPSDT) performance targets.

The following sections briefly describe these measures of quality.

Use of Healthcare Effectiveness Data and Information Set (HEDIS) Measures as Performance Measures for Quality of Care

According to the Division of Medicaid, it will use HEDIS measures in the categories of obesity, asthma, diabetes, and congestive heart failure as performance measures for MSCAN. However, although MSCAN was

implemented in January 2011, the division had not set any target levels of service or related health outcome measures as of September 2011.

The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS is a tool used by more than ninety percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of seventy-five measures across eight domains of care, with sixty-two used for Medicaid. Thirty-four states currently use HEDIS measures to compare their progress on health outcomes to the progress of other states.

The DOM selected four of the HEDIS measures to monitor prevalent conditions found in the MSCAN-eligible target populations. Exhibit 7, below, lists these measures.

Exhibit 7: HEDIS Measure Quality Categories and Indicators Selected by DOM for MSCAN

Quality Category	Quality Indicators
Obesity	Adult body mass index assessment; weight assessment and counseling for nutritional and physical activity
Asthma	Use of appropriate asthma medications
Diabetes	Comprehensive diabetes care (i. e., A1c testing, LDL screening, eye exams, BP control and medical attention for nephropathy)
Congestive Heart Failure	ACE inhibiter therapy in all patients with congestive heart failure, unless contraindicated

SOURCE: Mississippi Division of Medicaid Staff.

While DOM selected the above HEDIS measures and quality indicators, the division did not specify target service levels or outcome measures. The division noted that after receiving data regarding Mississippi's progress on these HEDIS measures for one full MSCAN program year, it would set its performance goals for subsequent years.

Magnolia's Use of HEDIS Measures

According to representatives of the Magnolia Health Plan, the HEDIS measures and indicators that will be utilized in addition to the ones selected by the Division of Medicaid include the number of well care visits for children and adolescents, chronic disease management visits and screenings, and the frequency and timeliness or prenatal

care. Even though the Magnolia representatives provided a list of the HEDIS measures to be used, they did not provide goals or outcome measures in regard to target levels of performance.

UnitedHealthcare's Use of Quality Report Measures

UnitedHealthcare representatives provided a list of selected quality indicators that they will monitor at least quarterly, some of which include HEDIS quality indicators. These quality indicators included call center statistics, enrollee communication statistics, satisfaction surveys, and HEDIS measures, where applicable.

While the HEDIS measures selected did state in what areas the quality will be monitored with an associated NCQA performance goal, UnitedHealthcare provided no clear definition for each measure. Also, UnitedHealthcare's semi-annual audit of its quality management program listed the HEDIS measures that would be utilized but had no target levels of service or outcome measures in place for MSCAN.

Use of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey as Performance Measures for Quality of Care

The Division of Medicaid's staff stated that it will utilize the CAHPS survey to collect information regarding MSCAN enrollees' experience and satisfaction with care. Magnolia and UnitedHealthcare will administer this survey to their respective enrollees and submit the results to the Division of Medicaid upon completion. The division's staff noted that the results of this survey should be available in the spring of 2012.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an experience of care survey that is a component of the HEDIS measures that will be utilized by both Magnolia and UnitedHealthcare. This is a subjective method of measuring enrollees' satisfaction levels with the services provided and ease of access to healthcare services. This survey is typically administered to program enrollees annually and the results are submitted to the NCQA for compilation and used for comparative purposes.

Both Magnolia and UnitedHealthcare began administering this survey to their respective MSCAN enrollees in late August and early September 2011. The division's staff noted that the results of this survey should be submitted to them by the MCOs upon completion, hopefully no later than the spring of 2012.

Use of Early and Periodic Screening Diagnosis and Treatment Services as Performance Measures for Quality of Care

The Division of Medicaid specifies in its contracts with the two MCOs the performance requirements that both should achieve through Early and Periodic Screening Diagnosis and Treatment (EPSDT) services. The division has established the EPSDT requirements of eighty-five percent for screening rates and ninety percent for immunization rates.

The Early and Periodic Screening Diagnosis and Treatment (EPSDT) is a required service under the Medicaid state plan to provide early and periodic screening and diagnosis of eligible Medicaid participants under the age of twenty-one to ascertain physical and mental defects and to provide treatment to correct or ameliorate defects and chronic conditions found.

The Division of Medicaid's contracts with Magnolia and UnitedHealthcare specified EPSDT performance requirements, with a requirement for compliance of eighty-five percent for screenings and a requirement of ninety percent for immunizations. In addition, for a child who has been enrolled in MSCAN from birth through twelve months, the requirement for compliance with the EPSDT periodicity schedule is six screenings.

The individual responsible for the Medicaid program in each state typically reviews compliance with EPSDT requirements in conjunction with the federal requirement for a medical audit. Therefore, since the Division of Medicaid will perform the medical audit annually, the managed care organization's compliance with the EPSDT requirements will be reviewed after completion of the first MSCAN program year.

Federal Requirement for a State Quality Assessment and Improvement Strategy

The federal Centers for Medicare and Medicaid Services requires that the Division of Medicaid develop a State Quality Assessment and Improvement Strategy that incorporates goals and objectives for MSCAN and standards for quality measurement and improvement.

As noted on page 11, the federal Centers for Medicare and Medicaid Services requires that states with Medicaid managed care contracts develop a State Quality Assessment and Improvement Strategy (see Appendix A, page 57). This strategy must address:

- how the state will assess the quality of care delivered through the MCO contract(s); and,
- how the state, based on its assessment, will improve the quality of care delivered through the managed care organization contract(s).

According to CMS, MSCAN should report the following items in this strategy:

- a description of the goals and objectives of the state's managed care program, including priorities and strategic partnerships; and,

- a summary description of the state standards for quality measurement and improvement with reference as applicable to details included in the managed care organization contract.

As of July 29, 2011, the Division of Medicaid had not submitted the State Quality Assessment and Improvement Strategy and DOM staff noted that CMS has not established a time requirement or deadline. DOM staff hopes to have a strategy submitted to CMS by the end of 2011 or the beginning of 2012.

What impact has MSCAN had to date on quality of care?

The Division of Medicaid has not completed the State Quality Assessment and Improvement Strategy, which should contain outcome measures that the managed care organizations plan to measure and improve quality. Also, although both Magnolia and UnitedHealthcare have general measures that they plan to use to assess quality of care for MSCAN's enrollees, neither has data regarding whether the program has improved the quality of care for MSCAN enrollees to date compared to the quality of care received by those eligible populations that did not enroll in MSCAN.

One requirement of HB 71 was for PEER to determine the impact of MSCAN on the quality of care provided to enrollees. Therefore, PEER sought to review the actual performance of MSCAN in regard to DOM's goals, objectives, and outcome measures regarding quality. However, PEER determined that these measures were not in place because DOM has not yet completed and submitted the State Quality Assessment and Improvement Strategy to CMS. Also, the primary quality measures selected by DOM (i. e., HEDIS) are utilized for managed care organizations but not routinely for fee-for-service Medicaid.

State Quality Assessment and Improvement Strategy Not Yet Developed

The Division of Medicaid has not yet developed the State Quality Assessment and Improvement Strategy required by CMS. If the strategy had already been developed and implemented, goals and objectives for MSCAN and standards for quality measurement and improvement would already be in place.

As noted previously, DOM has not submitted the strategy to CMS and there is no time requirement or deadline. DOM

staff hopes to submit the strategy in late 2011 or early 2012. (See page 35.)

If DOM had already submitted the strategy, it would have been forced to develop goals and objectives for MSCAN and standards for quality measurement and improvement. Ideally, these would have been in place prior to implementation of the program, thus facilitating an evaluation of the program's quality.

No Clearly Defined Objectives or Outcome Measures for Disease Management and Case Management Programs

While the DOM's contracts with the MCOs require disease management and case management programs to be in place, the division has not defined specific implementation objectives or health outcome measures on how these programs should improve the quality of care received by MSCAN enrollees.

One quality initiative that is utilized by states to measure an MCO's impact on quality in managed care is through the use of disease management and case management programs. The DOM's contracts with Magnolia and UnitedHealthcare require both for MSCAN.

Exhibit 8, below, shows the total number of MSCAN enrollees that were participating in disease and case management programs as of August 2011. While these numbers represent an output measure for the number of participants, they do not reflect the types of services received for each of the programs. Also, these numbers represent only a small portion of the total MSCAN enrollees for each plan. Magnolia did note that its goal was to have nine percent of its enrollees participating in case management. As of June 30, 2011, Magnolia reported that four percent of its total enrollment was enrolled in case management. UnitedHealthcare did not specify a goal for disease or case management participation. The Division of Medicaid did not require specific implementation objectives or health outcome measures on how these programs should improve the quality of care received by MSCAN enrollees.

Exhibit 8: MSCAN Enrollees Participating in Disease Management and Case Management Programs as of August 2011

CCO Plan Name	Number of Enrollees in Disease Management	Number of Enrollees in Case Management
Magnolia Health Plan	430	1,436
UnitedHealthcare Plan	278	565

SOURCE: DOM staff.

No Comparative Data for Quality of Care for MSCAN vs. Fee-for-Service Medicaid

The fee-for-service Medicaid system has traditionally not utilized quality performance measures. Therefore, no measures are in place that can show whether MSCAN enrollees are receiving an increased and improved quality of care in comparison to those who are eligible for MSCAN but who elected not to participate and remain in FFS Medicaid.

While the contracts between DOM and Magnolia and UnitedHealthcare specify that in all aspects of the program, the requirements for performance must be at least equivalent to FFS Medicaid, the primary issue is that FFS has traditionally not utilized HEDIS or quality measures and therefore no comparison can be made. The utilization of HEDIS and CAHPS allows managed care plans to be compared to each other, but not to the population that remains in FFS Medicaid (for those programs with voluntary enrollment).

However, DOM staff noted that specific measures for quality such as EPSDT screenings and immunizations will be established upon completion of the State Quality Assessment and Improvement Strategy that it plans to submit to CMS in late 2011 or early 2012.

What is the evaluability status of MSCAN's quality measures?

Operational definitions of the MSCAN quality requirements are in place based on the sources of general measures that the Division of Medicaid will utilize in monitoring the quality of program providers' service structures. However, PEER cannot perform a comprehensive review of how MSCAN has impacted quality due to a lack of clearly defined outcome measures and performance targets.

The Division of Medicaid provides an operational definition of its quality requirements for managed care programs when it specifies the sources of general measures that are to be utilized in monitoring the quality of program providers' service structures, thus meeting PEER's first critical assessment element (see page 31 for a list of MSCAN's quality measures). These are the same primary quality tools that are utilized by other states that have entered into comprehensive managed care organization arrangements. However, the Division of Medicaid is not ready for a performance evaluation of its quality achievements under managed care, since, for example, with HEDIS, it has not established target service levels or outcome measures, has not established time frames for achieving expected outcomes, nor has it had a full program year for collection of adequate quality-related data. The other indicators of quality suffer from similar deficiencies.

One key tool that states' Medicaid managed care programs are required to prepare and submit to CMS is the State Quality Assessment and Improvement Strategy, which contains outcome measures on how the managed care organization's service plans will measure and improve quality. As noted previously, the Division of Medicaid is in the process of preparing this strategy but has not yet submitted it to CMS.

Additionally, while the DOM's contracts with the MCOs require disease management and case management programs to be in place, the division has not defined specific implementation objectives or health outcome measures on how these programs should improve the quality of care received by MSCAN enrollees.

PEER also notes that the fee-for-service Medicaid system has traditionally not utilized quality performance measures. Therefore, no measures are in place that can directly compare whether MSCAN enrollees are receiving an increased and improved quality of care in comparison to those who are eligible for MSCAN but elected not to participate and remain in FFS Medicaid.

Exhibit 9, page 39, summarizes the evaluability of MSCAN's performance measures for quality of care as of September 2011.

Exhibit 9: Evaluability of MSCAN Quality Measures as of September 2011

Performance Measure	Purpose	Status as of September 2011	Monitoring Frequency	Comments
HEDIS	Compilation of performance measures that address the quality of services provided within managed care programs.	In progress. Both MCOs are expected to submit a progress report to DOM on HEDIS measures by the end of 2011. A full HEDIS report should be available from the NCQA in August 2012.	Magnolia and UnitedHealthcare provide periodic progress reports to DOM. A full HEDIS report is produced by the NCQA annually.	Currently, DOM has defined the HEDIS measures that will be used to measure MSCAN quality, but no target levels of service or outcome measures have been established. Can compare various managed care programs, but does not provide a direct quality comparison to FFS Medicaid.
CAHPS Survey	Experience of care survey within managed care programs.	Both MCOs began administering the CAHPS survey in August and September of 2011. The results are expected to be provided to DOM in December 2011.	Annually	Does not provide a direct quality comparison to FFS Medicaid.
EPSDT	Provides early and periodic screening and diagnosis to Medicaid beneficiaries under the age of twenty-one.	DOM has set an 85% screening requirement and 90% immunization requirement for EPSDT in MSCAN. The review of these rates will occur upon completion of the first full program year.	Annually	EPSDT is also required in FFS Medicaid, therefore screening and immunization rates can be compared.

The Division of Medicaid has not yet developed the State Quality Assessment and improvement Strategy required by CMS. If the strategy had already been developed and implemented, goals and objectives for MSCAN and standards for quality measurement and improvement would already be in place (see page 36).

SOURCE: PEER analysis of DOM quality measures.

MSCAN's Access to Care: Performance Measures, Impact, and Evaluability

This chapter addresses the following questions:

- What performance measures for access to care does the Division of Medicaid have in place for MSCAN?
- What impact has MSCAN had to date on access to care?
- What is the evaluability status of MSCAN's access measures?

What performance measures for access to care does the Division of Medicaid have in place for MSCAN?

The Division of Medicaid has several operational definitions for and performance goals for MSCAN access measures. The division noted that the primary access measure that will be utilized for MSCAN is ensuring that enrollees travel no more than sixty minutes or sixty miles in rural regions and thirty minutes or thirty miles in urban regions for access to primary care. The division also established timeframe requirements for MSCAN enrollees to receive services for urgent care, routine care, and wellness care. Both Magnolia and UnitedHealthcare measure access through the number and types of network providers and the ratio of providers by type to enrollees.

The Division of Medicaid has multiple access measures and requirements in place for both managed care organizations regarding:

- provider and service locations;
- timeliness of receiving an appointment with a primary care physician;
- the number and types of providers in the network;
- the number of providers accepting new MSCAN enrollees as patients; and,
- the ratio of providers by type to MSCAN enrollees.

In addition, female enrollees must have access to a women's health specialist.

Use of Provider and Service Locations as Performance Measures for Access to Care

The Division of Medicaid's primary access measure required in the contracts with the managed care organizations is that enrollees travel no more than sixty minutes or sixty miles in the rural regions and thirty minutes or thirty miles in the urban regions for primary care services.

The Division of Medicaid's access measures for the provider network require the managed care organizations to ensure that primary care services enrollees travel no more than sixty minutes or sixty miles in the rural regions and thirty minutes or thirty miles in the urban regions for all service types. (See Appendix C, page 62, for a list of the counties classified as urban and rural in Mississippi for purposes of MSCAN.) Both Magnolia and UnitedHealthcare produce GeoAccess maps quarterly (or upon significant provider changes) that provide the capability to review these access requirements for participating hospitals, pharmacies, primary care physicians, and specialty providers within their respective networks. They submit these maps to the Division of Medicaid. (See page 44 for discussion of these access reports.)

Use of Timeframes for Appointments as Performance Measures for Access to Care

The division's contracts with the MCOs specify required timeframes for enrollees to receive urgent care, routine care, and wellness care from a primary care physician.

In the contracts with Magnolia and UnitedHealthcare, the Division of Medicaid requires that MSCAN enrollees:

- receive urgent care services within one day of scheduling an appointment with a primary care physician;
- receive routine sick care services within one week of scheduling an appointment with a primary care physician; and,
- receive wellness care services within one month of scheduling an appointment with a primary care physician.

Regarding emergency services, the contract specified that these should be available to enrollees within thirty minutes' typical travel time twenty-four hours a day, seven days a week.

The MCOs do not actively monitor providers' adherence to these timeframes, but do react and monitor if an enrollee files a grievance or complaint regarding timeframes.

Use of Number and Types of Providers as Performance Measures for Access to Care

According to the contracts, both Magnolia and UnitedHealthcare must allow enrollees to choose their primary care physicians and must report any changes to their respective provider networks (i. e., number of providers and types of providers) on a monthly basis.

The Division of Medicaid's contracts with the managed care organizations specify that MSCAN enrollees may select the providers of their choice to serve as primary care physicians and have ninety days from the time of initial enrollment to change providers. Also, each enrollee must be able to choose from at least two network providers for his or her primary care physician.

Also, both managed care organizations must report changes to the provider networks on a monthly basis to DOM by number and type of provider. Exhibit 10, below, shows the total number of providers for Magnolia and UnitedHealthcare by month from January 2011 through June 2011.

Exhibit 10: Number of MSCAN Providers for Magnolia and UnitedHealthcare from January 2011 through June 2011

Magnolia Providers	January	February	March	April	May[1]	June
Primary Care Physicians	737	932	1,020	1,150	1,512	1,572
Hospitals	42	44	48	52	64	64
Pharmacies*	729	730	730	731	735	735

*Total number of pharmacies excludes out-of-state pharmacies.

UnitedHealthcare Providers	January	February	March	April	May	June
Primary Care Physicians	1,534	1,734	2,241	2,316	2,090	2,109
Hospitals	49	53	66	70	71	73
Pharmacies**	--	--	--	--	766	767

**UnitedHealthcare began reporting the total number of participating pharmacies in its monthly management reports in May 2011.

NOTE: Hospitals are included in MSCAN provider networks for purposes of diagnostics and outpatient treatment.

SOURCE: PEER analysis of DOM monthly management reports.

As shown in Exhibit 10, the number of Magnolia network providers who serve as primary care physicians has increased continuously each month since the program's inception. The number of UnitedHealthcare network providers who serve as primary care physicians increased from inception of the program in January 2011 until May 2011, when the numbers began to decrease slightly. PEER notes that this decrease is attributable in part to the fact that UnitedHealthcare's reporting categories in the

monthly management reports changed slightly beginning in May 2011. (Although UnitedHealthcare had been reporting the information since January 2011, DOM did not require standardized reporting format until June 2011.)

Appendix D, page 64, lists providers for both Magnolia and UnitedHealthcare by type of practice. Because the two managed care plans reported the number of providers by different categories, no direct comparison should be made with respect to the types of providers in the network that serve as primary care physicians.

Use of Number of Providers Accepting Enrollees as New Patients as Performance Measures for Access to Care

The Division of Medicaid also requires that each managed care organization submit GeoAccess maps and provider network reports for those network providers that will accept new MSCAN enrollees.

As an additional measure of access, the Division of Medicaid also requires Magnolia and UnitedHealthcare to provide information to the division on a monthly basis regarding the number of open-panel and closed-panel providers in their networks. An *open-panel provider* is willing to accept MSCAN enrollees as new patients. A *closed-panel provider* participates in MSCAN but will only see patients who had previously received that provider's services and subsequently enrolled in MSCAN. Exhibit 11, below, shows the number of participating open-panel MSCAN providers in relation to the total number of network providers as of August 2011.

Exhibit 11: MSCAN Open-Panel Primary Care Providers* as of August 2011

Managed Care Organization	Number of Network Primary Care Providers	Number of Open-Panel Network Primary Care Providers
Magnolia Health Plan	1,630	1,572
UnitedHealthcare Plan	2,398	2,398

* An *open-panel provider* is willing to accept MSCAN enrollees as new patients.

SOURCE: Mississippi DOM, as of August 2011.

As shown in Exhibit 11, as of August 2011, the majority of providers in the Magnolia provider network were open-panel, with fifty-eight listed as closed-panel (approximately 3.5 percent of total providers). All UnitedHealthcare providers were listed as open-panel.

Use of Ratios of Providers to Enrollees as Performance Measures for Access to Care

Magnolia and UnitedHealthcare also measure access in terms of the ratio of providers to enrollees, based on a standard that requires one provider for every two thousand enrollees.

Both Magnolia and UnitedHealthcare also measure access in terms of the ratio of providers to enrollees. The typical industry standard selected by both plans is that there should be one provider for every two thousand enrollees. Magnolia also has a separate standard for nurse practitioners, stating that one must be available for every one thousand enrollees.

What impact has MSCAN had to date on access to care?

Both managed care organizations produce GeoAccess maps that may be utilized to measure access in terms of distance and time of travel for their respective MSCAN enrollees, but these maps do not necessarily reflect enrollees' actual utilization of active providers in the program. Furthermore, no other extensive access measures are readily available on how MSCAN might improve access to care in comparison to those eligible beneficiaries who did not enroll in MSCAN. Therefore, PEER cannot conduct a comprehensive review of how MSCAN has impacted access to date.

As noted previously, the primary component in measuring and assessing access to care is the GeoAccess maps. These maps provide an overview of the distance and travel time between MSCAN enrollees and participating network hospitals, pharmacies, primary care physicians, and specialty providers in regard to the 60/30 standard (see page 41).

Impact of the 60/30 Requirement on Access to Care

While the GeoAccess maps illustrate the locations of providers who are accepting new MSCAN enrollees based on the 60/30 access requirements for primary care physicians, the maps may not reflect enrollees' actual utilization of healthcare services.

Both Magnolia and UnitedHealthcare produce quarterly GeoAccess maps in order to illustrate provider locations by type in regard to the 60/30 access requirement for primary care physicians. While these maps show the total number of providers by type within the network, this may not reflect utilization of active providers (i. e., the provider is filing claims for services provided to MSCAN enrollees). Therefore, while the GeoAccess maps are a useful tool, they would better depict access in the program by being coupled with active provider status as well as enrollee utilization data. Utilization data should be compared periodically to the 60/30 access standard. Utilization data is critical in making decisions about whether the 60/30 access standard needs to be refined.

Impact of the Provider/Enrollee Ratio on Access to Care

In regard to the access measure of one provider for every two thousand enrollees, both Magnolia and UnitedHealthcare reported ratios that met or exceeded this standard in most specialty types, although UnitedHealthcare noted that it did not meet this standard for the ratio of dermatologists to enrollees.

Another MSCAN measure of access to care is the ratio of providers to enrollees by type, such as primary care physicians and specialty providers.

Primary Care Physicians

In regard to primary care physician to enrollee ratios, Exhibit 12, page 46, shows the ratios for both Magnolia and UnitedHealthcare for primary care physicians. In comparison to typical industry standards of one provider for every two thousand enrollees, both Magnolia and UnitedHealthcare exceed this standard for primary care physicians.

Specialty Providers

PEER reviewed Magnolia's ratios of specialty providers to MSCAN enrollees as of June 29, 2011. (See Exhibit 13, page 47.) As shown in Exhibit 13, in comparison to typical industry standards of one provider for every two thousand enrollees, Magnolia was in compliance with the access standard of one specialty provider for every two thousand enrollees based on the specialty types provided.

PEER reviewed UnitedHealthcare's ratios of specialty providers to MSCAN enrollees as of September 1, 2011. (See Exhibit 13.) UnitedHealthcare was in compliance with the standard except for access of enrollees to dermatologists.

Exhibit 12: MSCAN Enrollee to Provider Ratios for Primary Care Physicians, Magnolia and UnitedHealthcare, from January 2011 through June 2011

Magnolia			
Month	Total Number of Enrollees	Total Number of Primary Care Physicians	Average Number of Enrollees per Primary Care Physician
January	32,838	737	44.56
February	33,540	932	35.99
March	33,165	1,020	32.51
April	30,590	1,150	26.60
May	30,532	1,512	20.19
June	30,838	1,572	19.62
UnitedHealthcare			
Month	Total Number of Enrollees	Total Number of Primary Care Physicians	Average Number of Enrollees per Primary Care Physician
January	25,185	1,534	16.42
February	23,151	1,734	13.35
March	28,615	2,241	12.77
April	20,975	2,316	9.06
May	21,255	2,090	10.17
June	21,404	2,109	10.15

NOTE: The MSCAN access standard is one primary care physician per 2,000 enrollees.

SOURCE: PEER staff analysis of DOM monthly management reports.

Exhibit 13: MSCAN Enrollee to Provider Ratios for Specialty Providers, Magnolia (as of June 29, 2011) and UnitedHealthcare (as of September 1, 2011), from January 2011 through June 2011

Magnolia Provider Type	Provider Count	Actual Ratio: Providers per Number of Enrollees
Family Medicine	427	72.88
Internal Medicine	341	91.26
Obstetrics/Gynecology	188	165.54
Pediatrics	235	132.43
Nurse Practitioner	593	52.48
Cardiology	138	225.51
Dental	193	161.25
Gastroenterology	66	471.53
Nephrology	46	676.54
Neurology	86	361.87
Ophthalmology	149	208.87
Optometry	181	171.94
Orthopedic Surgery	83	374.95
Podiatrist	21	1,481.95
Pulmonologists	60	518.68
Surgery	194	160.42

UnitedHealthcare Provider Type	Provider Count	Actual Ratio: Providers per Number of Enrollees
Urology	67	315.55
Obstetrics/Gynecology	266	30.59
Allergy	13	1,626.31
Orthopedics	112	188.77
Pulmonology	52	406.58
Neurology	90	234.91
Dermatology	5	4,228.40
General Surgery	169	125.10
Gastroenterology	93	227.33
Cardiology	206	102.63
Ophthalmology	156	135.53
Oncology Hematology	77	274.57
Otolaryngology	63	335.59

NOTE 1: The MSCAN access standard is one specialty provider per 2,000 enrollees.

NOTE 2: Shading indicates noncompliance with the access standard.

SOURCE: Magnolia and UnitedHealthcare staff.

Delays in Data Submission Regarding MSCAN vs. Fee-for-Service Medicaid Access to Care

According to the Division of Medicaid's staff, it has not been possible to make direct comparisons between MSCAN enrollees and fee-for-service Medicaid beneficiaries regarding access to care because of delays in the submission of encounter data from the MCOs and coding and billing inconsistencies. The division's staff now reports that as of September 30, 2011, all MCO encounter data was in the division's data system for services provided from January through August 2011.

The Division of Medicaid noted that the initial date for receipt of Magnolia and UnitedHealthcare's encounter data was February 28, 2011. However, the Division of Medicaid stated that neither managed care organization had resolved coding discrepancies within their own data systems by the original deadline. As a result of the delay in data submission, the division conducted weekly meetings with both MCOs to target issues around encounter data submission. According to the Division of Medicaid, both MCOs were ready to begin testing their encounter data submission through the division's data gateway after two months of system modifications.

Beginning May 5, 2011, both MCOs submitted January encounter data to the division for testing. During the testing phases, the division identified system enhancements that were required for both the MCOs and the division's data systems. On June 1, 2011, the division began processing MSCAN encounter data. Each week, the division processed one month's encounter data until submissions were up to date. According to the division, as of September 30, 2011, all MCO encounter data is in the division's data system for MSCAN services provided from January through August.

Ultimately, it is the goal of the Division of Medicaid to utilize this service data to compare the average cost per claim/service to the estimated average claim rates to determine how much money MSCAN has saved. Therefore, the DOM should eventually have the means and data available to compare access to similar services for MSCAN enrollees and FFS Medicaid beneficiaries.

However, DOM staff also noted that while some comparisons may be made between the two populations, many of the services may not be directly comparable due to the way they are coded. (This issue was also noted by CMS on its website.) For example, one primary federal data source for Medicaid data is the Medicaid Statistical Information System (MSIS). The MSIS is the basic source of state-submitted eligibility and claims data on the Medicaid population, its characteristics, utilization, and payments. However, CMS notes that the definitions of medical service categories are not consistent between the MSIS and the other CMS data sources. Therefore, comparisons between MSCAN and fee-for-service Medicaid regarding access are

limited because the way services are coded in the two data systems is not the same.

What is the evaluability status of MSCAN's access measures?

PEER determined that operational definitions, access standards, and service requirements for a managed care program are in place for MSCAN. However, adequate performance data is missing on these and other indicators to allow evaluators to draw conclusions on whether managed care has improved enrollees' access beyond the access available to those in the fee-for-service Medicaid system.

Based on an analysis of available access information, PEER determined that both managed care organizations have in place the needed operational definitions, access standards, and service requirements for a well-defined managed care program. Included are measures for access to medical and other service providers, service locations, timeliness to receive an appointment with a primary care physician, the number and types of providers in the network, the number of providers accepting additional MSCAN enrollees, and the ratio of providers by type to MSCAN enrollees.

In addition, both organizations produce GeoAccess maps that may be utilized to measure access standards in regard to distance and time of travel by their respective MSCAN enrollees, but these maps do not reflect the utilization of active providers. While both Magnolia and UnitedHealthcare collect and utilize data on several provider and enrollee service utilization outputs, neither build on these data elements to design measures that reflect whether actual access to needed medical services has improved. Further, no access measures are readily available on how MSCAN has improved the access to care received in comparison to those eligible fee-for-service Medicaid beneficiaries that did not enroll in MSCAN.

While the Division of Medicaid staff noted that it periodically runs service utilization reports, coding and billing inconsistencies currently prevent a direct comparison of the services received by MSCAN enrollees to those services received by MSCAN-eligible populations that elected not to participate and remain in the fee-for-service system.

Based on PEER's analysis of available information, what is missing from an evaluability standpoint regarding access is adequate performance data on these and other such indicators to allow evaluators to draw conclusions on whether managed care has improved enrollee access beyond the access available to those in the fee-for-service system. Until such data is available, PEER cannot conclude on changes in access to care that have resulted from the implementation of the managed care system.

Exhibit 14, below, summarizes the evaluability of MSCAN's performance measures for access to care as of September 2011.

Exhibit 14: Evaluability of MSCAN Access Measures as of September 2011

Performance Measure	Purpose	Status as of September 2011	Monitoring Frequency	Comments
Provider and Service Locations – 60/30 Standard	Ensures that for primary care services, MSCAN enrollees travel no more than 60 minutes or miles in rural regions and no more than 30 minutes or miles in urban regions.	Both MCOs are in compliance with this standard in regard to primary care physicians. Also, both are in compliance with most, but not all, specialty providers.	Magnolia and UnitedHealthcare provide quarterly GeoAccess reports to DOM.	While these reports provide a depiction of physical location requirements, the DOM should build on these maps to incorporate active providers and reflect actual utilization of services.
Primary Care Physician Appointments	Specifies that MSCAN enrollees must receive urgent care appointments within one day of scheduling, routine care services within one week, and wellness care services within one month.	DOM monitors grievances regarding appointment times within grievances and appeals reports.	Monthly reviews of grievances and appeals reports	Is only monitored when a MSCAN enrollee complains
Number and Types of Providers	Ensures that each MCO network has an adequate number of and types of providers to meet the needs of MSCAN enrollees.	Both MCOs report the number and types of providers to DOM within the monthly management report.	Monthly	Provides output measures for the provider network. In addition, each MCO must meet the industry standards for the ratio of specialty providers to MSCAN enrollees as noted below.

Exhibit 14 (continued)

Performance Measure	Purpose	Status as of September 2011	Monitoring Frequency	Comments
Number of Open-Panel Providers	Provides for a measure of MSCAN participating providers who will or will not accept new MSCAN enrollees.	DOM tracks the number of open and closed-panel providers monthly in conjunction with the GeoAccess reports.	Monthly	An output measure on the number of providers who accept new MSCAN enrollees. In addition, the GeoAccess reports must reflect only the locations of open-panel providers.
Ratio of Providers to MSCAN Enrollees	The accepted managed care industry standard is there should be one specialty provider for every 2,000 MSCAN enrollees.	Magnolia noted compliance of the industry standard for all specialty providers. UnitedHealthcare noted compliance for all specialty providers except dermatologists.	Magnolia and UnitedHealthcare provide these ratios in conjunction with the quarterly GeoAccess reports to DOM.	Provides a general measure on the number of specialty providers to enrollees, but does not reflect the physical location or saturation areas of these providers.

NOTE: Although the Division of Medicaid's contracts with the managed care organizations require monthly reporting of utilization and encounter data, which would allow direct comparison of MSCAN to FFS regarding access to care, the division has not used utilization and encounter data as performance measures. Coding issues within each of the MCOs' data systems have delayed the reporting of this data to the division. According to the division's staff, as of September 30, 2011, all of the encounter data was current.

SOURCE: PEER analysis of DOM access measures.

Steps to Ensure Future Evaluability of MSCAN

Mississippi should take the lessons learned from implementation of MSCAN and focus on what steps are needed next to prepare the program for future evaluability.

While the Mississippi Legislature did not establish MSCAN specifically as a pilot program, due to its limited implementation in regard to eligible target populations and a voluntary enrollment option, it has operated as a *de facto* managed care pilot program for Mississippi. Standard accepted practices emphasize the need for a strong evaluation plan prior to a pilot program implementation, but MSCAN did not have such a plan in place prior to implementation on January 1, 2011. Since the success of this program targeting such high-cost and high-cost need enrollees will likely drive the direction of managed care in Mississippi in the future, it is critical to have a strong evaluation and assessment plan in place.

As noted in this report, several key reports and a full year of MSCAN program data should be available in early 2012. At that point, the Division of Medicaid should ensure that the following actions are taken to facilitate future evaluability of MSCAN's cost savings, quality of care, and access to care.

- To help ensure evaluability of cost savings:
  - -- ensure that the Milliman capitation rate and inpatient cost targets analysis compares the capitated rates to the fee-for-service expenditures; and,
  - -- review the inpatient hospital expenditures and cost savings targets to ensure that a 10% net savings was achieved for these services.
- To help ensure evaluability of quality of care:
  - -- complete the State Quality Assessment and Improvement Strategy and submit it to CMS;
  - -- select target levels of service or outcomes for the HEDIS quality measures utilized for MSCAN;
  - -- established time frames for achieving expected outcomes;
  - -- develop specific implementation objectives or outcome measures on how disease management and case management programs should improve quality of care;

- -- review the results of the CAHPS survey administered by Magnolia and UnitedHealthcare to MSCAN enrollees regarding their experience of care;
- -- enter into a contract with an external third party organization for the External Quality Review of medical decisions and quality of care;
- -- audit a sample of medical records for MSCAN enrollees to ensure that the services provided were medically necessary; and,
- -- ensure that the performance goals for EPSDT screening and immunization rates were achieved per contractual requirements with each MCO.

- To help ensure evaluability of access to care:
  - -- build on the GeoAccess maps to develop maps that incorporate active providers and reflect actual utilization of services; and,
  - -- use utilization and encounter data to compare how MSCAN has improved access to care to access to care for fee-for-service Medicaid beneficiaries that did not enroll in MSCAN.

Recommendations

1. The Legislature should require the PEER Committee to monitor and evaluate the continued implementation of MSCAN by using a tiered evaluation approach.

   a. At the midpoint of the 2012 MSCAN program year, PEER should evaluate the State Quality Assessment and Improvement Strategy that DOM will provide to CMS in early 2012 to ensure that operational definitions, as well as performance goals, objectives, and outcome measures, are in place.

      This review should include, but not be limited to, a review of specific outcome measures developed by the DOM such as specific HEDIS measure targets, a review of the Milliman follow-up capitation rate and inpatient cost target analysis, and a review of the analysis performed by the External Quality Review Organization upon its completion.

      PEER should also compare these measures to those of other states who have similar Medicaid managed care structures and target populations.

   b. At the midpoint of the 2013 MSCAN program year, PEER should perform a follow-up evaluation of MSCAN. This evaluation should compare how MSCAN performed during its second full program year in comparison to the baseline data established in the initial program implementation year regarding specific quality and access outcome measures, as well as documented cost savings.

2. The Division of Medicaid should amend the initial MSCAN contracts with Magnolia and UnitedHealthcare through the addition of a renewal option for one additional year (through December 31, 2014) instead of utilizing another request for proposals process in 2013. This would allow PEER to perform a more comprehensive evaluation for MSCAN (see Recommendation 1) while ensuring that the Legislature has sufficient time to review the findings and allow a decision to continue or repeal the managed care program during the 2014 regular legislative session. Also, this one-year renewal option would allow for a more continuous system of care and

would be less likely to disrupt or require transition for a new contracting process.

3. The Division of Medicaid should analyze its data collection and reporting systems to identify potential data elements that could be utilized to compare quality and access of services of MSCAN enrollees with those same eligibility categories in the FFS system, as long as program enrollment is voluntary. Potential measures could include, but would not be limited to, the use of enhanced benefits of MSCAN, such as unlimited office visits, the number of preventable inpatient hospitalizations and hospital readmissions, EPSDT screenings, and the number of active specialists participating in MSCAN versus fee-for-service Medicaid.

Appendix A: Federal Requirements for States' Medicaid Managed Care Programs

Federal Code Reference	Requirement	Details
42 C.F.R. § 434.40	Contract Terms – Capitation Payments	State contracts with managed care organizations must: • If the contractor assumes the full underwriting risk, specify that payment of the capitation fees to the contractor during the contract period constitutes full payment by the agency for the cost of medical services provided under the contract; and, • Specify the actuarial basis for computation of the capitation fee.
42 C.F.R § 438.50	State Plan Requirements	The state plan must specify: • The types of entities with which the state contracts; • The payment method it uses (for example, whether fee-for-service or capitation); • Whether it contracts on a comprehensive risk basis; and, • The process the state uses to involve the public in both design and initial implementation of the program and the methods it uses to ensure ongoing public involvement once the state plan has been implemented. o State plan assurances o Limitations on enrollment o Priority for enrollment o Enrollment by default
42 C.F.R § 438.66	Monitoring Procedures	The state agency must have in effect procedures for monitoring the MCO's, at a minimum, operations related to the following: • Recipient enrollment and disenrollment; • Processing of grievances and appeals; • Violations subject to intermediate sanctions; and, • All other provisions of the contract, as appropriate.

Federal Code Reference	Requirement	Details
42 C.F.R § 438.104	Marketing	Each contract with an MCO must comply with the following requirements: • Provides that the entity does not distribute any marketing materials without first obtaining state approval; • Distributes the materials to its entire service area as indicated in the contract; • Ensures that, before enrolling, the recipient receives, from the entity or the state, the accurate oral and written information he or she needs to make an informed decision on whether to enroll; and, • Does not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.
42 C.F.R. § 438.202	State Quality Assessment and Improvement Strategy	Each state contracting with an MCO must: • Have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PHPs. • Obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final. • Ensure that MCOs comply with standards established by the state, consistent with this subpart; • Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy periodically, as needed; and, • Submit to CMS the following: o A copy of the initial strategy and a copy of the revised strategy whenever significant changes are made. o Regular reports on the implementation and effectiveness of the strategy.

Federal Code Reference	Requirement	Details
42 C.F.R. § 438.206	Availability of Services	Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO must consider the following: • The anticipated Medicaid enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO, PIHP, and PAHP. • The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. • The numbers of network providers who are not accepting new Medicaid patients. • The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities. • Provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist. • Meet and require its providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services.
42 C.F.R. § 438.207	Assurances of Adequate Capacity and Services	Each MCO must submit documentation to the state, in a format specified by the state, to demonstrate that it complies with the following: • Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area. • Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

Federal Code Reference	Requirement	Details
42 C.F.R. § 438.240	Quality Assessment and Performance Improvement Program	Plans must have an ongoing quality assessment and performance improvement program that: • Conducts performance improvement projects; • Submits performance measurement data to the state; • Have in effect mechanisms to detect both underutilization and overutilization of services; and, • Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.
42 C.F.R. § 438.350	Annual External Quality Review	States must use, with limited exception, a utilization and quality control peer review organization to conduct an independent, external review of the quality of services furnished, and the results must be made available to the state and certain federal officials.
42 C.F.R. § 438.400	Grievance and Appeals	States must provide an opportunity for a fair hearing to any individual whose Medicaid claim is denied or not acted upon with reasonable promptness
42 C.F.R. § 438.402	Grievance and Appeals	Managed care contractors must provide an internal grievance procedure that: • Is approved in writing by the state Medicaid agency; • Provides for prompt resolution of grievances; and, • Assures the participation of individuals with authority to require corrective action.
42 C.F.R. § 438.700	Sanctions	Each state that contracts with an MCO must, establish intermediate sanctions that it may impose. The state may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.
42 C.F.R. § 434.53 (1999)	Periodic Medical Audits	States must: • Conduct audits at least once a year for each contractor; • Identify and collect management data for use by medical audit personnel; and, • Ensure that data include reasons for enrollment and termination and use of services.

SOURCE: PEER review of 42 C.F.R. Parts 434 and 438.

Appendix B: Counties Within the Division of Medicaid's Regions

North Region	Central Region	South Region
Alcorn	Calhoun	Adams
Attala	Chickasaw	Amite
Benton	Choctaw	Covington
Bolivar	Claiborne	Forrest
Carroll	Clarke	Franklin
Coahoma	Clay	George
DeSoto	Copiah	Greene
Grenada	Hinds	Hancock
Holmes	Issaquena	Harrison
Humphreys	Jasper	Jackson
Itawamba	Kemper	Jefferson
Lafayette	Lauderdale	Jefferson Davis
Lee	Leake	Jones
Leflore	Lowndes	Lamar
Marshall	Madison	Lawrence
Montgomery	Monroe	Lincoln
Panola	Neshoba	Marion
Pontotoc	Newton	Pearl River
Prentiss	Noxubee	Perry
Quitman	Oktibbeha	Pike
Sunflower	Rankin	Stone
Tallahatchie	Scott	Walthall
Tate	Sharkey	Wayne
Tippah	Simpson	Wilkinson
Tishomingo	Smith	
Tunica	Warren	
Union	Webster	
Washington	Winston	
Yalobusha	Yazoo	

SOURCE: Milliman Capitation Rate Development for MSCAN Coordinated Care Program.

Appendix C: Classification of Mississippi Counties as Urban or Rural for MSCAN

Rural-Urban Continuum Codes distinguish metropolitan (metro) counties by the population size of their metropolitan statistical area (MSA) and nonmetropolitan (nonmetro) counties by degree of urbanization and adjacency to a metro area or areas. The metro and nonmetro categories have been subdivided into three metro and six nonmetro groupings, resulting in a nine-part county codification, with one representing the most urbanized county and nine representing the most rural county. All U.S. counties and county equivalents are grouped according to their official metro-nonmetro status announced by the federal Office of Management and Budget (OMB).

For the purposes of MSCAN, the DOM defined any county receiving a one through three coding through the Rural-Urban Continuum as urban and any county with a four through nine coding as rural. This classification resulted in seventeen counties in Mississippi being defined as urban and sixty-five defined as rural.

The county listing on page 63 shows which Mississippi counties the Division of Medicaid defined as urban and rural according to the federal Rural-Urban Continuum Codes.

Urban Counties	Rural Counties	
DeSoto Marshall Tate Tunica Copiah Hinds Madison Rankin Simpson Forrest George Hancock Harrison Jackson Lamar Perry Stone	Jones Warren Adams Bolivar Coahoma Lauderdale Lee Leflore Lowndes Oktibbeha Sunflower Washington Attala Claiborne Holmes Lafayette Leake Lincoln Marion Panola Pearl River Quitman Scott Yazoo Alcorn Calhoun Chickasaw Clay Grenada Humphreys Itawamba Jefferson Monroe	Montgomery Neshoba Newton Noxubee Pike Pontotoc Prentiss Tallahatchie Tippah Union Wayne Winston Yalobusha Amite Benton Covington Greene Jefferson Davis Lawrence Smith Tishomingo Wilkinson Carroll Choctaw Clarke Franklin Issaquena Jasper Kemper Sharkey Walthall Webster

SOURCE: Mississippi Division of Medicaid staff.

Appendix D: Numbers and Types of Network Providers for Magnolia and UnitedHealthcare, January through June 2011

Magnolia Providers	January	February	March	April	May[1]	June
Pediatricians	95	97	113	140	187	191
Family and General Practitioners	273	292	310	327	478	501
Internists	106	112	118	156	207	210
Obstetricians/Gynecologists	21	21	23	27	33	33
Nurse Practitioners	239	267	308	341	414	439
Physician Assistants	3	3	3	3	10	10
Other Specialists	0	140	145	156	183	188
Others DOM-Approved	0	0	0	0	0	0
Total PCPs	**737**	**932**	**1,020**	**1,150**	**1,512**	**1,572**
Hospitals	42	44	48	52	64	64
Pharmacies[1]	729	730	730	731	735	735

UnitedHealthcare Providers	January	February	March	April	May	June
Anesthesiology	0	0	0	1	1	1
Developmental Behavioral Pediatrics	0	0	0	0	0	1
Emergency Medicine	2	3	5	7	7	8
Family Practice	908	915	1,134	1,161	1,209	1,212
Gastroenterology	0	0	2	2	3	3
General Practice	69	77	99	100	103	106
Geriatric Medicine	1	1	2	2	2	2
Infectious Disease	1	1	1	1	1	1
Internal Medicine	325	368	459	476	480	490
Obstetricians/Gynecologists	0	1	1	2	2	2
Other[1]	39	158	270	285	NA	NA
Pathology	0	1	1	1	1	1
Pediatrics	189	206	262	273	275	277
Psychiatry	0	0	1	1	1	1
Thoracic Surgery	0	0	1	1	1	1
Urgent Care	0	1	1	1	1	1
Urological Surgery	0	1	1	1	1	0
Vascular Surgery	0	1	1	1	2	2
Total PCPs	**1,534**	**1,734**	**2,241**	**2,316**	**2,090**	**2,109**
Hospitals	49	53	66	70	71	73
Pharmacies[2]	NR	NR	NR	NR	766	767

[1]Does not include out-of-state pharmacies.

[2]UnitedHealthcare did not begin reporting the total number of MSCAN participating pharmacies until the May 2011 report.

SOURCE: Magnolia Health Plan and UnitedHealthcare staff.

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

November 3, 2011

Mr. James A Barber, Deputy Director
Joint Committee on Performance Evaluation and
Expenditure Review
Post Office Box 1204
Jackson, MS 39215-1204

Dear Mr. Barber:

Staff of the Division of Medicaid (DOM) has reviewed the draft of the PEER report entitled *An Evaluability Assessment of the Mississippi Coordinated Access Network which was received on October 28, 2011.* Corrections of factual errors in the draft report were discussed in a meeting with Lonnie Edgar on November 2, 2011.

In response to information included in the report, DOM would like to state that drafts of our State Quality Assessment and Improvement Strategy and our Request for Proposals (RFP) for an External Quality Review Organization (EQRO) were forwarded to the Centers for Medicare and Medicaid (CMS) on November 1, 2011. The draft quality strategy includes specific performance measures and target goals for level of services for the MississippiCAN program. It is noted throughout the report that DOM has not yet submitted these documents to CMS and that DOM needs target goals for performance measures. These documents have now been submitted to CMS and the drafts of the State Quality Assessment and Improvement Strategy and RFP for the EQRO can be provided at your request.

Additionally, DOM has begun the process of pulling 2010 fee-for-service baseline data to be used in comparison to 2011 MississippiCAN data. HEDIS measures will be calculated for all baseline data for which an appropriate comparison can be made. This information is expected to be available for the next PEER review.

Thank you for the opportunity to review and respond to the draft report.

Sincerely,

Robert L. Robinson
Executive Director

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