MISSISSIPPI DIVISION OF
MEDICAID

2022 ANNUAL REPORT

STATE FISCAL YEAR 2022

JULY 1, 2021 - JUNE 30, 2022

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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.

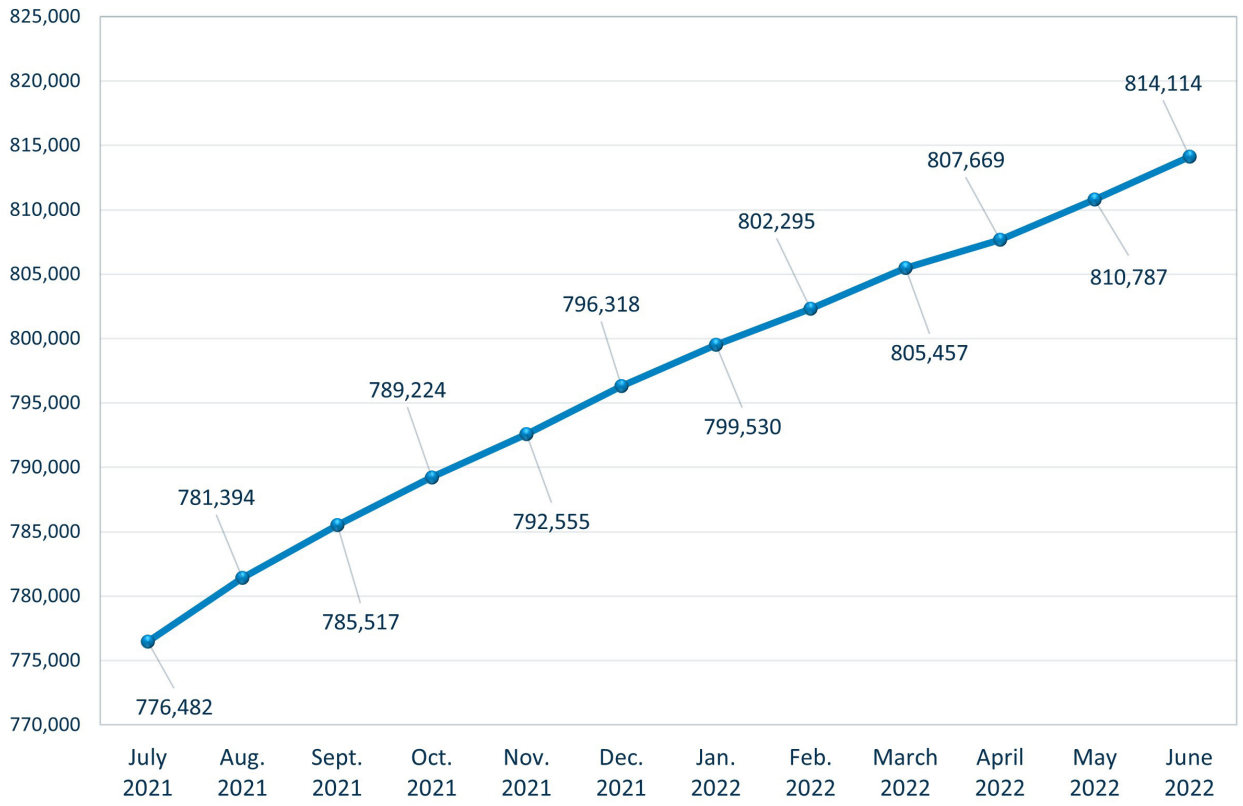
FEDERAL MATCH RATE

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. Combined with the state's pre-FFCRA FMAP of 78.31%, the blended federal match for state fiscal year 2022 equates to 84.37%.

ENROLLMENT | *FY22 Medicaid Members by Month*

TOTAL ENROLLMENT BY MONTH



The figures above reflect the Medicaid enrollment count for each month of fiscal year 2022; 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

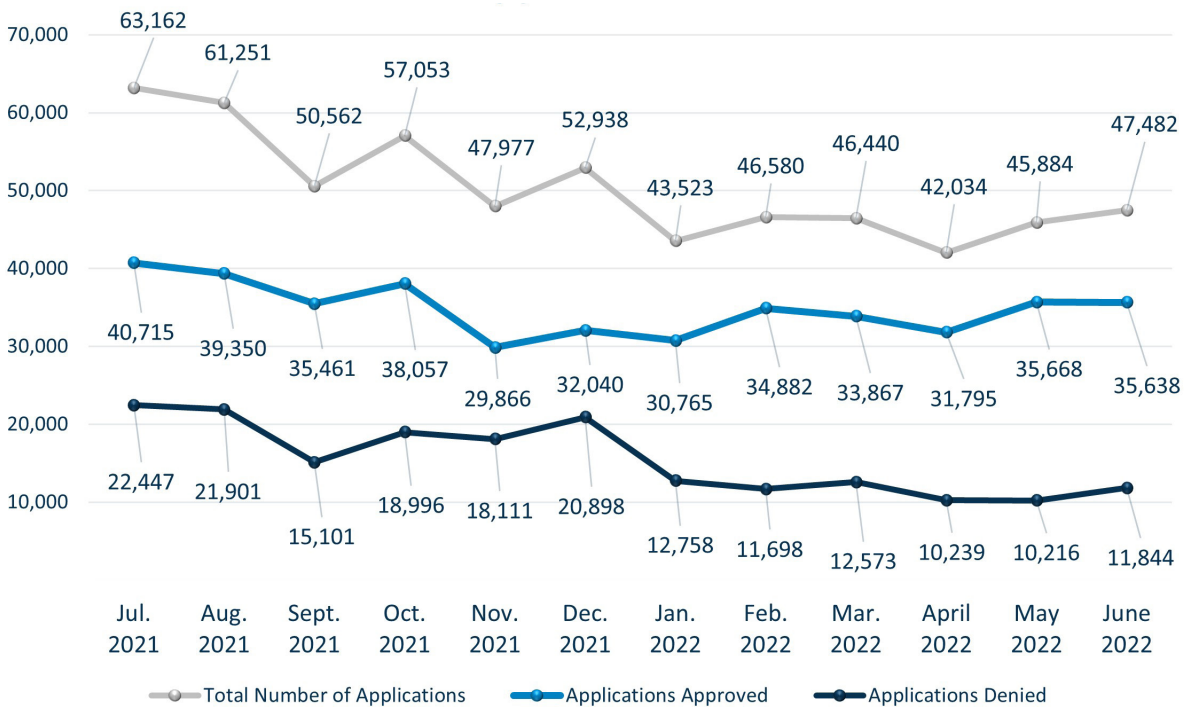
In response to the COVID-19 pandemic, Congress passed the Families First Coronavirus Relief Act (FFCRA) in March of 2020 to support states in their efforts to combat the disease.

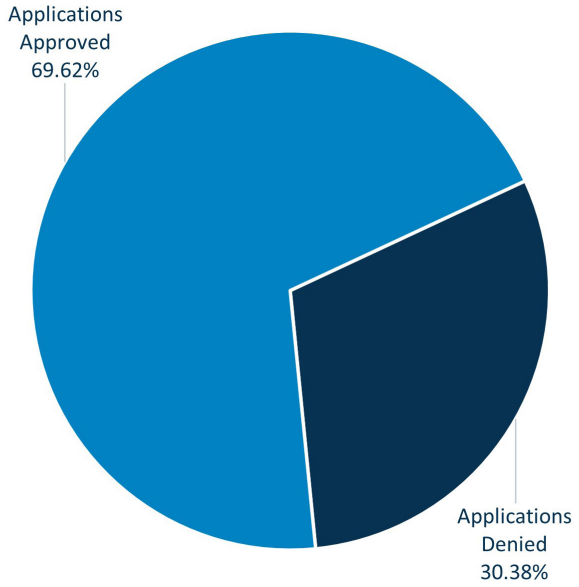
In order to receive that support, states were required to not take any adverse action on those who were eligible for benefits at the beginning of the public health emergency. Adverse actions include termination of eligibility or reduction in benefits.

States were only allowed to take adverse action in cases of death, the beneficiary moving out of state or the request for closure by the beneficiary.

ENROLLMENT | *Medicaid Applications in FY22*

APPLICATIONS APPROVED/DENIED





The figures above reflect the total number of applications received, applications approved, and applications denied for state fiscal year 2022 by month, which ranged from July 1, 2021, through June 30, 2022. These figures include both initial applications and applications for annual renewal.

TOTAL NUMBER OF APPLICATIONS

614,886

APPLICATIONS APPROVED

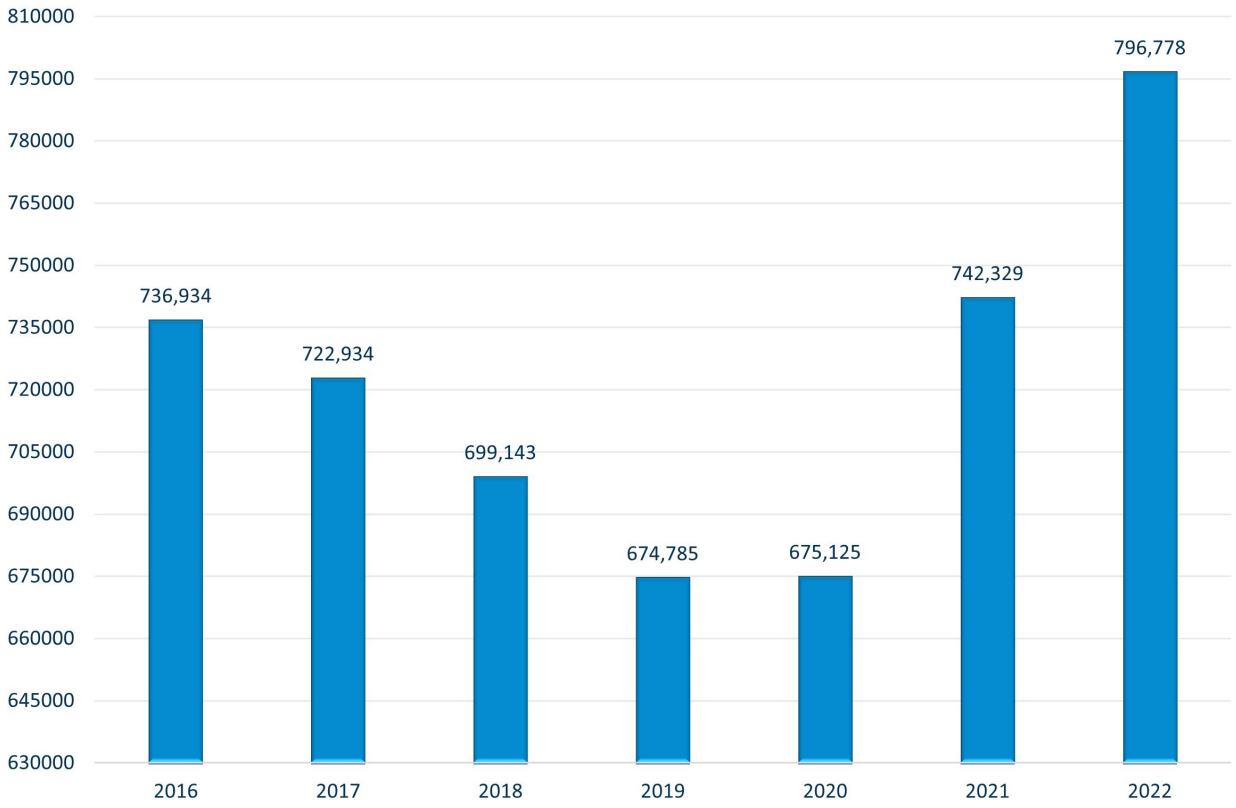
428,104

APPLICATIONS DENIED

186,782

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

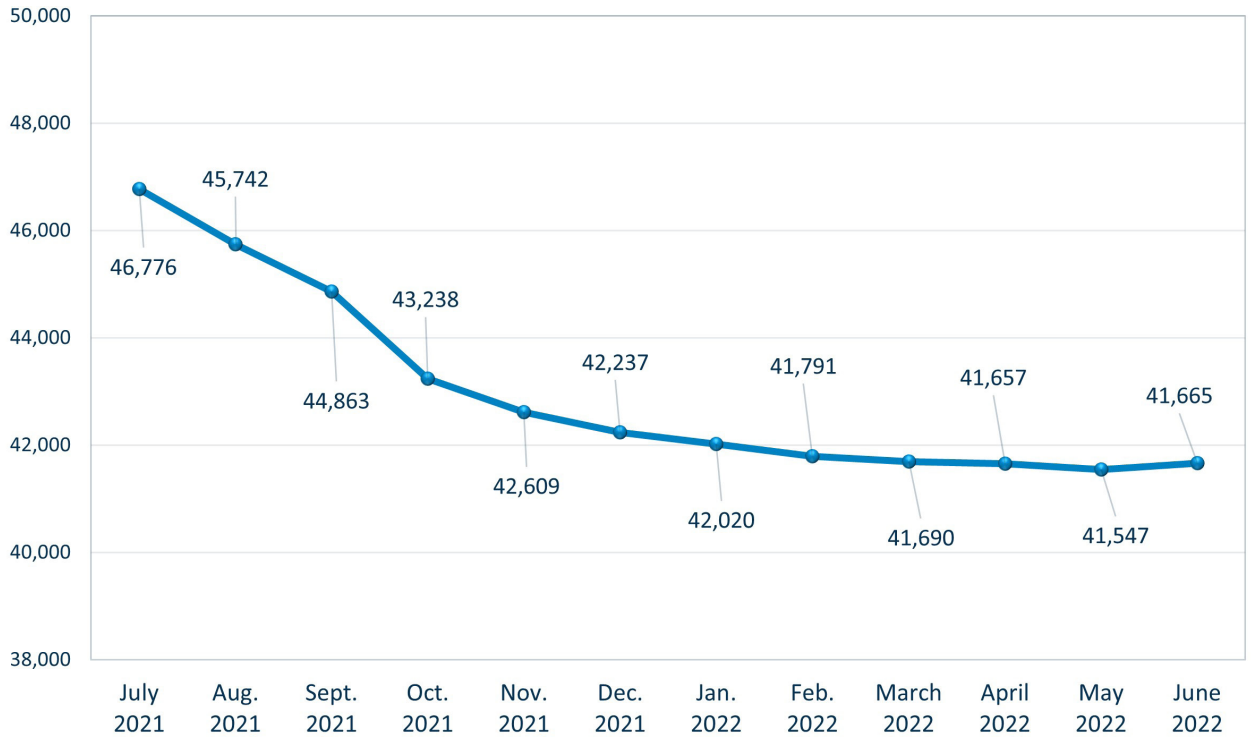
Each state has authority to choose eligibility requirements within federal guidelines. In Mississippi, Medicaid eligibility is based on factors including family size, income, and the Federal Poverty Level (FPL).

- 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 | *FY22 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 2022. 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).

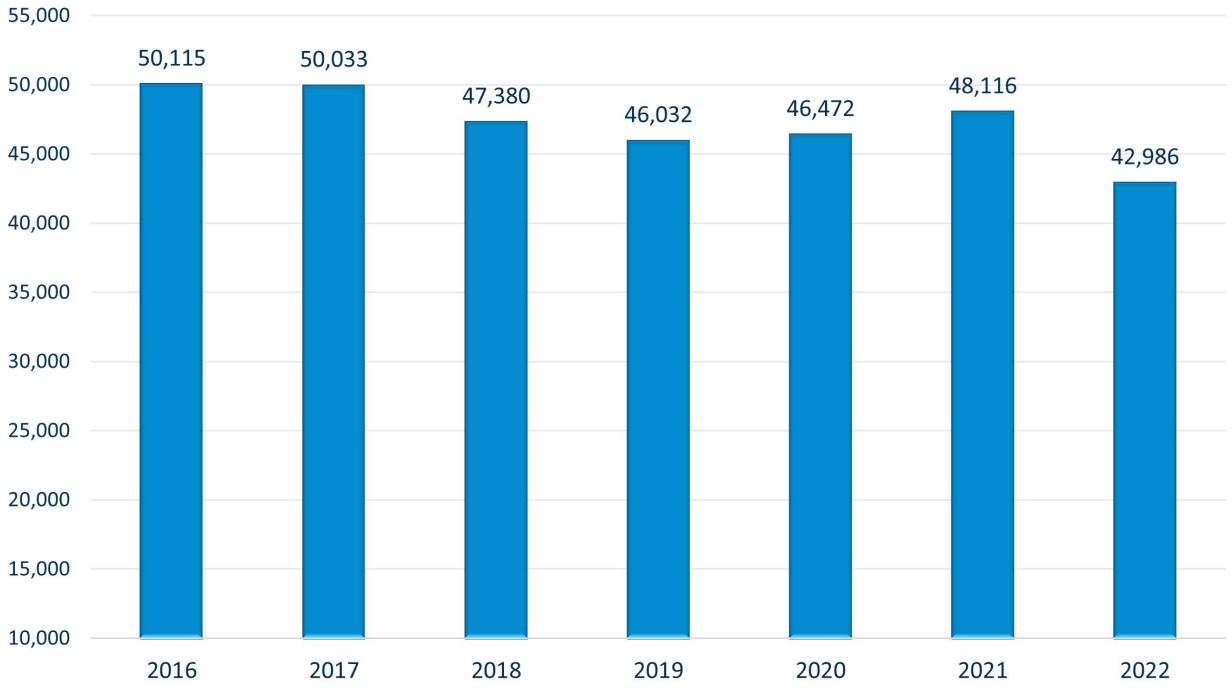
To be eligible for CHIP, a child cannot be eligible for Medicaid. Also, at the time of application, a child cannot be covered by another form of insurance to qualify for CHIP.

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

DOM projects CHIP enrollment to remain elevated compared to years prior to the pandemic due to the maintenance of effort required by FFCRA to receive the additional FMAP.

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

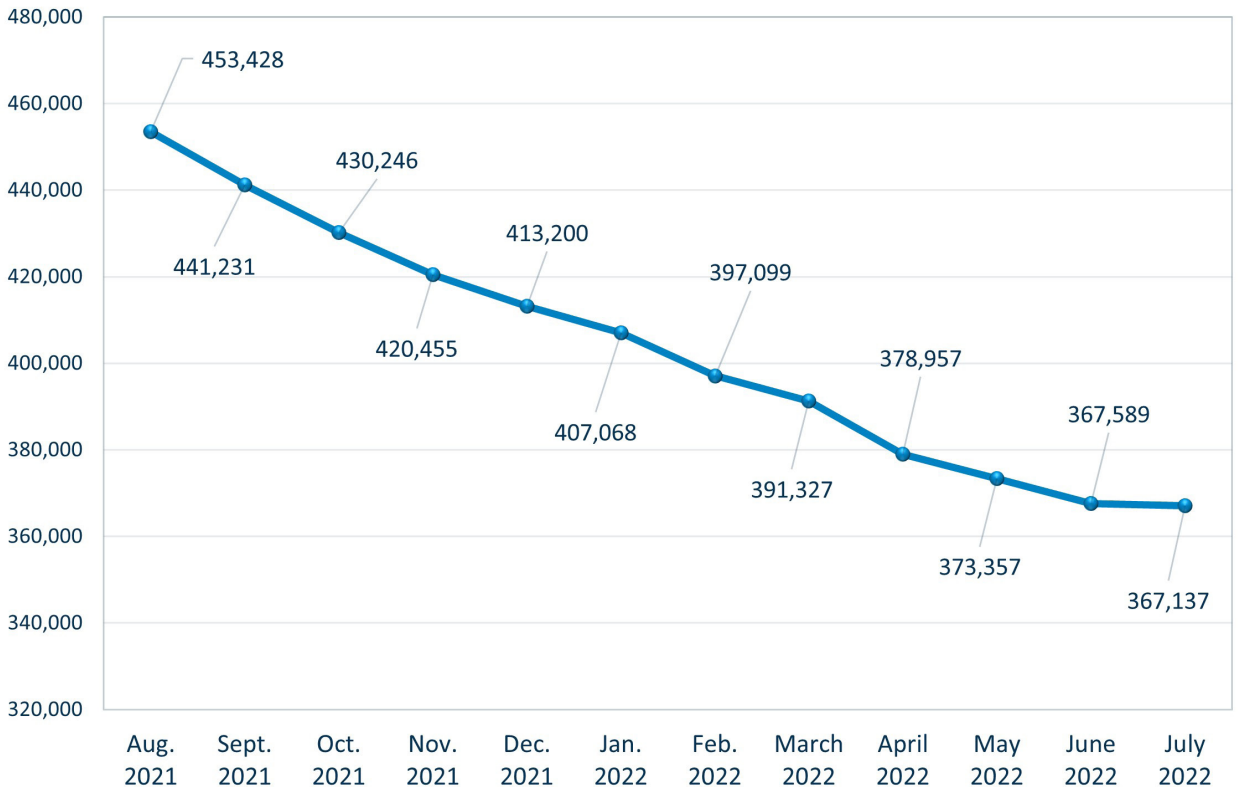
Beginning January 1, 2015, CHIP services have been provided through coordinated coordinated care organizations (CCOs) with contractual arrangements paid using actuarially-sound per member per month capitation rates.

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 | *FY22 MississippiCAN Members by Month*

TOTAL ENROLLMENT BY MONTH



The figures above reflect MississippiCAN enrollment for fiscal year 2022. Enrollment reports are continually updated and available on the Medicaid website under Resources (http://medicaid.ms.gov/resources).

MISSISSIPPICAN OVERVIEW

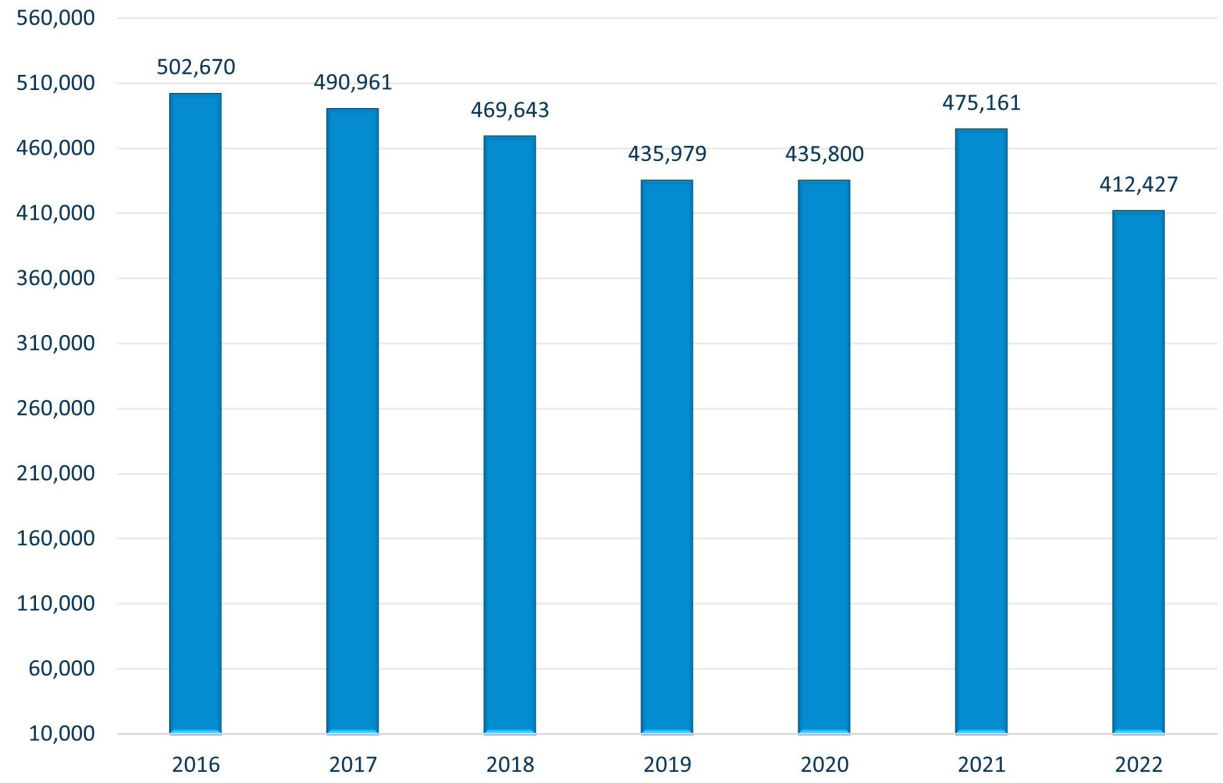
Authorized by the state Legislature in 2011, DOM oversees a Medicaid managed care program for beneficiaries called MississippiCAN.

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 | *FY22 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

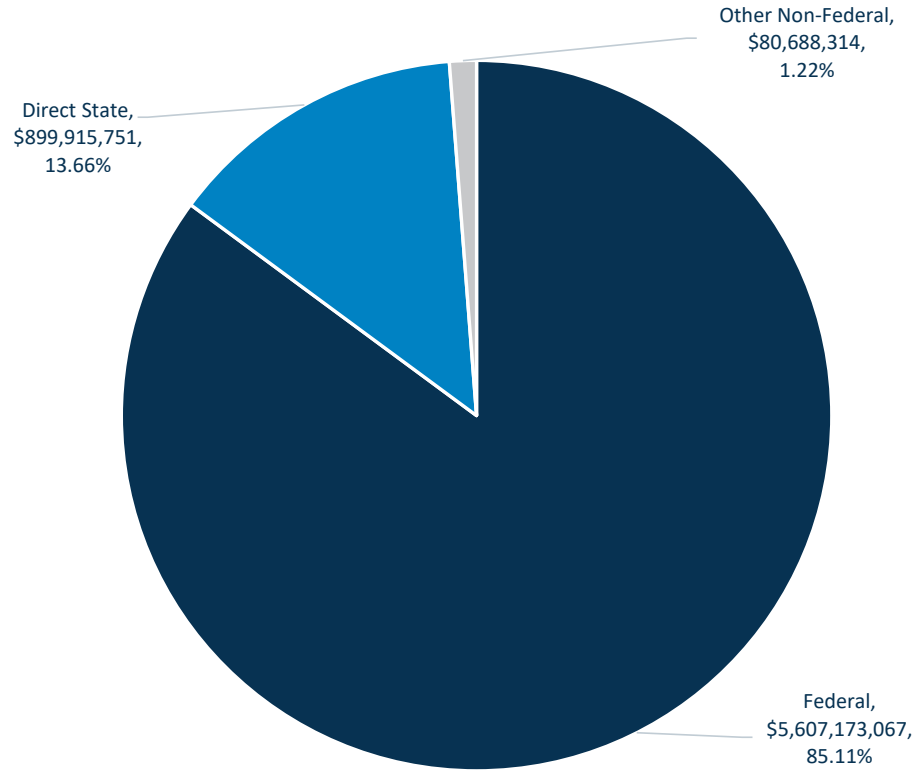
$6 billion

FEDERAL

$5.1 billion

DIRECT STATE

$900 million



84.37% > *Fiscal year 2022 blended FMAP for Mississippi*

FINANCE OVERVIEW

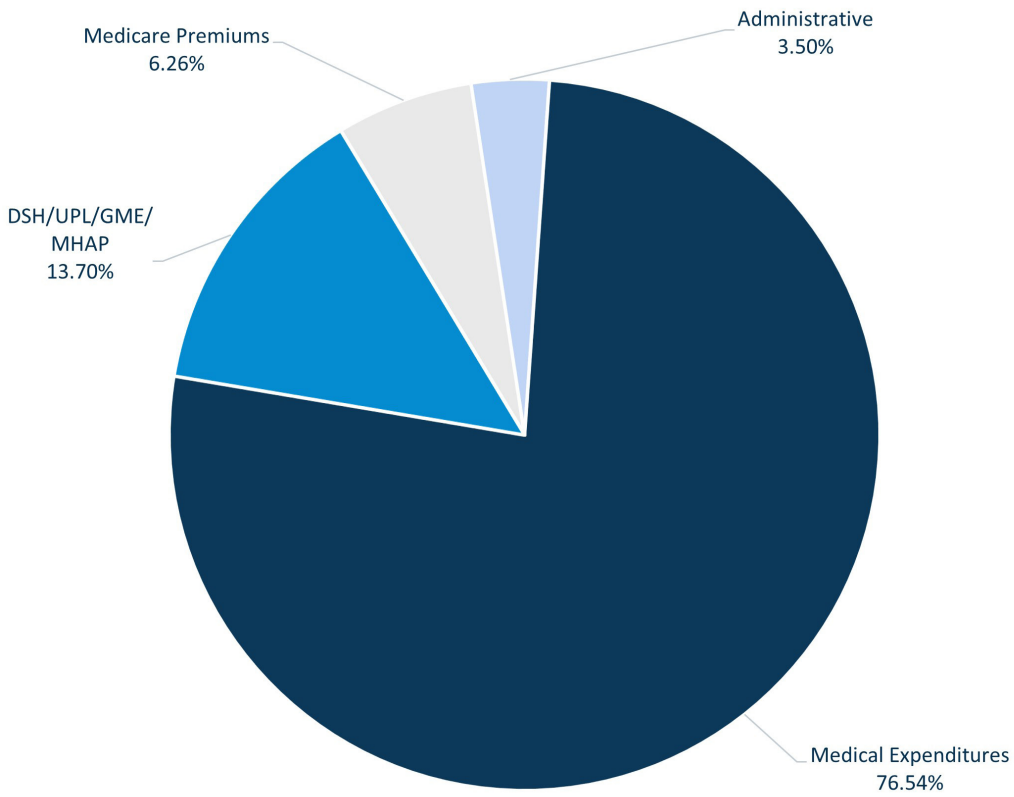
A significant portion of DOM's annual budget comes from federal matching funds, which is calculated by the Federal Medical Assistance Percentage (FMAP). The Families First Coronavirus Relief Act (FFCRA), passed by Congress in March of 2020 in response to the COVID-19 pandemic, increased Mississippi's FMAP by 6.2 percentage points. Combined with the state's pre-FFCRA FMAP of 78.31%, the blended FMAP for state fiscal year (FY) 2022 equates to 84.37%.

- Of the entire Medicaid budget, more than 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 2022, administrative expenditures totaled $214,391,898.

- 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

$4,685,291,546

DSH/UPL/GME/MHAP

$838,348,059

MEDICARE PREMIUMS

$382,959,389

ADMINISTRATIVE

$214,391,898

FY2022 TOTAL

$6,120,990,892

FINANCE | *Medical Assistance and Care*

SUPPLEMENTAL PAYMENTS AND OTHER TYPES OF CARE AND SERVICES

- The total amount paid for medical assistance and care in fiscal year 2022 includes supplemental payments and other types of care and services, such as:

$838,348,059

- Mississippi Hospital Access Program (MHAP) payments, Disproportionate Share Hospital, and Upper Payment Limit funds

$1,000,000

- State grant funding for the Delta Health Alliance project

$263,500

- Health Information Technology (HIT) incentive payments from the Centers for Medicare and Medicaid Services

$126,647,848

- Children's Health Insurance Program (CHIP)

$382,959,389

- Medicare Premiums

PROGRAM INTEGRITY | *Activites & Audits*

MISSION

- To identify and stop fraud and abuse in the Mississippi Medicaid program.
- To identify weak areas in policy and controls 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 or abuse by investigating and auditing providers by analyzing records, medical charts, eligibility records and payment histories as well as conducting interviews with provider staff and Medicaid beneficiaries.

Looking back over calendar year 2021, Medicaid had the following activity:

Total overpayments identified	$7,647,370.64
Total amount recovered	$1,649,742.37
Number of Opened Investigation Cases	232 cases
Number of Cases Resulting in Corrective Action	27 cases
Number of Cases Referred to MFCU	19 cases
Number of Recovery Audit Contractor (RAC) Cases	319 cases
Total recovered by RAC	$127,838.53
Total PI Recovery SFY 2022	$1,777,580.90

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
- Beneficiary identification card abuse investigations
- Review National Correct Coding Initiatives edits
- Nurse staff reviews for medical necessity
- Analytic consultant on contract staff

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

Training
- Webinars recommend current fraud and abuse practices to review
- Medicaid Integrity Institute — offers training on provider reviews, best practices, and latest fraud, waste, and abuse trends
- Conferences and other training opportunities for Medicaid staff and participation in external training as necessary to educate providers

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/

MEDICAID AUDITS

Based on analysis of provider billing patterns that indicate possible overpayments by the Division of Medicaid, the Office of Program Integrity will

Continued on page 13

initiate an audit. The audit can be a desk audit, which is done entirely based on billing records and/or actual claims records, or it can be a field audit in which the Medicaid auditor goes to the provider's place of business to conduct the record review and any related interviews of medical staff and providers such as physicians or hospital personnel. If the audit 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 appeal an adverse audit and request an administrative hearing before a Hearing Officer, who will thereafter make a written recommendation to the executive director for a 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 audit may result in a credible allegation of fraud. Some of these investigations may result only in recovery of funds from the provider for improper claims. 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 the Medicaid number of any provider that has 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 audits is the use of data analysis tools such as algorithms that uncover areas of potential fraud and abuse in the Medicaid system. The algorithms are created through

Continued on page 14

research using multiple means such as Medicare Fraud Alerts, newspaper articles, websites, 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 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 recognized standards of health care.

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.

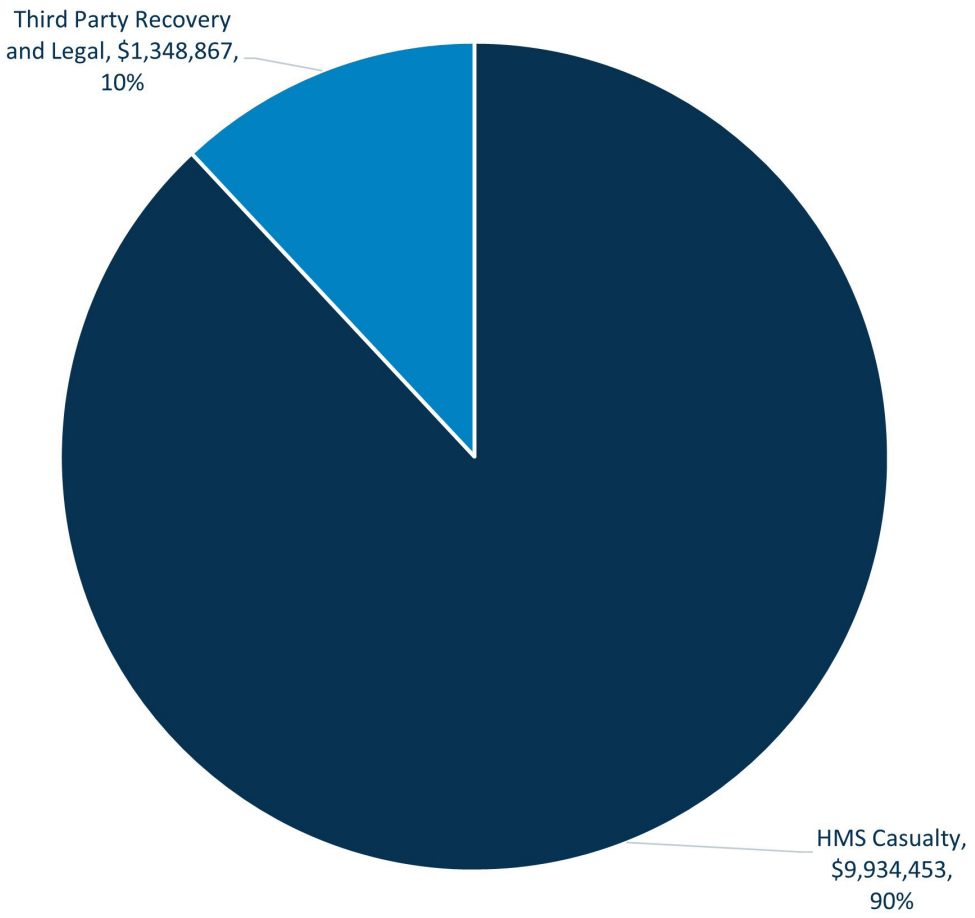
Program Integrity works closely with multiple external partners and contracted vendors providing a range of different services, such as creating reports, reviewing claims, and providing research for provider reviews.

EXTERNAL CONTRACTS MANAGEMENT DIVISION

The External Contracts Management (ECM) Division is primarily responsible for managing reports and complaints of fraud submitted to OPI by the Managed Care Organizations (MCOs). The Director 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. The ECM is primarily responsible for managing the duties performed by the RAC contractor and overseeing the day-to-day operations of the recovery audit program within OPI. OPI has been without a RAC Contractor since March of 2022. SPA 22-0024 was submitted to allow the Division to request an exception to the Recovery Audit Contractors (RAC) requirements for a period of one (1) year from the approval date of SPA 22-0024 to attempt to procure a new Contractor. CMS approved the State Plan Amendment on December 12, 2022, with an effective date of July 1, 2022 – June 30, 2023.

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

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 2022 are listed below.

THIRD PARTY RECOVERY AND LEGAL

$1,348,867

HMS CASUALTY

$9,934,453

TOTAL FUNDS RECOVERED

$11,283,320

HCBS | *Home and Community Based Services*

Waiver	Avg. of participants FY 2022	Waiting list	Fed. authorized slots in FY 2023	Total cost per person FY 2022*	Estimated state cost to fund all slots FY 2023**
Assisted Living	727	16	1,100	$18,139.16	$3,467,844.61
Elderly and Disabled	16,993	7,474	22,200	$17,178.68	$66,281,531.76
Independent Living	2,349	672	5,800	$21,551.83	$21,725,106.71
Intellectual Disabilities/ Developmental Disabilities	2,623	2,620	4,150	$51,398.86	$37,072,455.75
Traumatic Brain Injury/ Spinal Cord Injury	833	63	1,100	$27,803.99	$5,315,566.81
Totals	**23,525**	**10,845**	**34,350**		**$133,862,505.64**

* *Total cost per person is based on FY2022 data as of June 30, 2022. Costs may be adjusted based on claims submitted throughout the timely filing period.*

** *Estimated state cost to fund all slots based on FY2023 blended FMAP of 82.62%.*

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.

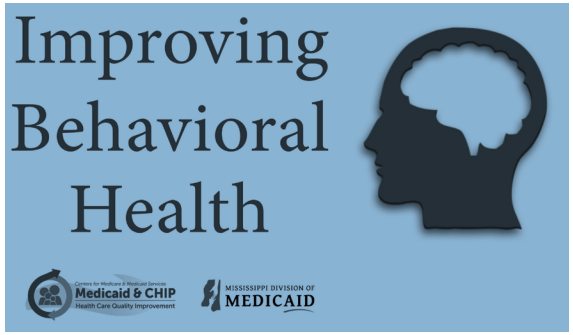
SOURCE NOTES

- 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 2022).
- Total Cost Per Person – D+D' from the monthly 372 report on the last day of the fiscal year (6/30/2022).

HIGHLIGHTS | *2022 Developments*

BEHAVIORAL HEALTH LEARNING COLLABORATIVE

- In fall of 2021, Mississippi Medicaid was one of five states chosen to participate in the Improving Behavioral Health Follow-up Care Learning Collaborative, Behavioral Health Affinity Group, sponsored by CMS, to improve the timeliness of behavioral health follow-up care among beneficiaries.
- Monthly workshops for the Collaborative began in October, and DOM partnered with the Mississippi Department of Mental Health, the Mississippi Association of Community Mental Health Centers, NAMI Mississippi and other organizations to work with national experts on improving Child, Adult and Health Home Core Sets.



COORDINATED CARE FRQ RELEASED IN DECEMBER

- Mississippi Medicaid released a Request for Qualifications (RFQ) on Dec. 10, 2021, seeking qualified vendors for its Coordinated Care program. With this procurement, DOM is seeking for the first time joint administrative CCO services for both MississippiCAN and the Children's Health Insurance Program (CHIP).

CMS: PAYMENT ERROR RATE AMONG LOWEST IN NATION

- Mississippi Medicaid's overall payment error rate was the fourth lowest among the 34 states with publicly available results, according to state-specific data released by the Centers for Medicare and Medicaid Services (CMS). The data also showed Mississippi Medicaid had the third lowest eligibility error rate in the nation.

PLAN FOR CENTRALIZED CREDENTIALING PROCESS

- As part of an on-going effort to cut down on red tape and reduce administrative burdens for health care providers, Mississippi Medicaid developed plans to implement a centralized credentialing process for providers enrolling with any MississippiCAN or Children's Health Insurance Program (CHIP) coordinated care organizations (CCOs).
- Announced in April 2022, the plan offered immediate administrative relief without jeopardizing health plan accreditation.
- With support from the state Legislature, the plan enables providers to credential through a single avenue that will qualify them, and then allow them to contract with any CCO.

CONTACT US | *More Information*

MORE INFORMATION

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MISSISSIPPI DIVISION OF
MEDICAID