MISSISSIPPI DIVISION OF
MEDICAID

2023 ANNUAL REPORT

STATE FISCAL YEAR 2023

JULY 1, 2022 - JUNE 30, 2023

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OVERVIEW | *Program Basics*

INTRODUCTION

The Mississippi Division of Medicaid (DOM) is a state and federal program created by the Social Security Amendments of 1965 (PL 89-97), authorized by Title XIX of the Social Security Act to provide health coverage for eligible, low-income populations. The Mississippi Legislature enacted the Mississippi Medicaid program in 1969.

All 50 states, five territories of the United States and District of Columbia participate in this voluntary matching program.

Each state runs its own Medicaid program within federal guidelines, jointly funded by state and federal dollars. For Medicaid, the Federal Medical Assistance Percentage (FMAP) is used to calculate the amount of federal matching funds for state medical services expenditures. Currently, Mississippi has the highest FMAP in the country.

While each state runs its own Medicaid program, the eligibility of beneficiaries is determined by household income and Supplemental Security Income (SSI) status, based on the Federal Poverty Level (FPL) and family size. FPL is set by the Department of Health and Human Services, and DOM is obliged to adhere to it.

WHO WE SERVE

Roughly one in four Mississippians receive health benefits through Medicaid or CHIP. Beneficiaries do not directly receive money from Medicaid for health benefits. Rather, health care providers are reimbursed when beneficiaries receive medical services.

MISSISSIPPICAN

Authorized by the state Legislature in 2011, DOM oversees a Medicaid managed care program for beneficiaries, the Mississippi Coordinated Access Network (MississippiCAN).

Advantages to managed care include increasing beneficiary access to needed medical services, improving the quality of care, and cost predictability.

MississippiCAN is administered by three different coordinated care organizations (CCOs), and approximately 65 percent of DOM beneficiaries are enrolled in the program.

FEDERAL MATCH RATE

DOM provides health coverage for 27.7% of the state's population. A significant portion of DOM's annual budget comes from federal matching funds, which is calculated by the FMAP.

The Families First Coronavirus Relief Act (FFCRA), passed by Congress in March of 2020 in response to the COVID-19 pandemic, increased Mississippi's FMAP by 6.2 percentage points. This is added to the state's pre-FFCRA FMAP of 77.86%. The blended FMAP for state fiscal year (FY) 2023 equates to 83.87%.

ENROLLMENT | *FY23 Medicaid Members by Month*

TOTAL ENROLLMENT BY MONTH

The figures above reflect the Medicaid enrollment count for each month of fiscal year 2023; they do not include Children's Health Insurance Program (CHIP) beneficiaries. Enrollment reports are continually updated and available on the Medicaid website under Resources (http://medicaid.ms.gov/resources).

ENROLLMENT DURING COVID-19

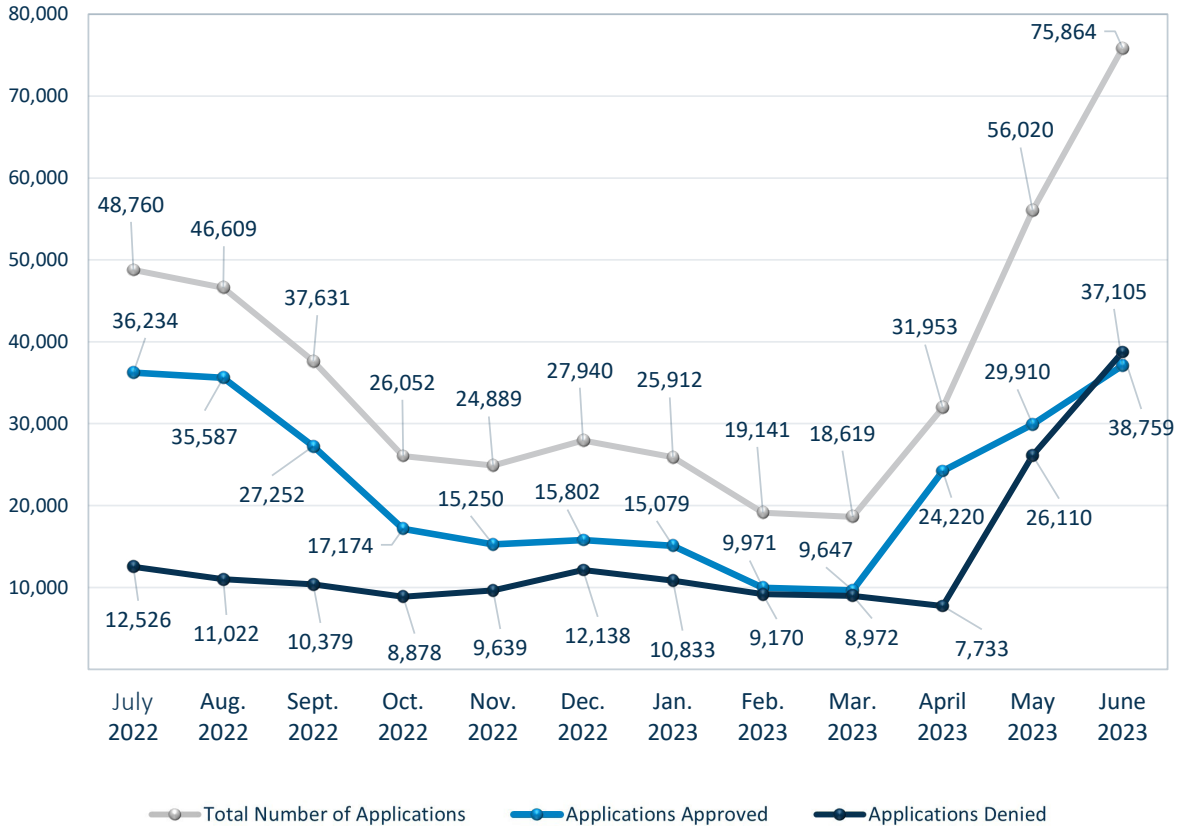
In response to the COVID-19 pandemic, Congress passed the Families First Coronavirus Relief Act (FFCRA) in March of 2020 to support states in their efforts to combat the disease.

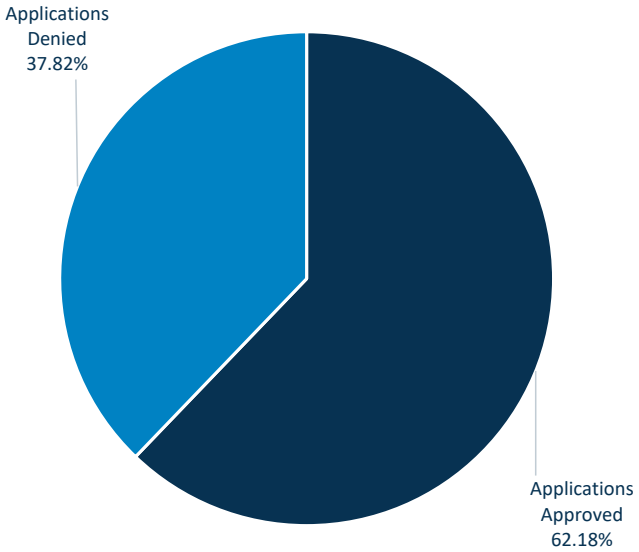
In order to receive that support, states were required to not take any adverse action on those who were eligible for benefits at the beginning of the public health emergency. Adverse actions include termination of eligibility or reduction in benefits.

In December 2022, Congress passed the Consolidated Appropriations Act (CAA). Per the CAA, the continuous coverage condition that prohibited states from disenrolling members from Medicaid was set to expire on March 31, 2023.

ENROLLMENT | *Medicaid Applications in FY23*

APPLICATIONS APPROVED/DENIED





The figures above reflect the total number of applications received, applications approved, and applications denied for state fiscal year 2023 by month, which ranged from July 1, 2022, through June 30, 2023. These figures include both initial applications and applications for annual renewal.

TOTAL NUMBER OF APPLICATIONS

439,390

APPLICATIONS APPROVED

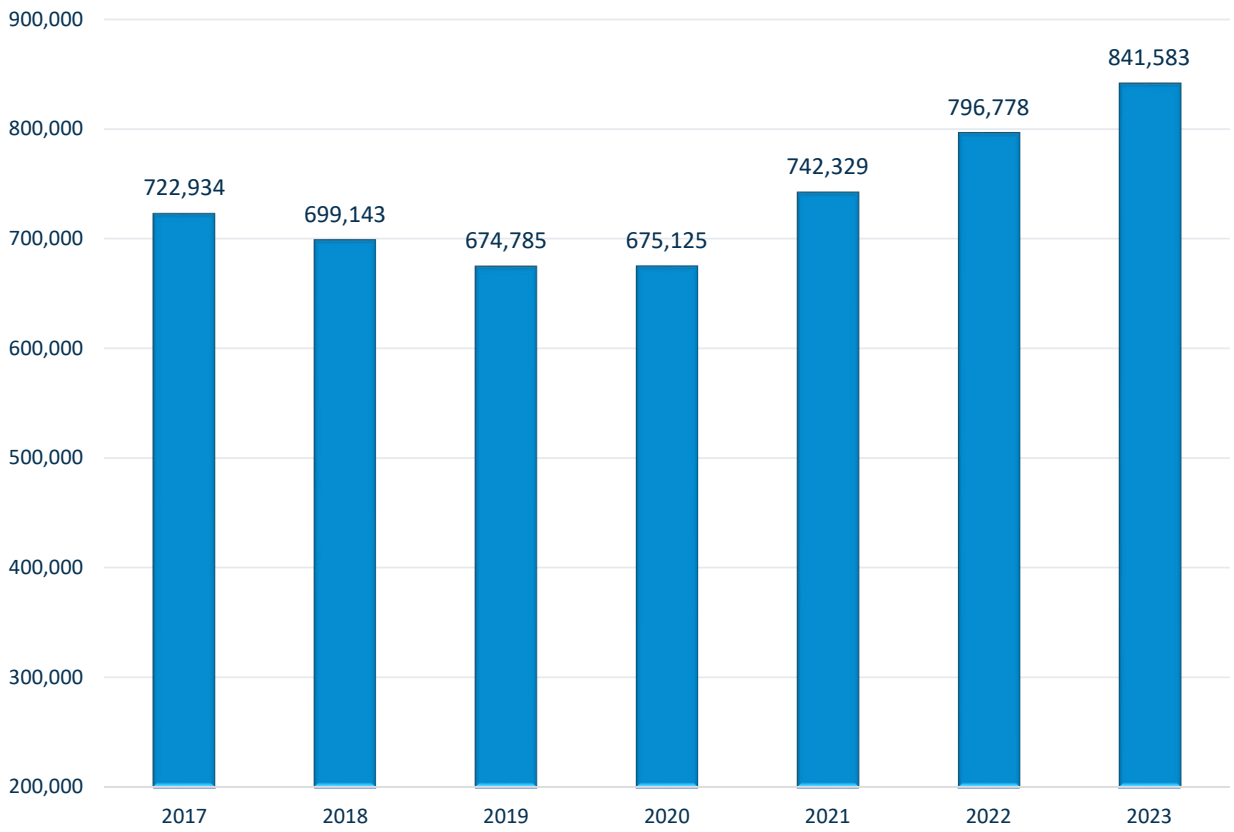
273,231

APPLICATIONS DENIED

166,159

ENROLLMENT | *Medicaid Members Annual Averages*

ANNUAL AVERAGES BY FISCAL YEAR



The figures above reflect the average annual Medicaid enrollment count for each of the past seven fiscal years; they do not include CHIP beneficiaries. Enrollment reports are continually updated and available on the Medicaid website under Resources (http://medicaid.ms.gov/resources).

FEDERAL POVERTY LEVELS

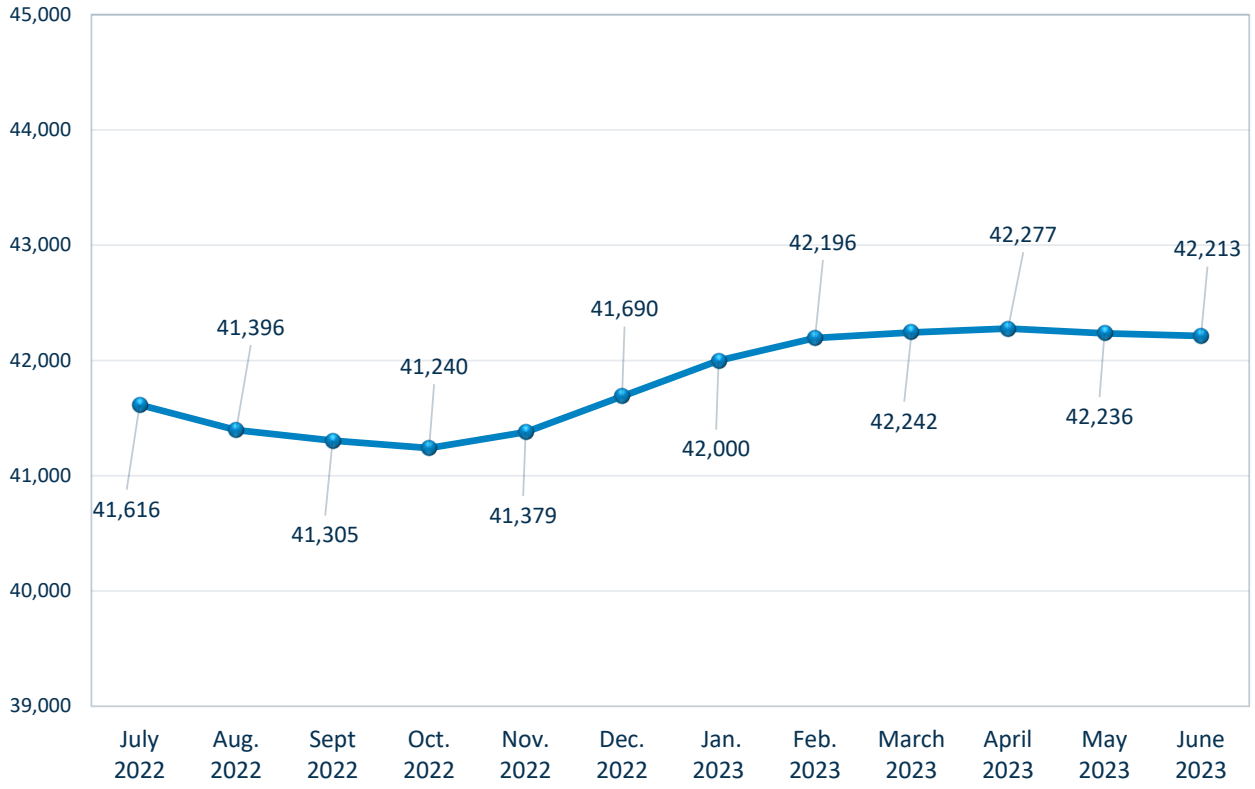
Each state has authority to choose eligibility requirements within federal guidelines. In Mississippi, Medicaid eligibility is based on factors including family size, income, and the Federal Poverty Level (FPL).

- Infants from birth to age 1 — **194% FPL**
- Children age 1 up to 6 — **143% FPL**
- Children age 6 up to 19 — **133% FPL**
- Pregnant women — **194% FPL**
- CHIP children up to age 19 — **209% FPL**

Eligibility for people who receive Supplemental Security Income (SSI) and the aged, blind, or disabled are based on additional requirements such as income and resource limits.

ENROLLMENT | *FY23 CHIP Members by Month*

TOTAL ENROLLMENT BY MONTH



The figures above reflect the Children's Health Insurance Program (CHIP) enrollment count for each month of fiscal year 2023. Enrollment reports are continually updated and available on the Medicaid website under Resources (http://medicaid.ms.gov/resources).

CHIP OVERVIEW

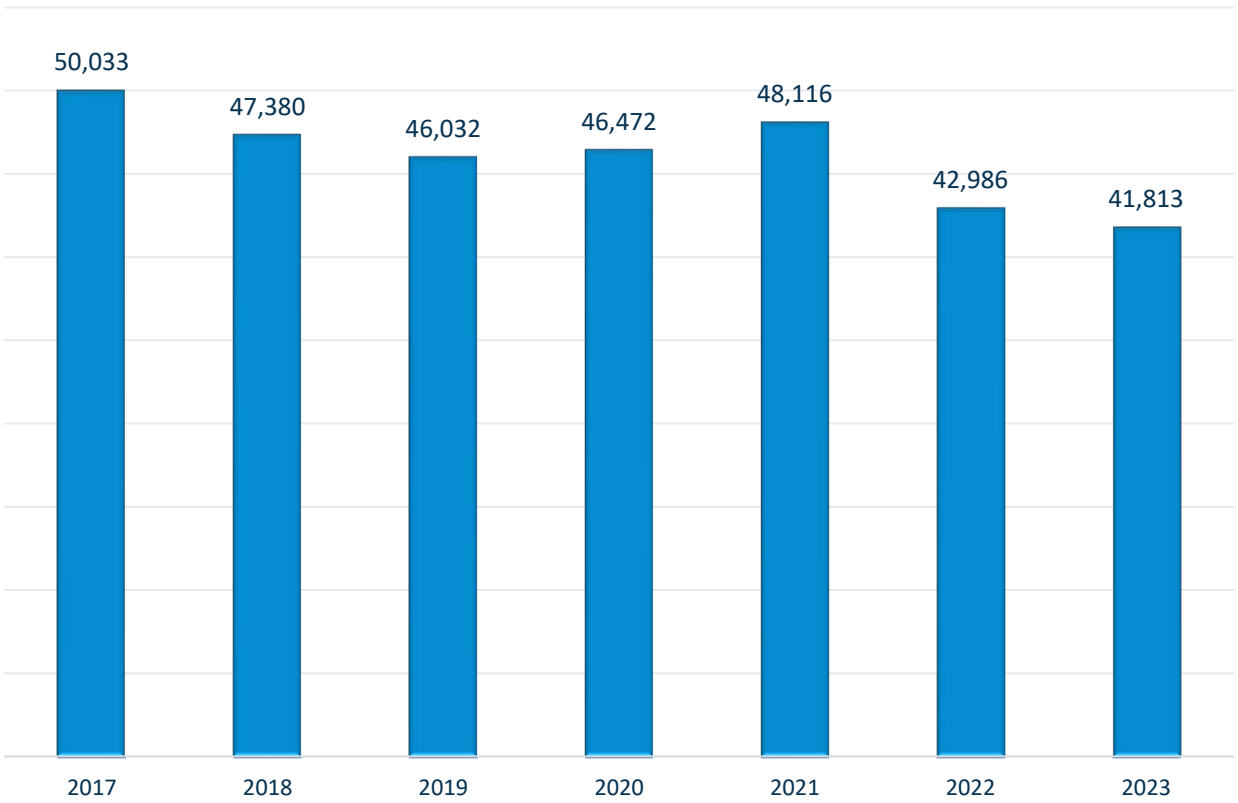
The Children's Health Insurance Program (CHIP) provides health coverage for children up to age 19, whose family income does not exceed 209 percent of the federal poverty level (FPL).

To be eligible for CHIP, a child cannot be eligible for Medicaid. Also, at the time of application, a child cannot be covered by another form of insurance to qualify for CHIP.

A child who subsequently gains other full health insurance coverage is no longer eligible for CHIP and must be disenrolled.

ENROLLMENT | *CHIP Members Annual Averages*

ANNUAL AVERAGES BY FISCAL YEAR



The figures above reflect the average annual CHIP enrollment count for each of the past seven fiscal years. Enrollment reports are continually updated and available on the Medicaid website under Resources (http://medicaid.ms.gov/resources).

CHIP OVERVIEW

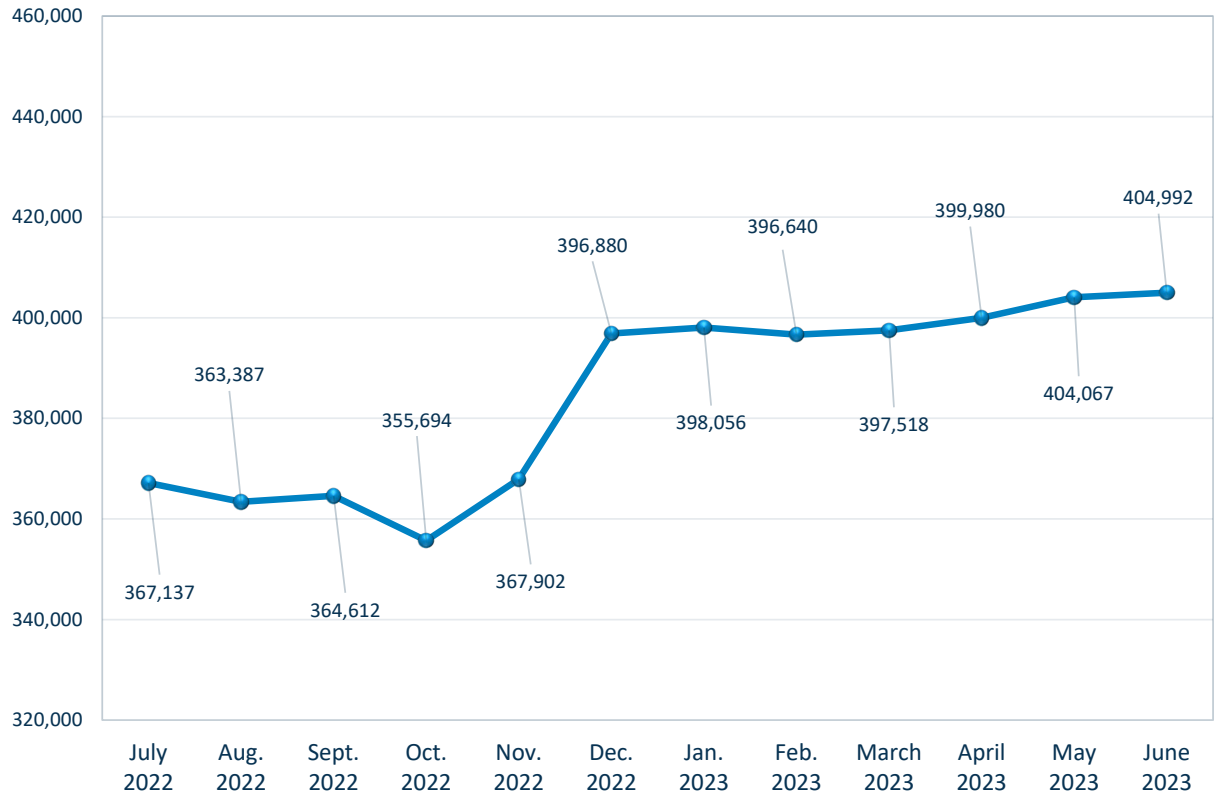
Beginning January 1, 2015, CHIP services have been provided through coordinated coordinated care organizations (CCOs) with contractual arrangements paid using actuarially-sound per member per month capitation rates.

CHIP is currently administered by two CCOs. The current CHIP contracts with Molina Healthcare and UnitedHealthcare Community Plan took effect Nov. 1, 2019.

All CHIP beneficiaries can select which plan they want during annual open enrollment which will be held October through December.

ENROLLMENT | *FY23 MississippiCAN Members by Month*

TOTAL ENROLLMENT BY MONTH



The figures above reflect MississippiCAN enrollment for fiscal year 2023. Enrollment reports are continually updated and available on the Medicaid website under Resources (http://medicaid.ms.gov/resources).

MISSISSIPPICAN OVERVIEW

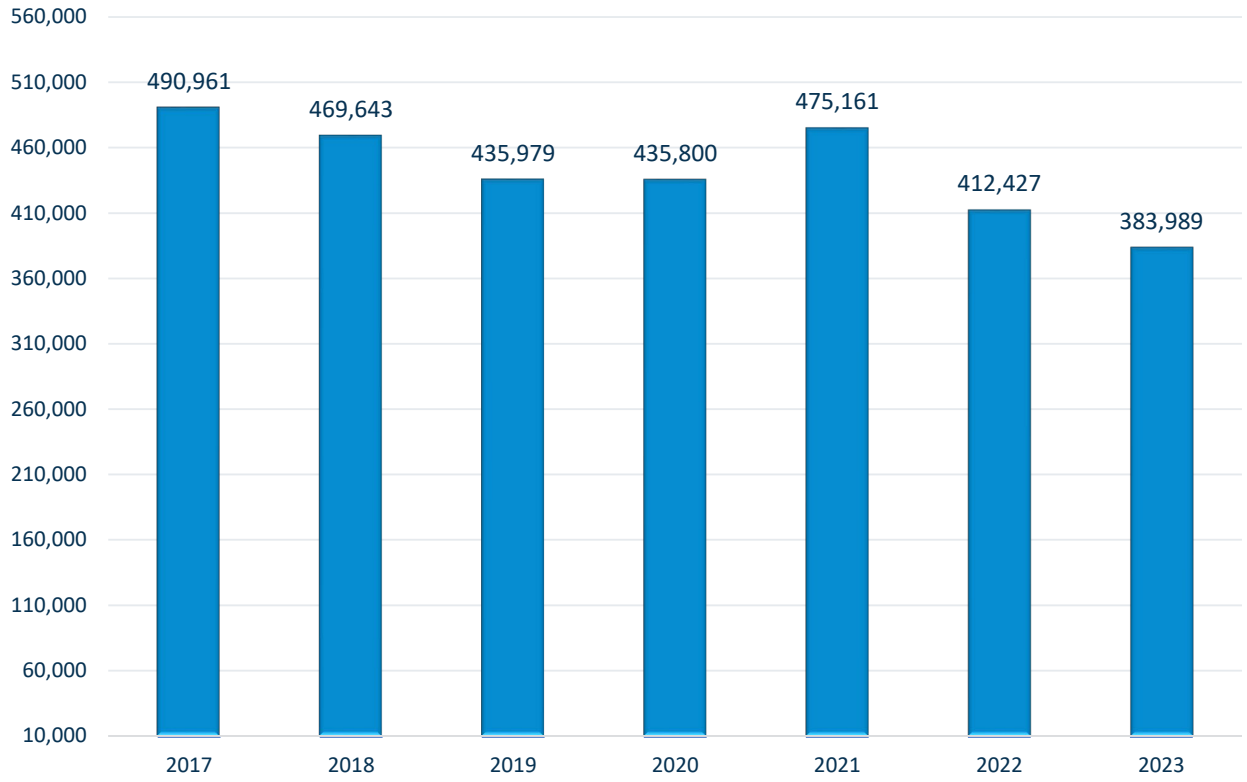
Authorized by the state Legislature in 2011, DOM oversees a Medicaid managed care program for beneficiaries called MississippiCAN.

MississippiCAN is designed to get a better return on Mississippi's health care investment by improving the health and well-being of Medicaid beneficiaries. MississippiCAN is a statewide coordinated care program designed to meet the following goals:

- improve beneficiary access to needed medical services,
- improve quality of care, and
- improve program efficiencies as well as cost predictability.

ENROLLMENT | *FY23 MississippiCAN Members Annual Averages*

ANNUAL AVERAGES BY FISCAL YEAR



The figures above reflect the average annual MississippiCAN enrollment count for each of the past seven fiscal years. Enrollment reports are continually updated and available on the Medicaid website under Resources (http://medicaid.ms.gov/resources).

MISSISSIPPICAN OVERVIEW

MississippiCAN is currently administered by different coordinated care organizations (CCOs): Magnolia Health, UnitedHealthcare Community Plan and Molina Healthcare, who are responsible for providing services to beneficiaries who participate in the MississippiCAN program.

Beneficiaries have the option of enrolling in the CCO of their choice. Health care providers who serve beneficiaries covered by Medicaid or CHIP should verify the beneficiary's eligibility at each date of service and identify to which network they belong.

The next open enrollment period will be held October through December 2023.

Providers are encouraged to enroll in all Mississippi Medicaid programs.

FINANCE | *Medicaid Funding by Source*

TOTAL

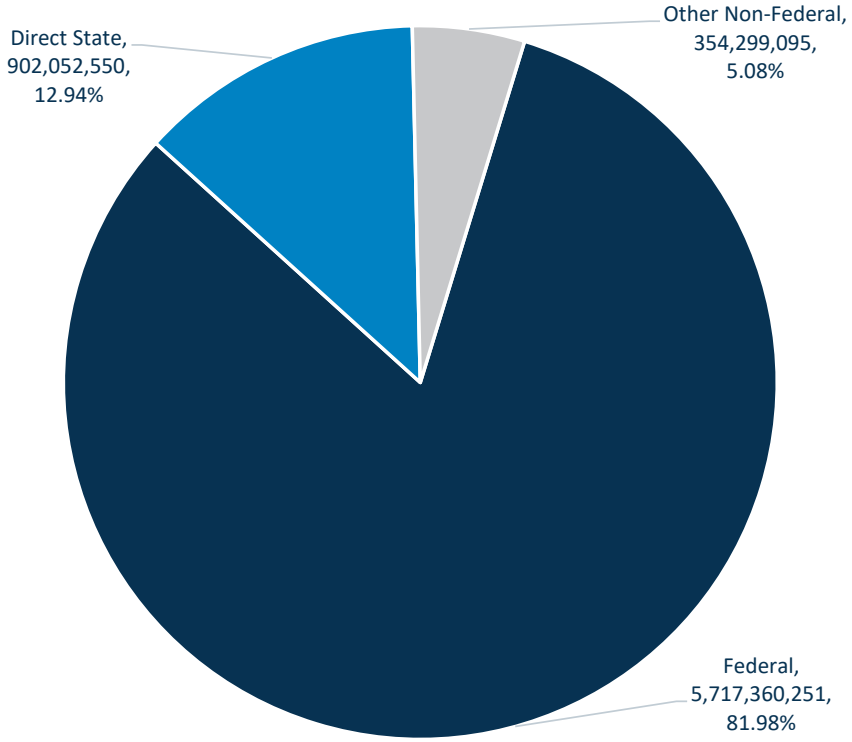
$6.9 billion

FEDERAL

$5.7 billion

DIRECT STATE

$902 million



83.87% > *Fiscal year 2023 blended FMAP for Mississippi*

FINANCE OVERVIEW

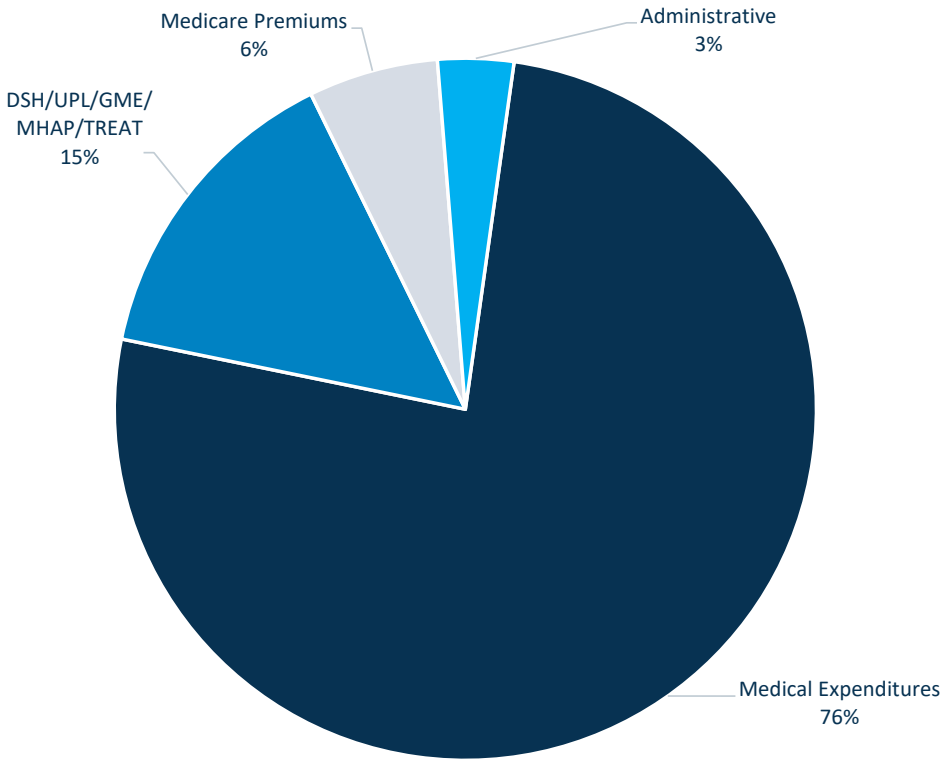
A significant portion of DOM's annual budget comes from federal matching funds, which is calculated by the Federal Medical Assistance Percentage (FMAP). The Families First Coronavirus Response Act (FFCRA), passed by Congress in March of 2020 in response to the COVID-19 pandemic, increased Mississippi's FMAP by 6.2 percentage points. This is added to the state's pre-FFCRA FMAP of 77.86%. The blended FMAP for state fiscal year (FY) 2023 equates to 83.87%.

- Of the entire Medicaid budget, 96% goes toward reimbursement for health services provided to Medicaid beneficiaries. The cost for administering the program is relatively low when compared to other state Medicaid programs. For FY 2023, administrative expenditures totaled $242,571,119.

- Nearly every dollar Medicaid receives is matched with federal funds. Depending on the project and office area, Medicaid matching rates range from 90% federal/10% state to a 50% federal/50% state match at minimum.

FINANCE | *Medicaid Expenditures*

TOTAL SPENDING



Note: *The Medical Expenditures amount includes the Children's Health Insurance Program (CHIP), MississippiCAN, Long Term Care and Home and Community Based Services. Medicare Expenditures include Part A Premiums, Part B Premiums and Part D.*

MEDICAL EXPENDITURES

$5,274,023,660

DSH/UPL/GME/MHAP

$1,008,977,170

MEDICARE PREMIUMS

$415,029,476

ADMINISTRATIVE

$242,571,119

FY2023 TOTAL

$6,940,601,425

SUPPLEMENTAL PAYMENTS AND OTHER TYPES OF CARE AND SERVICES

> The total amount paid for medical assistance and care in fiscal year 2023 includes supplemental payments and other types of care and services, such as:

GRADUATE MEDICAL EDUCATION

$41,468,600

HOSPITAL EMERGENCY PAYMENT

$137,579,801

MISSISSIPPI HOSPITAL ACCESS PROGRAM

$600,338,098

DISPROPORTIONATE SHARE HOSPITAL

$160,950,310

NURSING FACILITY UPL

$10,537,992

PHYSICIAN UPL

$59,671,144

EMERGENCY AMBULANCE ACCESS (TREAT)

$7,431,225

PROGRAM INTEGRITY | *Activites & Audits*

MISSION

- To identify and stop fraud and abuse in the Mississippi Medicaid program.
- To identify weak areas in policy and control within and external to the agency that might allow fraud, waste, or abuse to occur.
- To make recommendations for change and improvement to operations and processes at the agency to reduce the possibility of fraud, waste, and abuse.
- To determine possible provider and recipient fraud and/or abuse by investigating and auditing providers and analyzing claims data, medical records, eligibility records and payment histories as well as conducting interviews with provider staff and Medicaid recipients.

Looking back over FY 2023, the Medicaid Office of Program Integrity had the following activity:

Total overpayments identified	$8,601,454.59
Total amount recovered	$2,201,439.74
Number of Opened Investigation Cases	339 cases
Number of Cases Resulting in Corrective Action	**22 cases**
Number of Cases Referred to MFCU	10 cases
Number of Recovery Audit Contractor (RAC) Cases	132 cases
Total recovered by RAC	$31,275.58
Total PI Recovery SFY 2022	$2,232,715.32

ACTIONS TO COMBAT FRAUD, WASTE & ABUSE

DOM's actions and activities in detecting and investigating suspected or alleged fraudulent practices, violations and abuse are listed below:

Reporting Fraud
- Fraud reporting hotline
- Website Fraud and Abuse Complaint Form

Reporting Review and Analysis
- Utilization reports
- Data mining
- Intake from other Medicaid program units

Reviews and Oversight
- Provider Audits
- Recipient identification card abuse investigations
- Review National Correct Coding Initiatives edits
- Nurse reviews for medical necessity
- Analytic consultant on contract staff

Database Reviews
- Provider Enrollment Chain of Ownership System
- Prescription Monitoring Program (PMP)

Training
- Medicaid Integrity Institute — offers a variety of training for Program Integrity staff on provider reviews, best practices, and latest fraud, waste, and abuse trends and schemes
- Conferences and other training opportunities for Medicaid staff and participation in external training as necessary to educate providers and to stay abreast of trends, schemes, and updates from CMS
- Webinars provide current fraud and abuse practices to review and the latest trends and schemes
- Enhancing our collaborative relationship in working with the MFCU with managed care training and investigative training

HOW TO REPORT FRAUD & ABUSE

Anyone can report fraud or abuse:

Email: fraud@medicaid.ms.gov
Toll-free: 800-880-5920 | Phone: 601-576-4162
Fax: 601-576-4161
Mailing address: 550 High Street, Suite 1000, Jackson, MS 39201
Online: www.medicaid.ms.gov/contact/report-fraud-and-abuse/

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MEDICAID AUDITS

Based on analysis of provider billing patterns that indicate possible overpayments by the Division of Medicaid, the Office of Program Integrity will initiate an investigation. The investigation can be a desk review, which is done based on a review of claims data reports and other documents, or it can be a field investigation in which the Medicaid auditor goes onsite to the provider's place of business to conduct the record review and obtain medical records and conduct any related interviews of medical staff.

If the investigation indicates the provider has likely abused the Medicaid system by generating unnecessary costs to Medicaid from excessive or unnecessary services, the auditor will prepare and present the findings report. The provider then has an opportunity to refute the findings. If the provider refutes the findings, the provider must submit document to support the resolution.

The auditor will review the documentation and either accept the documentation or not accept. A demand is then issued for the identified overpayment.

The provider then has an opportunity to appeal an adverse audit and request an administrative hearing before a Hearing Officer, who will thereafter make a written recommendation to the executive director of the final decision. Should the provider disagree with the executive director's decision, then the provider may file an appeal with the courts.

INVESTIGATIVE REVIEW & REFERRAL PROCESS

Often, what began as a routine investigation may result in a credible allegation of fraud. Some of these investigations may result only in recovery of improperly paid claims funds from the provider, or the provider may be educated on the issue.

However, if the evidence supports a credible allegation of fraud by the provider, then the case is referred to the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General for possible criminal prosecution or civil action in accordance with the MOU between the two agencies.

The Office of Program Integrity also terminates providers that have been found guilty of a felony, sanctioned by the Office of Inspector General, sanctioned by Medicare, or debarred by other states.

DATA ANALYSIS & MEDICAL REVIEW

Key to the development of investigations is the use of data analytical tools found from data mining such as algorithms that uncover areas of potential fraud and abuse in the Medicaid system.

The algorithms are created through research using multiple means such as Medicare Fraud Alerts, provider bulletin updates, newspaper articles, trends, schemes, and other sources. Since 2020, the Program Integrity has not had a full-time statistician or data analyst, and this is an addition which could significantly augment and improve the work of Program Integrity. Program Integrity works closely with multiple external partners and contracted vendors providing a range of different services, such as data mining, creating reports, reviewing claims, and providing research for provider reviews.

When investigations involve issues of medical judgment, or the medical necessity of treatment and services, the registered nurses in the Medical Review Division review claims of both providers and beneficiaries to determine the medical necessity and appropriateness of services rendered and to ensure quality to meet professionally

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recognized standards of health care. Program Integrity also works with DOM's Utilization Management/Quality Improvement Organization (UM/QIO) to conduct medical necessity review.

MEDICAID ELIGIBILITY QUALITY CONTROL

The Medicaid Eligibility Quality Control Division (MEQC) determines the accuracy of decisions made by the Eligibility Unit at Mississippi Medicaid in enrolling beneficiaries. MEQC verifies that persons receiving Medicaid benefits are eligible and that no one is refused benefits for which they are eligible.

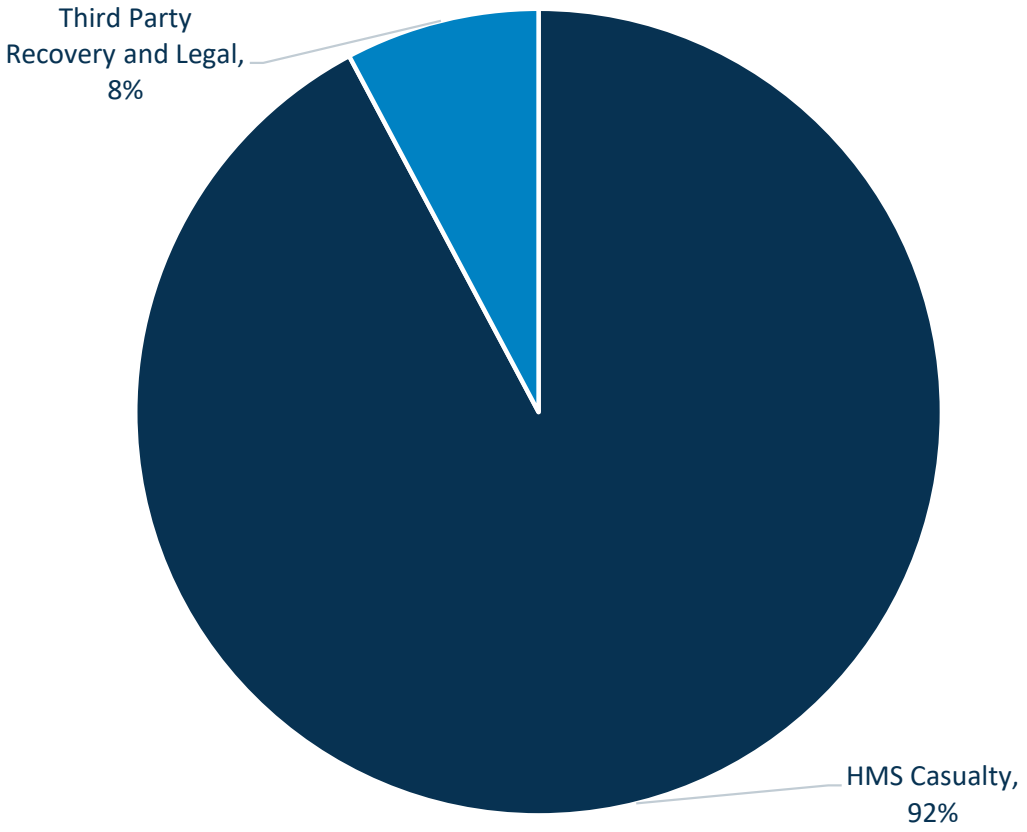
EXTERNAL CONTRACTS MANAGEMENT DIVISION

The External Contracts Management (ECM) Division is primarily responsible for program integrity oversight of the Managed Care Organizations (MCOs). The ECM staff and MCO liaison monitors MCO compliance with 42 CFR §438, 42 CFR §455, Mississippi Coordinated Access Network (Mississippi CAN) Contracts, Children's Health Insurance Program (CHIP) Contracts, Fraud and Abuse Compliance Plan, and the Program Integrity Fraud and Abuse Standard Operating Procedures.

ECM provides oversight over the Recovery Audit Contractor (RAC), an organization that conducts post-pay audits of claims to correct improper payments. Currently, PI has a RAC Waiver with CMS.

ECM also manages the Beneficiary Health Management Program, which is responsible for identifying potential candidates for the Pharmacy Lock-In Program. Data reports are reviewed to identify candidates based on criteria from the Administrative Code. Beneficiaries are also referred to the MCOs when appropriate for lock-in as well.

THIRD PARTY RECOVERY | *Amounts Recovered*



RECOVERED FUNDS

The Office of Third Party Recovery and the Legal department assigned by the Office of the Attorney General collect funds through estate recovery and from third parties by reason of assignment or subrogation.

In collaboration with the legal staff and HMS Casualty, a breakdown for the funds recovered for fiscal year 2023 are listed below.

THIRD PARTY RECOVERY AND LEGAL

$543,784

HMS CASUALTY

$6,444,197

TOTAL FUNDS RECOVERED

$6,987,981

HCBS | *Home and Community Based Services*

Waiver	Avg. of participants FY 2023	Waiting list	Fed. authorized slots in FY 2024	Total cost per person FY 2023*	Estimated state cost to fund all slots FY 2025**
Assisted Living	827	101	1,100	$11,742.96	$2,945,134.37
Elderly and Disabled	17,232	7,445	22,200	$18,535.15	$93,817,515.24
Independent Living	2,420	523	5,800	$17,418.35	$23,034,026.04
Intellectual Disabilities/ Developmental Disabilities	2,629	2,738	3,250	$49,364.70	$36,579,242.70
Traumatic Brain Injury/ Spinal Cord Injury	833	30	1,150	$16,334.22	$4,282,832.48
Totals	**23,941**	**10,837**	**33,500**		**$160,658,750.83**

* *Total cost per person is based on FY2023 data as of June 30, 2023. Costs may be adjusted based on claims submitted throughout the timely filing period.*

** *Estimated state cost to fund all slots based on FY2025 blended FMAP of 77.20%.*

HOME AND COMMUNITY BASED SERVICES OVERVIEW

- 1915(c) Home and Community Based Services (HCBS) Waivers provide home and community-based services as an alternative to care provided in an institutional setting such as a nursing or intermediate care facility.
- Through a person-centered planning process, a combination of specialized waiver services, State Plan benefits, and other supports are identified to ensure quality care in the least restrictive setting available for this vulnerable population.

SOURCE NOTES

- The average number of current participants over the fiscal year is based on data submitted in the monthly legislative report.
- Number of participants on the wait list as reported in the monthly legislative report for the last month of the fiscal year (June 2023).
- Total Cost Per Person – D+D' from the monthly 372 report on the last day of the fiscal year (6/30/2023).

HIGHLIGHTS | *2023 Developments*

MESA PORTAL GOES LIVE FOR PROVIDERS

- On October 3, 2022, Mississippi Medicaid went live with a new provider enrollment and claims processing solution known as MESA, Medicaid Enterprise System Assistance. The agency's goal with MESA is to enhance connections between health systems and improve access to health information for Medicaid providers and the members they serve. The new system replaced outdated technology with a more efficient version that is easier to maintain.

- A new and improved provider portal allows a streamlined provider enrollment process. The provider enrollment process is now conducted online with the Division of Medicaid no longer accepting paper enrollment applications. Health care providers can submit and adjust claims in real-time for each claim type and submit batches of transactions, as well as verify a patient's eligibility status quickly and easily.

- The new system also allows for a centralized credentialing process, eliminating the need for providers to credential with Mississippi Medicaid and each coordinated care organization.

ANNUAL ELIGIBILITY RENEWALS RESUME

- During the COVID-19 pandemic yearly Medicaid renewals were paused; however, beginning April 1, 2023, Mississippi Medicaid resumed eligibility determinations in compliance with the requirements of the Consolidated Appropriations Act passed by Congress in December 2022.

- The process, commonly referred to as an "unwinding plan" will take 12 months to initiate renewals and 14 months to complete renewals for each of the approximately 880,000 Mississippians enrolled as of spring 2023.

- Following the Division's unwinding plan, each month the agency first tries to renew a member's benefits by looking at electronic verification sources. This is known as an "ex parte" renewal. If unable to approve a member this way, the member will be mailed a prepopulated renewal form and have 30 days to fill it out and mail it back to the Division so they can stay covered. The mailing also includes detailed instructions on the multiple ways members can return their renewal forms – including by phone, fax, and online submission.

CONTACT US | *More Information*

MORE INFORMATION

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MISSISSIPPI DIVISION OF
MEDICAID