



MISSISSIPPI DIVISION OF
MEDICAID

Annual Report for Fiscal Year 2016

MISSISSIPPI DIVISION OF MEDICAID



A Message From the Executive Director

I am honored to present the annual report for fiscal year 2016, which gives a basic overview of the Mississippi Division of Medicaid (DOM), as well as our activities and accomplishments throughout the past year.

In 2016, the agency completed a conversion to the Modernized Medicaid Eligibility Determination System (MEDS) updated eligibility system, a pains-taking process that has taken the better part of three years and will greatly improve efficiency in determining an applicant's eligibility. The agency successfully transitioned inpatient hospital services into its managed-care program, the Mississippi Coordinated Access Network (MississippiCAN), which will help improve the continuum of care for those beneficiaries and hopefully produce improved health outcomes, preventing costly readmissions.

In an effort to reduce expensive turnover and enhance employee morale and productivity, the agency implemented a comprehensive initiative that has already resulted in tangible steps improving the overall culture of DOM. As part of that initiative, a new, dynamic employee onboarding experience was implemented, and I personally visited all 30 regional offices to encourage all employees to take the lead in devising strategies to improve workplace culture.

The agency has continued to find ways to improve efficiency and innovate, such as implementing a reimbursement model for telehealth, and partnering with the University of Mississippi Medical Center for a project that allows practitioners to make better treatment decisions using Medicaid data. We've also taken an exhaustive examination of our annual spending and detailed how federal regulations restrict how the agency can and cannot operate in order to help the Legislature as they make difficult budgeting decisions.

We continually strive to do the most we can with what we have, to benefit the state with funding we receive. The division has a clear mission to provide access to quality health coverage for vulnerable Mississippians, and our success is due to state funding, health-care providers and the hard work our employees perform in serving eligible beneficiaries. Thank you for continuing to support this important mission for the health of eligible Mississippians.

Sincerely,

David J. Dzielak, Ph.D.
Executive Director



David J. Dzielak, Ph.D.

Overview and Program Basics

Background

Medicaid was created by the Social Security Amendments of 1965, to provide health coverage for eligible, low income populations.

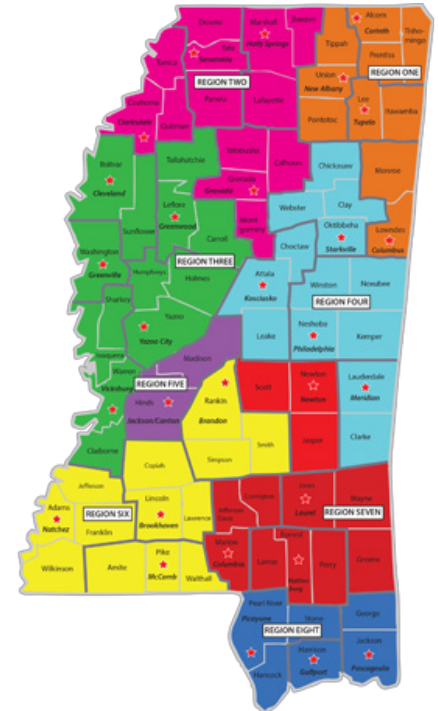
* In 1969, Medicaid was enacted by the Mississippi Legislature.

* While voluntary, all 50 states, five territories of the U.S. and District of Columbia participate in the Medicaid program.

Agency Overview

The Mississippi Division of Medicaid (DOM) has around 1,000 employees located throughout one central office, 30 regional offices and over 80 outstations.

DOM serves nearly 1 in 4 Mississippians who receive health benefits through regular Medicaid, the Children’s Health Insurance Program (CHIP), or Medicaid’s managed care program, MississippiCAN.



- ▶ As of July 2015, the U.S. Census estimates Mississippi has nearly **3 million residents**.
- ▶ As of the end of FY 2016, **total enrollment** for Medicaid and CHIP was **777,109**.
- ▶ **Over 25 percent** of Mississippians receive Mississippi Medicaid health benefits.

What is Medicaid?

Medicaid provides health coverage for eligible, low income populations in Mississippi. These populations include children, low income families, pregnant women, and the aged and disabled.

Beneficiaries do not directly receive money from Medicaid for health benefits. Medicaid is different from Medicare.

To qualify for Medicaid coverage, you must submit a completed application for Mississippi Medicaid health benefits and meet state and federal eligibility requirements. This umbrella term includes multiple health benefits programs administered by DOM: regular Medicaid, CHIP and Medicaid’s managed care program, MississippiCAN.

For Medicaid, the federal medical assistance percentage (FMAP) is used to calculate federal matching funds for medical service expenditures. The FMAP is 74.17 percent for fiscal year 2016.

What is MississippiCAN?

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

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

MississippiCAN is administered by two different managed care organizations – Magnolia Health and UnitedHealthcare Community Plan. Approximately 65 percent of our beneficiaries are enrolled in MississippiCAN.

Children’s Health Insurance Program (CHIP)

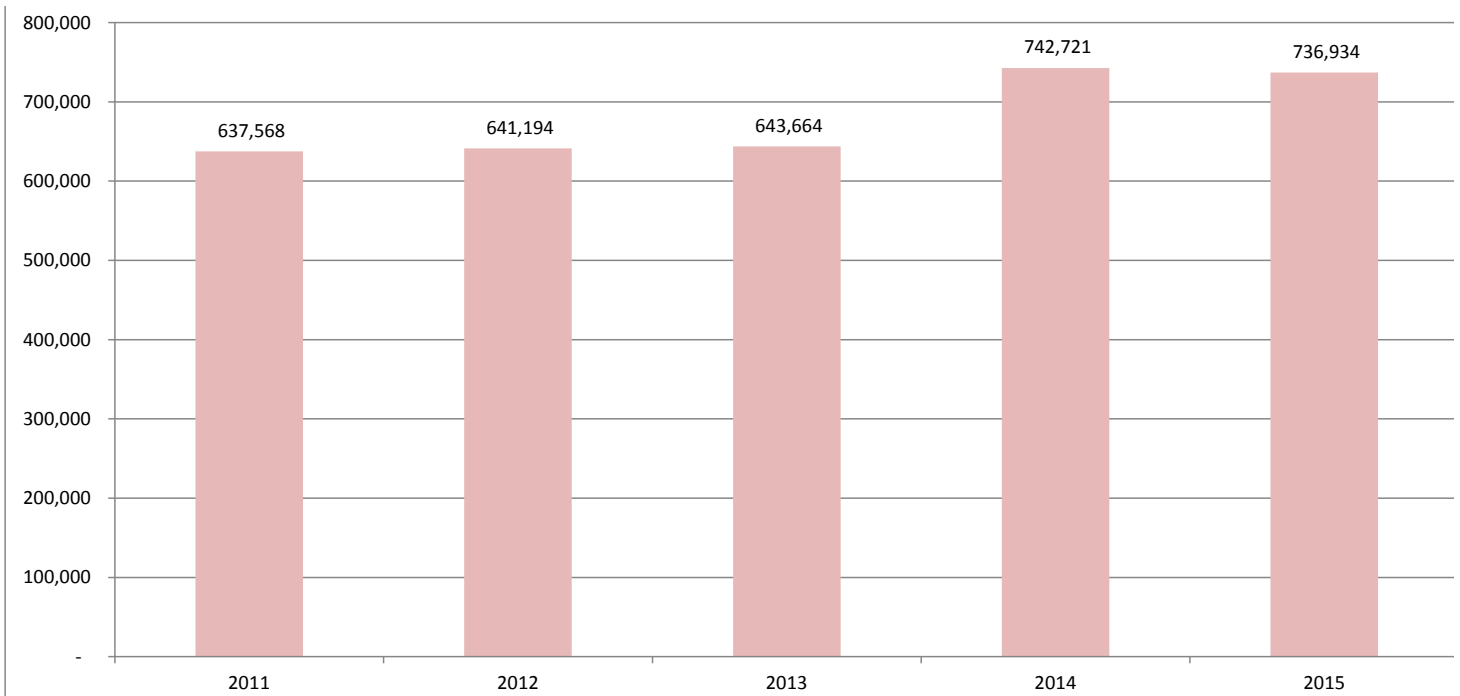
CHIP provides health coverage for uninsured children up to age 19, whose family income does not exceed 209 percent of the federal poverty level (FPL).

To be eligible for CHIP, a child cannot be eligible for Medicaid. Children with health insurance at the time of application are not eligible for CHIP.

CHIP is administered by two different managed care organizations – Magnolia Health and UnitedHealthcare Community Plan. As of January 2016, there were 50,899 beneficiaries in CHIP.

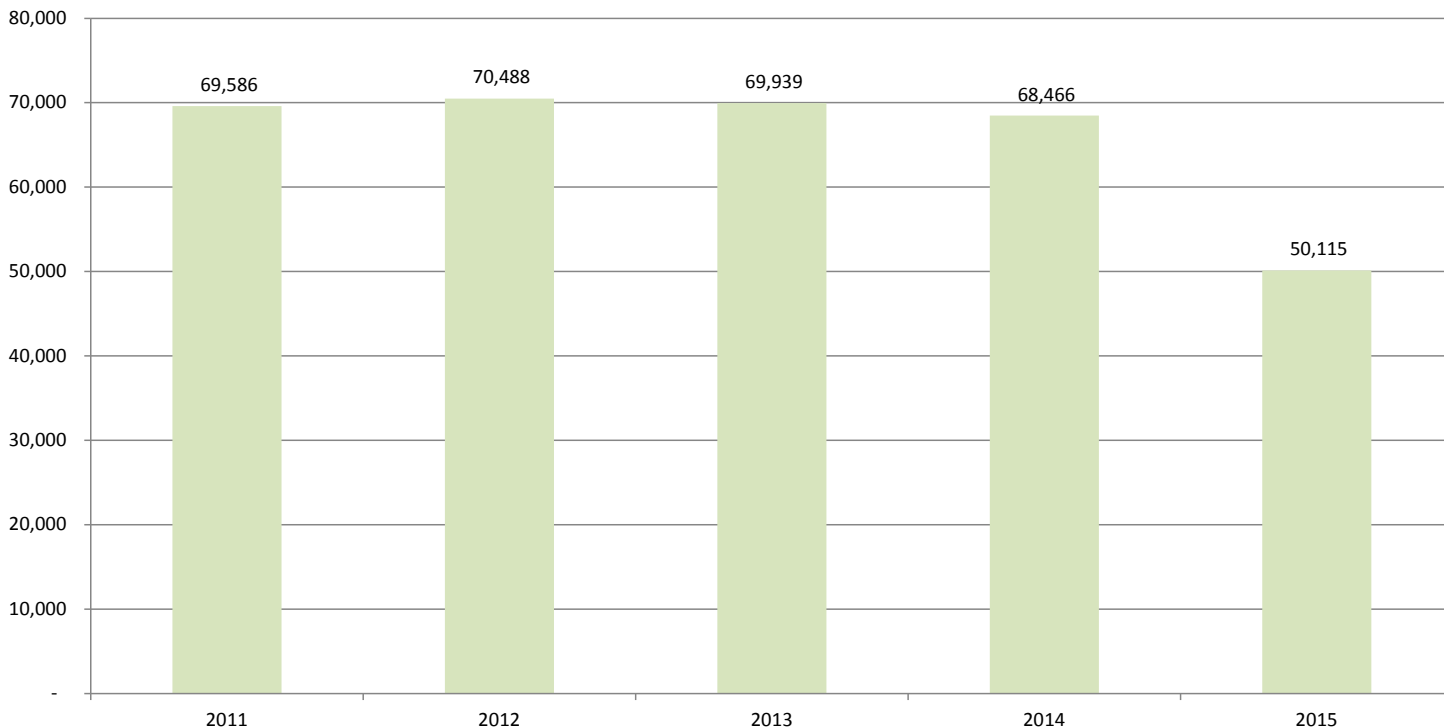
CHIP is separate from Medicaid. Effective Oct. 1, 2015, CHIP is paid 100 percent by federal funds through fiscal year 2019.

Medicaid Beneficiaries (Annual Averages)



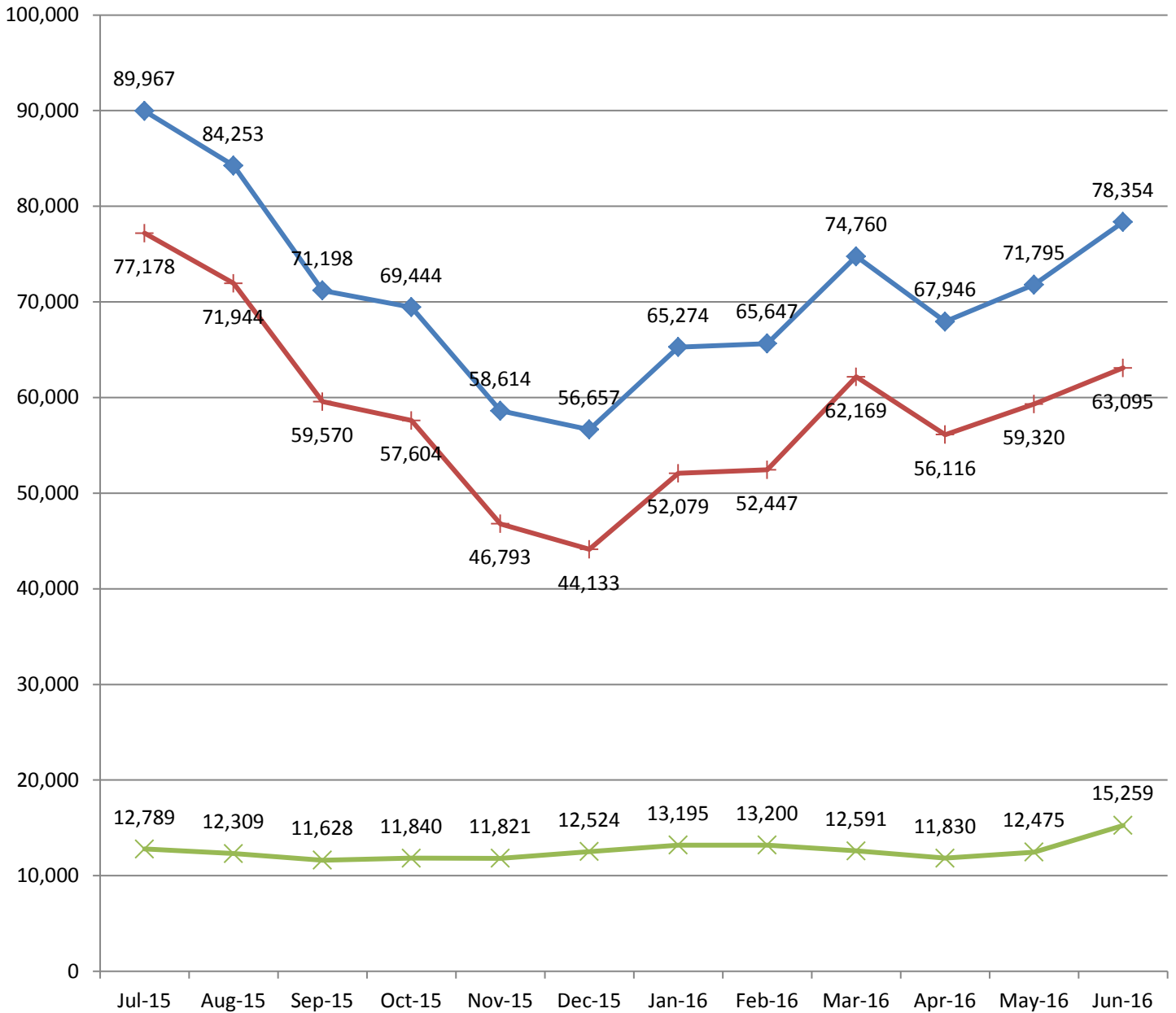
The figures above reflect Medicaid enrollment annual averages calculated by calendar year; they do not include Children’s Health Insurance Program (CHIP) beneficiaries.

CHIP Beneficiaries (Annual Averages)



The figures above reflect CHIP enrollment annual averages calculated by calendar year. Enrollment reports are continually updated and available on the Medicaid website under Resources (medicaid.ms.gov/resources).

Medicaid Applications



Total Number of Applications

853,909

Applications Approved

702,448

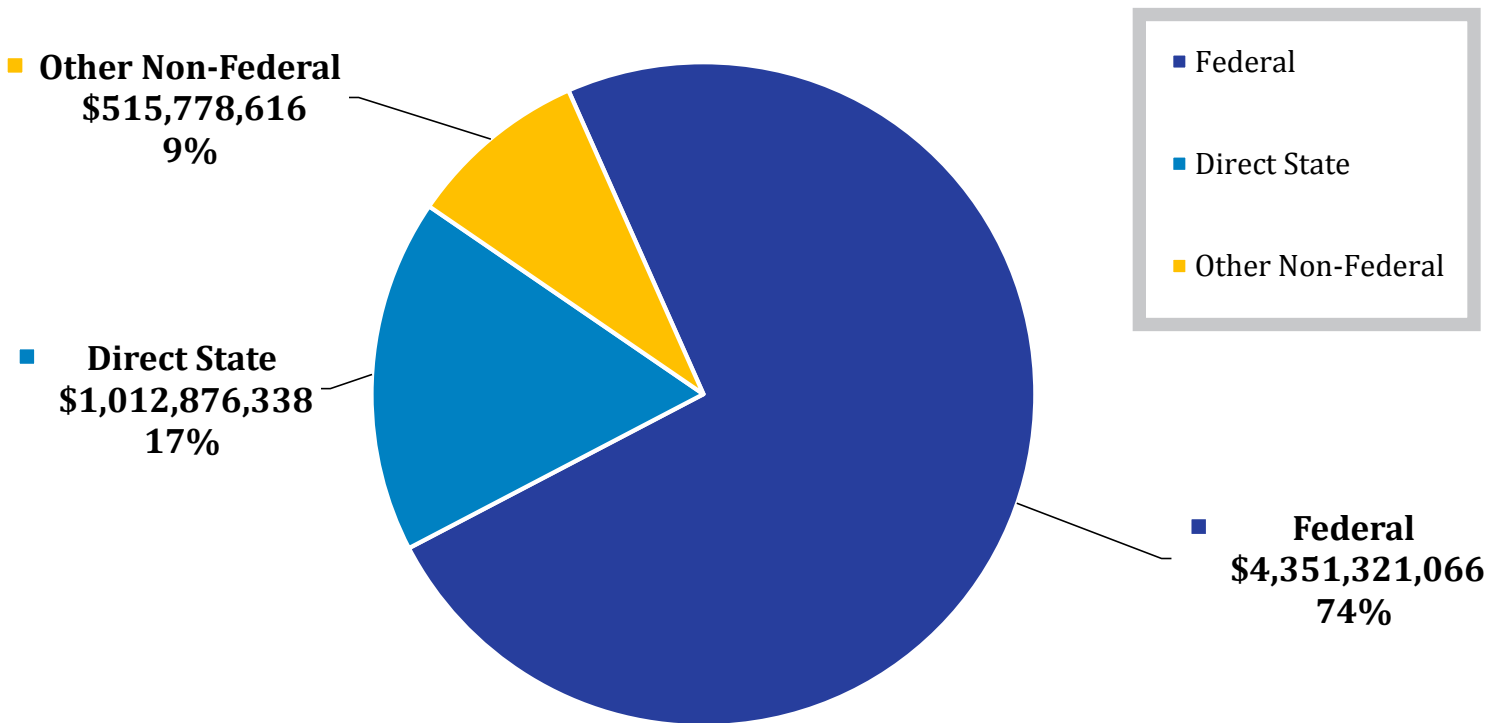
Applications Denied

151,461

The figures above reflect the total number of applications, applications approved, and applications denied by month for state FY2016.

Medicaid Funding by Sources

Total: \$5.88 billion | Federal: \$4.35 billion | Direct State: \$1.01 billion



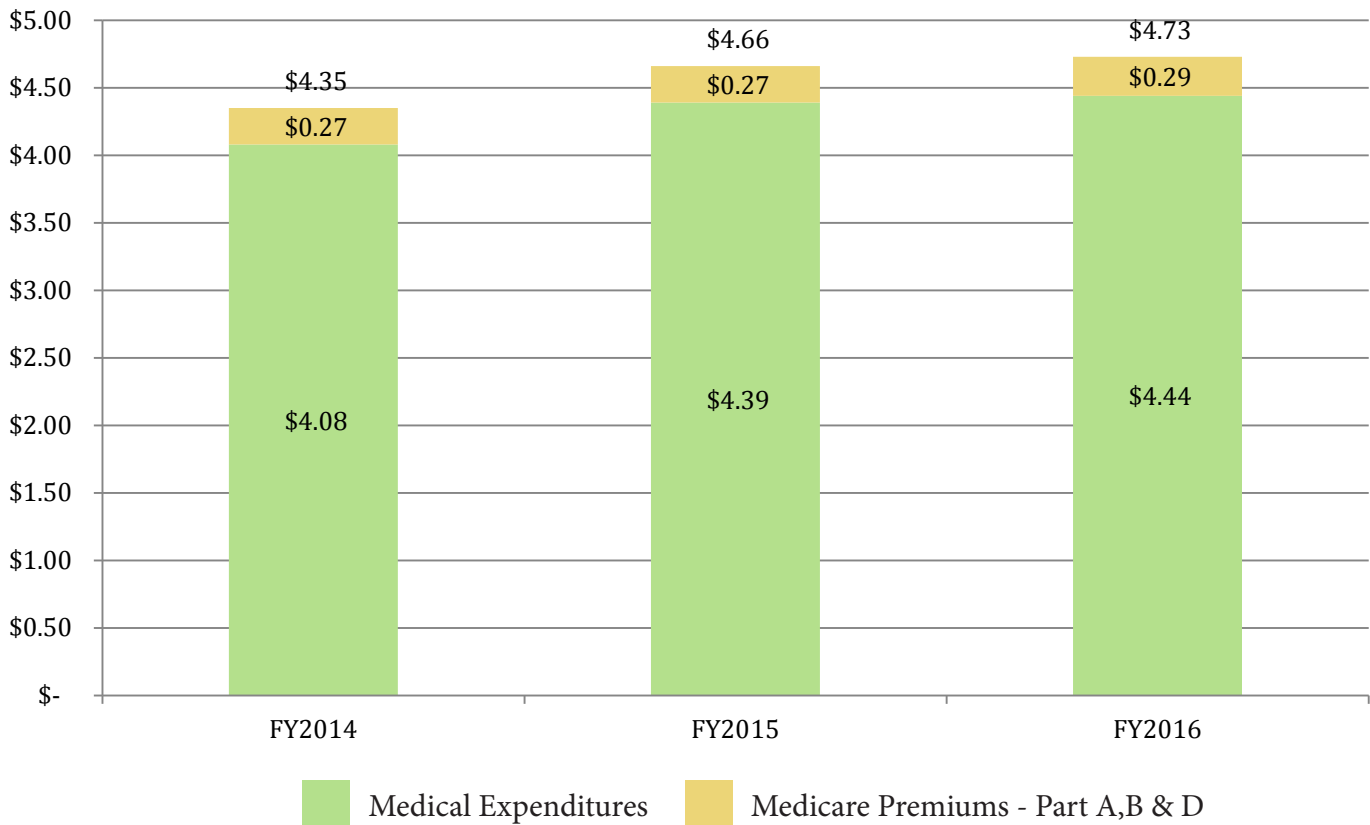
Administrative Expenditures

Administrative expenditures for FY2016 totaled \$173,725,488; the agency had 1,034 filled and vacant positions.

This figure represents agency salaries, fringe, travel, commodities, and equipment. It also includes contractual services which accounts for approximately 70 percent of total administrative expenditures. The majority of these contracts are related to the administration and monitoring of the agency’s medical service claims payments.

Specific planning and implementation administrative expenditures are paid with 90 percent federal funds. Administrative expenditures related to claims processing, survey and certification activities of long term care facilities, peer reviews, skilled professional medical personnel, and Medicaid Management Information Systems (MMIS) personnel are paid with 75 percent federal funds. The remainder of DOM administrative expenditures are paid with 50 percent federal funds.

Medical Service Cost Comparison (in billions)



Note: Medical Expenditures exclude Mississippi Hospital Access Program (MHAP) payments, Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) payments. Medicare Expenditures include Part A Premiums, Part B Premiums and Part D Claw back.

Medical Assistance and Care

The total amount paid for medical assistance and care under this article is \$5,219,930,674; this includes:

\$785,108,555

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

\$175,579,058

Children’s Health Insurance Program (CHIP)

\$10,159,201

Health Information Technology (HIT) incentive grants from the Centers for Medicare and Medicaid Services (CMS)

\$2,000,000

Transfers to other state agencies

The Office of Program Integrity

1 Investigation Review Division

The Investigation Review Division investigates and audits any type of provider who receives Medicaid payments, to determine whether that provider has committed fraud or abuse. If there is evidence that a provider has committed fraud against Medicaid, then the case is referred to the Medicaid Fraud Control Unit (MFCU) in the Attorney General's Office for possible criminal or civil action. If a provider has likely abused the Medicaid system, the Investigation Review Division will prepare and present a formal audit. 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.

Examples of fraudulent activity are where a durable medical equipment provider charges Medicaid for a wheelchair for a beneficiary who does not need a wheelchair, or where it was medically necessary for the recipient to receive the wheelchair, but the provider charged Medicaid \$5,000 for a \$1,000 wheelchair.

2 Medicaid Eligibility Quality Control Division

The Medicaid Eligibility Quality Control (MEQC) Division determines the accuracy of the decisions made by the Division of Medicaid and the Department of Human Services. MEQC verifies that persons receiving Medicaid benefits are actually eligible and ensures that no one is refused benefits for which they are entitled.

3 Data Analysis Division

Data Analysis Division unit is responsible for creating algorithms that uncover areas of fraud and abuse in the Medicaid system. The algorithms are created through research using multiple means such as Medicare Fraud Alerts, newspaper articles, websites, and other sources. This division also develops analysis reports for use in Investigation Review Division's and Medical Review Division's provider and beneficiary review cases. The Data Analysis Division works closely with multiple contracted agencies providing a range of different services, such as creating reports, reviewing claims, and providing research for provider reviews. The Medicaid Auditor within the Data Analysis Division records and collects data for internal and external program integrity analysis reports, and documents the recovery and recoupment of funds from Program Integrity cases.

4 Medical Review Division

The Medical Review Division unit utilizes Registered Nurses to review claims of both providers and beneficiaries to determine the medical necessity and appropriateness of services rendered to ensure quality to meet professionally recognized standards of health care.

Examples of provider fraud would be falsifying certificates of medical necessity, plans of treatment, and medical records to justify payment; soliciting or receiving kickbacks; and inappropriate billing such as up-coding or un-bundling. One of the most newsworthy fraud scenarios in beneficiary fraud is doctor/pharmacy "shopping" in order to obtain medications for either personal abuse or selling. Another example of beneficiary fraud is when the beneficiary "lends" his or her Medicaid Identification card to someone to obtain services.

Program Integrity Activities

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

The following are activities completed by Program Integrity during FY2016:

• Number of cases investigated	120
• Number of cases that resulted in corrective action	64
• Number of cases referred to Medicaid Fraud Control Unit	12
• Total amount of funds recovered by Program Integrity	\$4,537,471



In addition to performing audits, Program Integrity meets monthly with AdvanceMed, who is our Medi-Medi partner. AdvanceMed receives a monthly feed of Medicaid Management Information System (MMIS) claims data and runs the information through its algorithms to detect aberrant claims and providers. To date, information from AdvanceMed has assisted Program Integrity with opening 40 investigations.

Also, in state FY2016, DOM completed Recovery Auditor Contractor (RAC) provider audits, which resulted in \$450,159 in recovered funds. The Medicaid Integrity Contractor (MIC) is another contractor that is working with Program Integrity to perform provider audits. During state FY2016 \$1,500,493 was collected on MIC cases.

Third Party Recovery

The Office of Third Party Recovery and the Legal department assigned by the attorney general’s office work to collect funds through estate recovery and from third parties by reason of assignment or subrogation. In collaboration with the Legal staff and HMS Casualty, for FY2016 the following are funds recovered:

Third Party Recovery and Legal	HMS Casualty	Total Funds Recovered
\$1,818,403	\$3,452,174	\$5,270,577



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