WHITE COLLAR llc
FORENSIC INVESTIGATION

An Independent Review of Medicaid Managed Care Issues as Required in §43-13-117(H)(3)(b) and (c)

Prepared for
The Office of the Governor
Division of Medicaid

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INTRODUCTION

The Mississippi Legislature promulgated additional sections to Mississippi Code Section 43-13-117(H)(3)(b) & (c) mandating that the Mississippi Division of Medicaid ("Division or DOM") conduct annual Mississippi Coordinated Access Network ("MSCAN") program reviews or audits to be conducted by independent third parties. The mandate includes eleven (11) identified categories for review and analysis. Each category includes an Executive Summary, related Narrative, Findings and Recommendations, followed by identification of review Objective, Scope and Methodology.
The eleven (11) statutorily mandated categories include:

(i) The financial benefit to the State of Mississippi of the managed care program,
(ii) The difference between the premiums paid to the managed care contractors and the payments made by those contractors to health care providers,
(iii) Compliance with performance measures required under the contracts,
(iv) Administrative expense allocation methodologies,
(v) Whether non-provider payments assigned as medical expenses are appropriate,
(vi) Capitated arrangements with related party subcontractors,
(vii) Reasonableness of corporate allocations,
(viii) Value-added benefits and the extent to which they are used,
(ix) The effectiveness of subcontractor oversight, including subcontractor review,
(x) Whether health outcomes have been improved, and
(xi) The most common claim denial codes to determine the reasons for the denials.

MSCAN is a vendor managed program that is intended to improve the quality of healthcare coverage and beneficiary health outcomes, while providing Mississippi cost predictability and savings. Nationally, managed care as an operational health insurance program has become the norm in Medicaid over the last thirty years. In the early years of Medicaid through the mid-2000s, managed care only represented 15% or less of Medicaid beneficiaries nationwide. Now, more than 70% of beneficiaries are assigned to managed care programs across the United States.

Since its inception, the Division has made continual enhancements to MSCAN which has resulted in both stronger and more expansive program oversight of the Coordinated Care Organizations ("CCO"). This report is a retrospective review of the eleven identified mandates specified by the Mississippi Legislature covering the period June 30, 2018, through June 30, 2020. This has been confirmed through a review of related documents and discussions with DOM personnel.

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Overall, DOM's oversight ensures the CCOs are meeting their obligations.

Since 2011, MSCAN has generated measurable financial savings to Mississippi of $710,300,000.

Although there were differences between premiums paid to CCOs and CCO payments to providers, none were material. Premiums paid appeared to be based on actuarially sound rates.

CCOs have been compliant in achieving performance goals. Reporting has been consistent and has shown improvements among member health, until the pandemic period beginning in early 2020.

EXECUTIVE SUMMARY, BY MANDATE

§43-13-117(H)(3)(c)(i)—The Financial Benefit of the Managed Care Program to the State of Mississippi

This section mandated an analysis of the fiscal impact of the Division of Medicaid's (DOM) managed health care program ("MSCAN") to the State of Mississippi from its 2011 inception through State Fiscal Year 2022, to determine whether Mississippi's interests and the Medicaid beneficiaries are best served through its managed care program. On a cumulative basis since its adoption in 2011, MSCAN has generated measurable financial savings to the State of Mississippi of $710,300,000.

§43-13-117(H)(3)(c)(ii)—The Difference Between the Premiums Paid to the Managed Care Contractors and the Payments Made by Those Contractors to Health Care Providers

This mandate required the review and analysis of what DOM pays its contracted Coordinated Care Organizations (CCOs) and what they pay to their contracted providers. The report covers the audit period July 1, 2017, through June 30, 2020, and includes a comprehensive review of all payments to and from each CCO with a view towards ensuring that payments to providers are reasonable and consistent while the payments from DOM are within the actuarially sound range developed by its independent actuarial firm, Milliman, and adopted by DOM. While differences were noted that required separate identification and reconciliation, no material differences were observed. Additionally, premiums paid appeared to be based on actuarially sound rates.

§43-13-117(H)(3)(c)(iii)—Compliance with Performance Measures Required Under the Contracts

The purpose of this mandate was to review and evaluate each CCO's compliance with performance measures from their MSCAN contract with DOM to ensure that expected standards are being maintained. The period of analysis was from July 1, 2017, through June 30, 2022. Each contract has an Exhibit F section (Pages 257-262, generally of their DOM contract) that requires CCOs to report specific performance information to DOM. Exhibit F prescribes twenty-three (23) broad-based performance measures, which are monitored and reported to DOM on a monthly, quarterly, semi-annual, annual, or ad hoc basis, depending on the affected category.

The performance measures reviewed for the period covered by this review appear to show that the CCOs have been compliant in trying to achieve performance goals. Reporting has been consistent and has demonstrated improvements among member health, until the pandemic period beginning in early 2020 and continuing through 2021. The pandemic period brought forth limitations on member health outcomes improvement due to limitations with hospitalizations, physician visits, obstetric care, behavioral health, and substance abuse cases, among others.

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Overall, the MSCAN Coordinated Care Organizations are meeting their obligations.

Administrative Expense Allocation methodologies appear to meet industry standards and accounting rules.

The audit noted that certain CCO non-provider payments were inappropriately classified as medical costs. However, the amounts were immaterial and warranted no further audit work.

Not all CCO subcontracts were properly submitted to DOM for approval, in advance and in writing, as required.

DOM should require CCOs to properly submit subcontracts, as required by the MSCAN contract.

§43-13-117(H)(3)(c)(iv)—Administrative Expense Allocations

The purpose of this mandate was to evaluate the methodologies utilized by the CCOs to allocate administrative expenses. This audit did not reveal any administrative expense allocation methodologies which are not generally accepted in the industry, or, which violated Generally Accepted Accounting Principles ("GAAP") or Statutory Accounting Principles ("SAP"). The methods were reviewed to determine appropriateness within prescribed guidelines as well as to understand the overall impact to DOM.

§43-13-117(H)(3)(c)(v)—Whether Non-Provider Payments Assigned as Medical Expenses Were Appropriate

The purpose of this mandate was to analyze and evaluate the appropriateness of classifying expenditures made to non-healthcare providers by the CCOs, as medical costs.

This audit did determine that certain expenditures were inappropriately classified as medical costs during the period under review. However, the amounts were immaterial and warranted no further audit work. The determination of costs assigned as medical expenses were examined to determine whether general and administrative costs were erroneously classified as medical expenditures which could potentially artificially influence a myriad of issues related to rate setting and risk scores.

§43-13-117(H)(3)(c)(vi)—Capitated Arrangements with Related Party Subcontractors

The purpose of this mandate was to analyze the capitated arrangements with related party subcontractors for the three (3) Coordinated Care Organizations and their related party subcontractors for the State Fiscal Years 2018 through 2020. The goal of this review was to ensure that the interests of Mississippi and its Medicaid beneficiaries are best served through the related party arrangements of each CCO.

Integral to MSCAN and to the vendor-managed model, each CCO subcontracts key components to subcontractors, with which it may be related. The aim is to maximize financial and operational efficiency. Many contracted goods and services are not available locally, due in part to the specific nature of those services. The related parties can offer a level of services which are not practical on a local-plan basis. They include services such as 1) Claims processing, 2) Actuarial services, 3) Vision, 4) Dental, 5) Behavioral Health/ Substance Use Disorders, 6) Pharmacy, 7) Member Services, including enrollment, and 8) Regulatory Compliance.

The conventionally high costs of establishing and providing these services locally, by the CCOs, often outweighs the ultimate benefits, and places financial burdens on those CCOs, whose profit margins are traditionally low because of the persistent and growing disparities in the rates paid to healthcare providers by Medicaid, Medicare, and commercial insurance. These costs are shared across

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multiple health plans and entities, enabling the health plans to mitigate operating costs through economies of scale. The audit noted that not all CCO subcontracts were properly submitted to DOM for approval, in advance and in writing, as required. Subcontracts with related parties should be evaluated on a more restrictive basis to ensure that the terms, fees, and goods or services are appropriate and determined objectively.

This audit did not reveal any Corporate Allocation that was unreasonable or outside of industry practice for the time period under review.

§43-13-117(H)(3)(c)(vii) – Reasonableness of Corporate Allocations

The purpose of this mandate was to evaluate and determine the reasonableness of corporate allocations made by the CCOs, their parent companies, and related-party vendors. Parent companies routinely allocate indirect costs between health plans based on rational, systematic, and prescribed methods. The impact was reviewed to determine if local plan financial positions were improperly adjusted, which might potentially cause monies to be shifted to non-Mississippi companies without approval by DOM or the Mississippi Department of Insurance (DOI). This audit did not reveal any allocation that was unreasonable or outside of industry practice for the time period under review.

CCO value-added benefits are expansive and consistent with the populations being served.

DOM allows latitude for the CCOs to determine what value-adds best serve their populations but could do more outcome-based evaluations and require more reporting.

§43-13-117(H)(3)(c)(viii)—Value-Added Benefits and the Extent to Which They Are Used

The purpose of this mandate was to analyze the importance of value-added benefits within MSCAN, and the extent to which they are used by the CCOs during the audit period 2018-2020. Value-added benefits are those which are provided through the CCOs to improve services and outcomes for beneficiaries, beyond minimum required benefits and enhancing flexibility while addressing beneficiaries who are deemed high-risk. Each CCO has the discretion to design and offer a variety of value-added benefits to beneficiaries with the goal of reducing costs, improving access and care while enhancing health outcomes. Those value-added benefits are designed by the CCOs to accommodate the needs of the populations they serve and are routinely adjusted for the same reasons.

The review indicated that CCO value-added benefits are expansive and appear to be consistent with the populations being served. DOM allows latitude for the CCOs to determine what best serves their populations but could do more outcome-based evaluations.

While the audit noted that DOM does require and does review and approve CCO subcontracts, CCOs may not always submit subcontracts for DOM review.

This failure to submit such subcontracts may stem from CCOs not considering certain non-related parties to be covered under the requirements.

§43-13-117(H)(3)(c)(ix)—The Effectiveness of Subcontractor Oversight, Including Subcontractor Review

The purpose of this mandate was to analyze the effectiveness of subcontractor oversight, including subcontractor review by the CCOs and their related party subcontractors for the audit period 2018-2020. The audit report related to capitated arrangements notes that CCOs utilize subcontractors that specialize in providing select goods and services across multiple plans, thereby effecting a mitigated cost approach, benefiting those with whom it is bound to serve. The contractual requirements aid in improving operational efficiencies while ensuring enhanced services. Due to the expansive nature of services, they cannot be offered locally on a

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plan-by-plan basis but through subcontractor relationships, cost savings and improved service offerings can be achieved.

DOM gives each CCO a checklist of specific requirements which must be included in every subcontract supporting MississippiCAN. DOM must pre-approve all subcontracts and also retains the right to review or audit compliance. DOM may approve or disapprove of the proposed agreements and traditionally coordinates with the CCOs to achieve a positive outcome ultimately directed towards beneficiaries' health and optimum operational processes. However, it appears that even with all these contractual requirements, the CCOs may not always submit subcontract for prior approval to DOM. This may be because they do not always consider non-related parties to be covered under MSCAN requirements. This report recommends further evaluation of this issue.

The focus of health care outcomes is geared towards the improvement of beneficiary care while mitigating the associated costs.

Until the pandemic, many of the CCO and Medicaid tracked health outcomes were showing improvement.

In 2020 DOM implemented an incentive withhold program that paid CCOs back certain capitation amounts when they met target health metrics outcomes.

The audit recommended that DOM should mandate a uniform reporting standard across all CCOs.

§43-13-117(H)(3)(c)(x) –Whether Health Outcomes Have Been Improved

The purpose of this section was to analyze the health outcomes experienced by each Coordinated Care Organization (CCO) when determining whether the health of MSCAN beneficiaries has been improved over the 2018-2020 audit period. Specifically, the Performance Measures required to be reported by the CCOs are based on DOM's outlined health measures in conjunction with universally recognized Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures. The focus of health care outcomes is geared towards the improvement of beneficiary care while mitigating the associated costs in a host of specified categories. DOM outlined nineteen (19) performance measures within seven (7) principal categories of improvement. A number of measures appeared to show improvement, however, the pandemic caused setbacks in many areas.

Additionally, the audit noted that since 2020, DOM instituted an annual CCO incentive withhold program where quality measures are identified with targets set with results directly tied to CCOs receiving back capitation withhold amounts. However, the audit also noted that CCOs are not required to report outcomes in a standardized, uniform manner and recommends that DOM work towards changing that. Such change will benefit Mississippi's outcome studies.

Duplicate provider claims were one of the most frequent denial codes amongst all three CCOs. One other common claim denial reason is an all-encompassing incorrect claim category, which includes a myriad of reasons which cause a claim not to be paid initially.

§43-13-117(H)(3)(c)(xi)—The Most Common Claim Denial Codes to Determine the Reasons for the Denial

The purpose of this section was to analyze the reasons for claim denials submitted by healthcare providers through MSCAN by each CCO for reimbursement for the audit period 2018-2020. Claims are submitted for each service delivered by providers across the MSCAN population. The CCOs are paid on a per member, per month basis and, in turn, use those monies to reimburse contracted providers who deliver services and goods to beneficiaries for the claims submitted. The submission of millions of claims annually often results in the denial of those which do not meet all the specific criteria for payment. This can cause delays in provider payments, resubmission of applicable claims with additional required information, and can inhibit the timing of beneficiary care.

Submitted claims may be denied if they do not meet the required criteria for payment. The claims must include certain information which identifies the beneficiary, demographic information, place services are rendered, services rendered, provider rendering service, procedure codes attached to the services rendered, the diagnosis codes associated with the provider's diagnosis determination, date of illness/injury, referring provider (if any), insurance information, lab data, charges and number of units provided and the provider's identification number, among other things. An analysis of claim denials occurs to aid providers in filing clean claims for reimbursement without interruption.

A review of the denial reasons reveals comparable results between the plans. Each was asked to provide the top fifteen (15) denials over the three-year audit period from 2018 through 2020. Duplicate provider claims were one of the most frequent denial codes amongst all three CCOs. One other common claim denial reason is an all-encompassing incorrect claim category, which includes a myriad of reasons which cause a claim not to be paid initially.

ANALYSIS, BY MANDATE

§43-13-117(H)(3)(c)(i)—The Financial Benefit of the Managed Care Program to the State of Mississippi

Since its adoption in 2011, MSCAN has generated measurable financial savings to the State of Mississippi. The total state-share financial savings realized through the MSCAN contracts has been estimated at $710,300,000, on a cumulative basis, from inception through SFY 2022, as indicated in the following chart. The information contained in the chart has been extracted from Milliman's letter dated December 22, 2021, which outlined program savings.

The data referenced and utilized in this audit report includes statistical, actuarial, actual, and projected expenditures provided by the State's consulting actuary, Milliman, and by DOM. Annually, Milliman has prepared analyses of MSCAN program expenditures and projected fee for-service costs to determine savings. This information has been compiled beginning with program inception and continued each state fiscal year through 2022.

The information and analysis are based on each year's actual MSCAN expenditures compared with those costs which are projected to have been incurred under a traditional Medicaid fee-for-service model.

Prior to the development of Medicaid managed health care programs on a nationwide basis, Medicaid agencies paid claims for health care services provided on a fee-for-service basis. Fee-for-service ("FFS") was the exclusive and traditional payment model utilized by Medicaid agencies for many decades. Through this model, healthcare providers are reimbursed based on the number and type of services they provide or the procedures they conduct. Each service is paid at a preset amount.

	Amounts Reflected in Millions			
Measurement Period	**State Share of Savings ***	**Net Premium Tax Revenue**	**Savings Shared with CCOs**	**Total MSCAN Savings to Mississippi**
Calendar Year 2011 through SFY 2019	$130.60	$318.00	$-	$448.60
State Fiscal Year 2020	$21.30	$68.50	$(3.30)	$86.50
State Fiscal Year 2021	$15.60	$79.40	$(16.20)	$78.80
State Fiscal Year 2022	$21.10	$75.30	$-	$96.40
GRAND TOTAL ESTIMATED SAVINGS THROUGH MSCAN	**$188.6**	**$541.2**	**$(19.5)**	**$710.3**

* *Results have been adjusted to reflect actual experience between 2011 and 2019. Actual savings for State Fiscal Years 2020, 2021 and 2022 have not been finalized because all actual expenditure and projected fee-for-service costs are not complete. These figures can be updated once Milliman's work on SFYs 2020, 2021 and 2022.*

The State Share of Savings is the amount realized from the implementation of MSCAN shared savings program. The Net Premium Tax Revenue is the amount of State monies generated through the ACA imposed tax on insurers. The Savings Shared program represents funds shared with CCOs pursuant to a plan structured to improve care and mitigate costs. The Total MSCAN Savings to Mississippi is the combination of Savings realized through MSCAN, Premium Tax Revenue and Savings Shared with the CCOs.

In a managed health model, Medicaid agencies typically contract with managed care organizations ("MCO") for risk-based care services through fixed, periodic payments, and for a defined package of benefits. In Mississippi, these organizations are referred to as coordinated care organizations, or CCOs.

These capitation payments are traditionally made on a per member, per month (PMPM) basis with the determination of program savings centering on the costs that would have been incurred, without a managed health plan. Those costs have been projected, based on the traditional Medicaid fee-for-service model. The

projected fee-for-service costs are then measured against the actual expenditures made in the MSCAN model to quantify savings and reported by Milliman. The Division makes fixed periodic capitation payments to the contracted CCOs under the traditional per member, per month basis, with adjustments that are appropriate and accepted for Medicaid health plans.

Milliman calculates and reports financial savings on a total program basis, without reporting savings on a per Medicaid MSCAN member population basis which, if provided, could foster a more effective analysis of health outcomes, value-based evaluations, and enhance long-term planning. The financial savings reported are centered on global costs.

The projected savings for MSCAN have been calculated using a reduction in medical costs associated with a fee-for-service model, including specified general and administrative costs and profit margins. Milliman has assisted MSCAN in the implementation of a risk corridor which concentrates on limiting uncertainty brought about through the COVID-19 pandemic. The risk corridor addresses the potential for underutilization or overutilization of healthcare services and goods as well as behavioral health issues connected with treatment protocols.

Findings and Recommendations for §43-13-117(H)(3)(c)(i)—The Financial Benefit to the State Of Mississippi of the Managed Care Program

Findings

- MSCAN has generated state-share estimated savings to the State of Mississippi of over $710,300,000 from program inception in 2011 through 2022.
- The savings have been achieved through the implementation of a Medicaid managed care option which translates to enhanced availability of services and potentially improved health outcomes.
- MSCAN was designed and developed through coordination with the Centers for Medicare & Medicaid Services (“CMS”) for the improved health outcomes of DOM’s beneficiaries.

Recommendations

- The annual evaluation of MSCAN expenditures, projected costs and estimated savings should continue as long as the program is in existence.
- DOM staff should continue its strong focus on program benefits to the State and to beneficiaries.
- There is a need for a continued, consistent review of MSCAN activities designed to measure results, population statistics, program success and rates leading to most effective rate setting and program design.
- Milliman savings data is reported to DOM and should be designed to include a more detailed dataset on a per population basis, reflecting health impact leading to improved beneficiary health.
- Coordinated meetings between MSCAN personnel and a selected risk stratification and health assessment group should continue on a periodic basis with the goal of improving MSCAN, financial benefits to the State and improved health outcomes for MSCAN beneficiaries.

§43-13-117(H)(3)(c)(ii)—The Difference Between the Premiums Paid to the Managed Care Contractors and the Payments Made by Those Contractors to Health Care Providers

Since inception of MSCAN in 2011, Mississippi’s Division of Medicaid (DOM) has entered into contracts with CCOs to manage healthcare services for a segment of DOM beneficiaries. Those CCOs are paid a per member per month fee for each enrolled beneficiary. In turn, the CCOs enter contractual arrangements with healthcare providers to provide designated health services to its members. The rates paid to CCOs are required to be actuarially sound, as determined by independent third-party consulting actuaries. Mississippi engages Milliman to provide those services.

Once rates are determined, the CCOs then manage the revenues to ensure designated services are adequate, administrative and management expenses burdens are addressed, and a reasonable profit may be achieved. DOM pays the CCOs the capitation payment by the tenth (10^{th}) business day of the subsequent. The following table reflects the monies paid by DOM to the three CCOs, and the amounts the CCOs paid to providers in calendar years 2018, 2019, and 2020.

Magnolia Health	**2018**	**2019**	**2020**
Premiums Paid to CCO	$1,385,590,866	$1,634,904,271	$1,278,689,160
Amounts Paid to Providers	$1,051,232,577	$1,034,716,252	$917,878,036
Molina Healthcare	**2018**	**2019**	**2020**
Premiums Paid to CCO	N/A	$206,042,933	$405,172,938
Amounts Paid to Providers	N/A	$115,302,107	$319,082,601
United Healthcare	**2018**	**2019**	**2020**
Premiums Paid to CCO	$1,293,015,094	$1,359,622,855	$1,116,619,197
Amounts Paid to Providers	$929,088,394	$835,217,259	$737,648,275

The difference between the premiums paid to the CCOs and the amounts paid to health care providers includes general and administrative expenses, claims adjustment and adjudication costs, management expenses, and a reasonable profit.

The premiums paid to the CCOs were extracted from DOM disbursement journals and related records. The categories of payments to the CCOs were combined, which necessitated separate calculations to capture the actual premiums paid. The differences between premiums paid and the monies paid to healthcare providers *do not* represent only profits. The difference between what DOM pays and what is paid by the CCO to the provider is absorbed through general, administrative, operating, claims and related expenditures as allowed under the MSCAN contract. Any excess after those paid may be realized as a company profit.
The amounts paid to health care providers, by CCOs were extracted from audited financial statements, and the annual financial statements prepared by the CCOs for the National Association of Insurance Carriers ("NAIC").

Differences were noted during data analysis that required separate identification and reconciliation. The additional analysis was to ensure the capture of consistent data reported between the modified-cash basis accounting utilized by DOM, and the CCOs' accrual basis of accounting. Any unrelated costs were removed. After analysis, no material differences were observed.

The differences between premiums paid and amounts paid to providers were reviewed and analyzed, resulting in the finding that the categories of listed expenditures and amounts were consistent with expected CCO management and operations. The premiums paid were based on actuarially sound rates, as prescribed by the Centers for Medicare & Medicaid Services ("CMS"). The rates paid to the CCOs include four components: 1) Medical costs, 2) Premium tax of 3.0%, 3) Margin allowance of 1.8%, and 4) General and administrative costs. There were no material concerns noted by auditors during the evaluation of the premiums paid to CCOs nor from the CCO payments to health care providers during the audit period 2018-2020.

Auditors reviewed categories of expenditures made by the CCOs. The amounts paid by the CCOs were consistent with reported audited financial statements, regulatory filings, and reports to DOM. The CCOs are required under federal law to expend a minimum of eighty-five percent (85%) of premium revenues on medical costs, leaving the fifteen percent balance to cover all general, administrative, claims, management, and profit margin. Each CCO has met this requirement in each year examined.

The tables below show the vendors that are related to or subcontract with the CCOs to provide certain medical services. As with the CCOs, none of these businesses are wholly Mississippi-based. Some are related to the

CCO parent company, some are independent, third-party vendors to the CCOs. The business and financial resources paid under these contracts and directed out of Mississippi to these entities is significant when considering the overall amount of premiums paid to each CCO.

Magnolia Health

Vendor / Service Type	2018	2019	2020
Fee-for-Service*	$647,730,766	$612,977,908	$504,783,351
Envolve Pharmacy Solutions	$222,514,131	$235,069,314	$228,513,529
Cenpatico Behavioral Health	$93,157,487	$108,169,302	$122,461,108
Envolve Dental	$62,078,338	$54,279,856	$41,631,045
Envolve Vision	$17,512,074	$16,720,706	$13,683,402
MTM (NET) ^	$8,239,780	$7,499,165	$6,805,601
Total	**$1,051,232,577**	**$1,034,716,252**	**$917,878,036**

Molina Health

Vendor / Service Type	2018	2019	2020
Fee-for-Service*		$97,625,732	$266,176,421
CVS Health		$12,630,768	$38,443,141
Avesis Dental		$3,898,690	$11,315,863
March Vision		$974,911	$2,385,793
Southeastrans (NET)		$172,006	$761,383
Total		**$115,302,107**	**$319,082,601**

United Healthcare

Vendor / Service Type	2018	2019	2020
Fee-for-Service *	$590,181,532	$514,280,194	$438,897,343
OptumRx	$177,931,123	$176,012,596	$171,734,302
Optum Behavioral Health	$87,070,139	$78,138,148	$78,604,501
UHC Dental	$57,703,675	$48,249,333	$36,020,209
March Vision	$9,818,382	$8,646,517	$7,077,329
National MedTrans/MTM (NET) ^	$6,383,544	$9,890,470	$5,314,592
Total	**$929,088,394**	**$835,217,259**	**$737,648,275**

The total combined amounts paid by the CCOs for 2018 was $1.98B, 2019 was $1.985B and 2020 was $1.975B which included provider fee-for-service costs, pharmacy benefit manager, behavioral health, dental, vision and non-emergency transportation services.

Findings and Recommendations for §43-13-117(H)(3)(c)(ii)—The Difference Between the Premiums Paid to The Managed Care Contractors and the Payments Made by Those Contractors to Health Care Providers

Findings

- The contracted CCOs are Mississippi businesses. However, the CCO parent companies and the related subcontractor companies and affiliates are not Mississippi companies. The companies being paid by each Mississippi CCO are related but not based in the state so that the vast amount of monies being paid for described services are leaving Mississippi. The total being spent on out-of-state entities for services, over the three-year audit period, total over $900M.
- The monies being paid to the CCOs are within the actuarially determined range as developed by Milliman.
- The monies being paid to providers appear reasonable, though a review of all rates and claims would present an impracticable task due to the volume and proprietary nature of the payments.

Recommendations

- DOM and the Mississippi Department of Insurance ("DOI") should collaborate to address categories of expense which should remain in the state and/or be limited as to what can be sent to parent/related companies which are non-Mississippi based. Adjustments should be made to ensure that every possible dollar remain in the state.
- DOM and MSCAN should address, with each CCO, those expenditures which would be expected to remain in the state. The benefit to the State of Mississippi's businesses and economy is obvious.
- DOM and DOI should coordinate efforts to institute an advance approval process for any amounts which the CCO wish to be paid to out-of-state companies, including parent companies and related parties.

§43-13-117(H)(3)(c)(iii) –Compliance with Performance Measures Required Under the Contracts

Performance measures are used to gauge the effectiveness of health care service performance specific to Medicaid populations. On an annual basis, the Center for Medicare & Medicaid Services ("CMS") releases collections of core measures reflecting the quality of care for adults and children who participate in Medicaid programs. These measures are aggregated, quantified, and analyzed according to categories and activities used to identify prospects for improving care quality and enhancing efficiencies in the delivery of care.

To meet these requirements and to attempt to quantify certain outcomes and outputs, DOM has developed performance measures with involvement of a myriad of professionals and providers, as well as with input through CMS to ensure that those prescribed are not only meaningful but detailed and will lead to accurate data to improved health among beneficiaries.

The types of health care performance measures have traditionally included:

A. Quality and efficiency in member care,
B. Care outcomes,
C. The cost of healthcare services, and
D. Discrepancies in healthcare performance.

Each of these measures are essential ingredients to Medicaid manage health plans' goals of improving beneficiary health. The benefits extend to those beneficiaries, their families and society. Medicaid agencies have a vested interest in maximizing the dollars invested in beneficiaries' healthcare and objective performance measures allow for comparability and inform beneficiaries so that they can make informed decisions about the care received. Finally, performance measures allow Medicaid agencies to make superior decisions regarding health policies and programs.

The MSCAN contract mandates periodic reporting of results, as prescribed in Exhibit H, outlining forty-six (46) measures, each due on a recurring basis, as described above. These allow the CCOs to manage the populations they serve while seeking to mitigate the overall costs of healthcare delivery and services. Most of the performance metrics require monthly and quarterly reporting to DOM which enables the agency to continually evaluate the results being achieved.

The performance measures reviewed for the period covered by this review appear to show that the CCOs have been routinely compliant with contract terms, without limitation or incident. These reports have been reviewed for each of the fiscal years beginning July 1, 2018, through June 30, 2020, without exception. Reporting has been consistent and has demonstrated improvements among member health, until the pandemic period of early 2020 continuing through 2021. The pandemic period brought forth clear and impassable limitations on member health outcomes improvement due to limitations regarding hospitalizations, physician visits, obstetric care, behavioral health, and substance abuse cases, among others.

Each CCO has shown through its reported performance measures and narratives that they have implemented significant opportunities for health outcome improvement. Improvements were being realized, as reported in the Health Outcomes audit report, until the advent of pandemic precautions. CCOs implemented routine and episodic monitoring and reporting of performance metrics prior to and after the pandemic.

Discussions with relevant DOM personnel have supported the assertions that CCOs have complied with performance measures. CCOs have supported the written materials with evidence that suggests full compliance, though outcome results have fallen below what each would expect and prefer, due in large part to the pandemic.

Ultimately, the review showed that the CCOs are not only in compliance with contractual requirements, but are coordinating with DOM to enhance health outcomes, mitigate costs and continually evaluate the populations served to improve member care. The CCOs rely on both local and national support in the day-to-day operations allowing for nationwide comparisons between member populations, services delivered and opportunities for improvement. Beginning in state fiscal year 2020, MSCAN instituted an incentive withhold for the CCOs, which is tied to performance measures in an effort to promote improved health outcomes across the population.

Findings and Recommendations for §43-13-117(H)(3)(c)(iii)—Compliance with Performance Measures Required Under the Contract

Findings

- The Quality Team within MSCAN works with the CCOs towards ensuring proper and timely reporting on prescribed performance measures.
- Consistent review of the reports and analyses what is being generated is imperative to achieving improved health outcomes, while maximizing costs and returns.
- The reporting mechanisms on a monthly basis may be too frequent to provide meaningful data related to performance measures.
- Each CCO has reported different, but similar, objectives when evaluating performance measures across their affected populations and according to local and corporate goals.
- DOM, over the course of the audit period did not set expectations on performance measures, though that has since been modified through the 1% incentive withhold provision. That provision requires the CCOs to meet Annual Target Rates in order to have the 1% withhold returned. The performance measures are set forth, but the desired levels of achievement were not for 2018-2020.
- Each CCO reports its performance measures in different formats when it provides data to DOM.

Recommendations

- Quarterly reporting may foster a more comprehensive view and analysis along the course of a year, providing for comparability on a quarter-to-quarter basis and enabling a consistent semi-annual and annual review of results between populations and between health plans.
- More frequent reporting of results than on an annual basis would enable each CCO and DOM to address aberrant conditions and health issues which require more immediate attention for the benefit of MSCAN beneficiaries.
- The Quality Team should meet in conjunction with its receipt of interim quality data from the CCOs on a quarterly basis. This should not preclude comprehensive periodic meetings involving the Quality Team beneficiaries, other MSCAN/DOM employees and CCO representatives to outline goals and progress on a period to period and year-over-year basis. Each of the DOM prescribed Performance Measures must be evaluated, compared, and analyzed for future improvement of results and beneficiaries' health.
- Reporting the results of DOM's Quality Team's evaluation and detailed analyses should be shared with the CCOs towards improvements for the following year.
- DOM should mandate that the reports provided by the CCOs be consistent in presentation, quality, and quantity to foster comparisons and analysis.
- The reports provided by each CCO differ from one another, impeding the ability to make appropriate comparisons between plans. This can inhibit a comprehensive analysis by DOM and thereby its ability to set new outcomes measurement goals and objectives for the following year. Since inception, DOM has instituted additional procedures which include preparation of summary spreadsheets used for comparison and review.

§43-13-117(H)(3)(c)(iv) —Administrative Expense Allocations

Medicaid managed health plans generally incur two types of expenditures when operating: 1) Medical service costs and 2) General and Administrative costs. Medical service costs are those experienced through medical costs for members, paid to health care providers. General and administrative costs are those related to management and plan operations, including rent, salaries, enrollment, appeals, claims, legal, accounting, and associated costs. This audit was focused on the identified administrative costs and whether the reported costs are both reasonable and appropriate.

Medicaid health plans incur general and administrative expenses at the local plan level and at the corporate level. Those incurred at the plan level remain with the plan but those incurred at the corporate level are allocated among all affected plans nationally. Methodologies vary between organizations but generally are allocated based on a percentage of revenues, membership, direct allocation, total cost approach, or fixed percentages. Each of these methods has gained industry-wide acceptance and must be disclosed to CMS and also, within the audited financial statements.

The CCOs have fully executed management and administrative agreements in place between parent companies, related companies, and local plans. All differ in scope and content, but each allocate certain direct expenses to the local plan. Those expenses, which cannot be identified with a specific plan, are allocated using one of the methods discussed in the preceding paragraph. Each of the three CCOs use different methods for cost allocation, which precludes a true comparison of methods between plans. The allocation methods were also not entirely clear from the reports reviewed and filed about the Mississippi share or items.

However, total general and administrative expense amounts can be extracted and compared. The CCOs report general and administrative costs which range from 8.8% to 14.8%. The differences are appreciable but not

outside normal limits for Medicaid health plans as reported by Kaiser Family Foundation and Sherlock Medicaid Benchmarks. Additionally, 42 CFR 417 references apportionment and allocation of expenses for health plans and prescribes certain methods for CCOs to follow. Analysis of the contracted CCOs methods tracks the prescribed techniques.

The table on the following page reflects, on a plan-by-plan basis, Total Plan Revenue, Total Medicaid Revenue, General and Administrative Costs, Percentage of Costs to Medicaid Revenue and Percentage based on Membership for the 2018, 2019, and 2020 audit periods. Based on DOM personnel interviews and following an examination of these costs, it is not apparent that there is a detailed mechanism in place which would ensure that these costs and methodologies are routinely examined and reviewed on a line-item basis.

MississippiCAN
Plan Statistics
2018-2020

	Molina	Magnolia	United Healthcare
Revenue	Total Revenue & Medicaid Revenue	Total Revenue & Medicaid Revenue	Total Revenue & Medicaid Revenue
2018	$22,819,906	$1,280,365,797	$1,144,574,860
		$1,276,517,445	$1,035,640,618
%Medicaid Revenue	1.000%	99.699%	90.483%
2019	$383,350,855	$1,166,293,727	$993,404,401
	$329,064,347	$1,159,290,779	$887,448,611
% Medicaid Revenue	85.839%	99.400%	89.334%
2020	$481,557,247	$1,107,632,675	$1,083,761,007
	$407,066,080	$1,095,622,098	$963,857,324
% Medicaid Revenue	84.531%	98.916%	88.936%

	Molina	Magnolia	United Healthcare
	Member Months	Member Months	Member Months
2018	51,701	3,021,112	2,886,561
2019	732,600	2,633,781	2,457,361
2020	1,166,517	2,360,924	2,511,357
G&A			
2018	6,209,928	181,036,164	106,834,975
2019	35,976,297	143,485,086	78,313,042
2020	58,282,023	162,184,669	97,639,178
% of Medicaid Revenue			
2018	27.21%	14.18%	10.320%
2019	10.93%	12.38%	8.820%
2020	14.32%	14.80%	10.13%
% Per MM			
2018	0.227%	0.237%	0.279%
2019	0.223%	0.227%	0.277%
2020	0.287%	0.215%	0.261%

Molina 1st Year was 2018. G&A were abnormally high for the year.

Findings and Recommendations for §43-13-117(H)(3)(c)(iv) —Administrative Expense Allocation Methodologies

Findings

- The variation in general and administrative costs within MSCAN is significant enough to warrant a recurring, periodic review of costs which are submitted and for which reimbursement considered as part of the PMPM amount.
- Without a process in place to review these costs on an at least semi-annual basis could lead to excess general and administrative costs being allocated to local plans and Mississippi dollars being paid to out-of-state companies.

Recommendations

- These costs should be compared, monitored, and reviewed in conjunction with those which are paid to parent and related companies to ensure that as many dollars remain in Mississippi as practical. Failure to review these costs provides an avenue through which costs may be allocated outside of the local plans.
- DOM and DOI should collaborate towards instituting a pre-approval process for administrative costs to be shifted to parent and related parties which are able to be incurred locally versus in another state.
- Preapproving management costs, bonuses, corporate fees, charges, and expenses can improve local plan financial results but also will see more funds remaining in the state, improving DOM's return on its health care investments.
- The recommendation is made that the general and administrative allocation expense methods be reviewed on at least an annual basis to determine appropriateness when considering parent and affiliate companies.

§43-13-117(H)(3)(c)(v) —Whether Non-Provider Payments Assigned as Medical Expenses Were Appropriate

Federal regulations allow certain types of expenses to be included as part of medical costs. This is closely monitored by CMS as Medicaid plans are required to expend a minimum of eighty-five percent (85%) of premium revenue on health care costs. The balance, or fifteen percent (15%), is available for general and administrative costs as well as profit.

The 85% rule during the audit period, also known as the Medical Loss Ratio ("MLR"), is monitored by DOM and examined, for DOM, by its CPA firm, Myers and Stauffer, on an annual basis. Myers & Stauffer renders an audit opinion on the MLR and each CCO's compliance therewith. This rule ensures that monies intended for care are used to cover the cost of care for Medicaid beneficiaries. Certain general and administrative costs are allowed to be categorized as health care costs, including Quality Improvement measures. Health Care Quality Improvement ("HCQI") and Health Information Technology ("HIT") may be allowed as health care costs, depending on facts and circumstances.

Health Care Quality Improvement (HCQI) and Health Information Technology (HIT)	
HCQI	
Health outcome improvement	Effective care management; care coordination; chronic disease management; medication and care compliance initiatives
Hospital readmission prevention	Arranging/managing transitions from one setting to another, like hospital discharge to home or rehabilitation center; patient-centered education & counseling; personalized post-discharge reinforcement and counseling

Patient safety improvement and medical error reduction	Identification and use of best clinical practices; evidence-based medicine; prescription reviews to avoid drug interactions
Wellness and health promotion	Wellness assessments; healthy lifestyle coaching programs; public health education campaigns; member & provider outreach; provider & patient rewards, incentives, bonuses, & copayment reductions
HIT	
Health information technology expenses for health quality improvement	Health information technology (HIT) to support these issues, including communication of patient information, electronic health records, and patient portals; tracking medical data to lead to better outcomes; reporting data to national health organizations for study of improved interventions
SOURCE: Amounts allowed for Quality Improvement activities per the Code of Federal Regulations 45 CFR §158.150 and DOM contracts and records.	

Mississippi DOM may realize premium rebates from the CCOs should the MLR fall below the 85% mark. This is federally mandated, and not state based. In the review of the MLR calculations and supporting data for 2018, 2019, and 2020, there appeared to be no rebate opportunities. The annual reports issued by Myers and Stauffer reflect all categories of health care costs, those costs which are not medical but should be classed as such, and those costs which are, by definition, not appropriately classified as health care costs.

Myers and Stauffer then calculates the MLR and provides an audit report of its findings to DOM. In each year under audit, auditors discovered that the CCOs met or exceeded the minimum MLR percentage. The four instances where non-medical costs were inappropriately classified as medical costs were investigated and resolved without a material impact on the MLR.

Findings and Recommendations for §43-13-117(H)(3)(c)(v) —Whether Non-Provider Payments Assigned as Medical Expenses Are Appropriate

Findings

- Myers and Stauffer perform annual MLR work, which is appropriate. Their work is mandated by DOM and provides DOM with significant information upon which to act.
- Having the CCOs report on an annual basis regarding their operational costs for Myers and Stauffer to review is a sound business practice.

Recommendations

- Consider having Myers and Stauffer expand the scope to ensure that there are no costs included in medical which should not be, irrespective of materiality. This would include a review of each line item of expense and DOM could request data in such a way as to mitigate the audit costs while maintaining appropriate classification of expenses.
- Consider having MSCAN Compliance officer involved in this process, with Myers & Stauffer.
- Ensure that continuous monitoring occurs within MSCAN of all CCO expenditures for MLR determination purposes to effect safeguards against improper classifications.

§43-13-117(H)(3)(c)(vi) –Capitated Arrangements with Related Party Subcontractors

Based on a review of related party subcontracts, policies, procedures, corrective action processes, subcontractor requirements and associated information from the CCOs, along with a review of state contract requirements and associated data. DOM guidance similarly extends to all subcontract relationships with related parties. This report details information related to the specifics of those requirements, whether or not the parties are related. This guidance follows the CCO contracts, with amendments.

The MSCAN contracts between DOM and the CCOs contain specific language and requirements in Section 15, entitled *Subcontractual Relationships and Delegation*. This section details requirements for the CCOs to oversee and manage both performance and costs of related parties. Section 15 allows a CCO to contract for the "provision or purchase of services for and from third parties." CCOs were permitted to subcontract for services during the audit period 2018-2020, as they maintain ultimate responsibility for ensuring that all terms of the Contract are fulfilled, and compliance is maintained. Only the CCO is entitled to payment from DOM and, therefore, each CCO is solely responsible for any obligations to its subcontractors under DOM pre-approved subcontracts.

The subcontractor, irrespective of their relationship with the CCO, must agree to comply with the delegated activities and reporting requirements in accordance with the CCO's obligations. The subcontracts do not, in any way, limit the CCOs responsibility for compliance with their MSCAN contract.

Additionally, any subcontractor's activities and performance must be monitored by DOM and are subject to annual reviews and audits. The results of such CCO reviews must be included in the contractually required Annual Quality Management Program Evaluation they have to send to DOM. If contract noncompliance occurs, the CCO is required to take corrective action that includes, but may not be limited to, modification of activities, corrective action plans (CAP) or subcontractor termination. CCOs are obliged to warrant that all subcontractors completely and adequately report on activities and contract breaches.

Federal law also bars contracts with individuals or entities which are excluded from participation in the Medicare or Medicaid programs and the agreement between DOM and the CCOs specifically states the same. The related parties have all been reviewed as a part of this audit and each determined to not be "excluded parties."

DOM may seek remedies against the CCO if it finds that the subcontractor has not satisfactorily performed the contractually required tasks. The CCOs are also responsible for the acts of their subcontractors. All subcontract documents, files, and data must be maintained at the CCO offices for audit upon request by DOM. Further, CCOs are not allowed to subcontract any portion of the services they are required to perform without the prior written approval of DOM. All subcontracts are required to be submitted to DOM for advance, written approval not less than thirty (30) days prior to the contracts expected beginning, though DOM staff indicated that there have been contracts that were executed without DOM's advance approval, in violation of the CCO's contractual requirements.

The CCOs have the right to arrange financial terms with each related party without advance notification to DOM and without contract limitation. Most fees and payments under the related party subcontracts have been determined to be paid on a per member, per month (PMPM) or a capitated basis. This audit included a review of each subcontract, and to determine which are deemed related parties.

A detailed review of audited financial statements, annual NAIC reports, and associated information involving all three CCOs reveals that over the course of 2018, 2019, and 2020, the CCOs, have remitted a combined $595,000,000, $639,000,000, and $695,000,000 respectively through their related party subcontractors, many of

whom are located outside the State of Mississippi. This represents a substantial outflow of monies from Mississippi to the CCOs and then to the related out-of-state parties.

Understanding the volume of diverted money from Mississippi suggests several questions, including:

1) Are all the CCO subcontracted goods and services with out-of-state related parties appropriate, and could those goods and services be contracted with in-state companies?
2) Are the PMPM fees charged through related party subcontracts reasonably determined or at a fair-market-value rate for Mississippi?
3) Why are there no contract provisions which speak to related party subcontracts on a more specific basis,
4) Why is the Mississippi Department of Insurance not involved with DOM in addressing the financial arrangements with related party subcontractors to better monitor the expenditure of Mississippi funds from state plans and then from the state plans to related party, out-of-state companies?
5) How much, if any, of those funds ultimately diverted to non-Mississippi companies could be put to use with Mississippi companies?

The CCOs instituted policies and procedures involving related party subcontracts, in compliance with contract requisites for oversight and monitoring. Below is a high-level overview of the oversight programs instituted by the CCOs.

CCO #1 adopted an oversight program for third parties, including related parties, into its normal operations. The operational and performance standards are aligned with Contract requirements and with the particulars of CCO#1. Performance standards were outlined in each related party subcontract, along with detailed reporting requirements and other compliance mandates.

CCO#2 adopted policies and procedures associated with related party performance monitoring and oversight of delegated entity contracts and relationships which mirror those of non-related party subcontracts. The CCO has the option of delegating a host of services to third parties under the auspices of a governing board which ensures that the subcontractors maintain compliance with contract requirements, including monthly and quarterly reporting of delegated activities coupled with an annual audit. There is no difference in the contractual requirements between related parties and unrelated parties. The provisions encompass the contractual provisions in the Contract with DOM.

CCO#3 developed written protocols for the management and oversight of subcontractors. The written policies set up an oversight board to ensure compliance. The policies mandate performance along with continual DOM reporting. Reporting is required on an annual basis, along with monthly accounts, which vary based on the subcontracted goods and services.

A review of each subcontract looked at consistency related to compliance with the contract, reporting requirements, and any other issue that was also mandated through the MSCAN contract. There are DOM approved subcontracts which involve a host of Medicaid managed health plan services and goods, none of which appears out of line with the MSCAN contract or with normal CCO operations.

Findings and Recommendations for §43-13-117(H)(3)(c)(vi) –Capitated Arrangements with Related Party Subcontractors

Findings

- DOM has crafted a professionally written Contract for MSCAN and the CCOs, excepting detailed and specific conditions for related party subcontractors. The requirements for Subcontractor agreements allows for the CCO to enter into these contracts but with the advance, written approval of DOM. The

contracts have not always been presented to DOM for advance approval, despite the contractual requirement.
- The subcontracts must be kept locally and available for inspection upon request by DOM, its agents, and auditors.
- The Contractor and Subcontractor oversight prescribed by DOM, using both the language in the Contract itself and the subcontract agreements enables DOM to save time, money and gain the reports necessary to maintain legal, operational, and financial efficiencies, but the processes preclude an objective review and analysis of related party subcontracts as demonstrated by the vast monies paid by the CCOs to non-Mississippi companies.

Recommendations
- As part of its continuing efforts to enhance and improve operational and financial efficiencies, the three CCOs must continue to oversee and manage each Subcontractor relationship, irrespective of whether it is a local, national, or related party.
- The fact that all subcontracts have not been properly submitted to DOM for approval, in advance and in writing is concerning in that CCOs may not be taking the contract provisions as seriously and literally as they are required.
- Subcontracts with related parties should be evaluated on a more restrictive basis to ensure that the terms, fees, and goods or services are appropriate and determined objectively.
- DOM should determine the most effective reporting guidelines for related party subcontracts, which may vary from non-related party agreements. Perhaps an annual report is insufficient to properly monitor related party subcontractor performance.
- The CCOs must ensure timely and accurate reporting of all Subcontractor activities, as required in the subcontract, and as prescribed in the Contract with DOM. This should include consistent monthly, quarterly, and annual reports provided internally for analysis and opportunities to improve as well as in meeting the obligations of the CCO itself.
- The CCOs should establish and maintain consistent reporting by and between all subcontractors which are associated with the three CCOs. The reports should be required on a monthly basis where it is most appropriate and quarterly, should the reporting be too cumbersome.
- DOM's reporting requirements appear sufficient to ensure Contract compliance and effectiveness if DOM reviews the reports consistently, and any action required taken within a reasonable amount of time to avoid any MSCAN interruptions.
- There should be a more than annual review of related party subcontracts, with the evidence suggesting a semi-annual or quarterly reporting mechanism to be instituted.
- It is highly recommended that DOM institute a systematic set of procedures, communicated to each CCO in the strongest of terms, which direct CCOs to comply with the contract submission requirements and that penalties for failure to follow the contract be considered.

§43-13-117(H)(3)(c)(vii) – Reasonableness of Corporate Allocations

The critical nature of this audit centers on what is "reasonable" as defined in both law and accounting. The reasonableness standard maintains multiple applications in the financial and legal world. Generally, the standard is associated with a mandate that expectations placed on a party are considered reasonable or unreasonable given a facts and circumstance situation. The expectation is that any actions taken should be rational, systematic, and appropriate in the ordinary and normal course of business. The business judgment rule is a legal principle which prescribes that the parties involved act in good faith and in the best interest of the indicated subject. Reasonableness in accounting terms refers to an examination method which has at its core the verification and validation of accounting information. Alternatively, the measure is one which compares one entity to others in the same industry.

Medicaid health plans follow the basic premise of allowability, allocability and reasonableness when considering general and administrative expenses. Costs must be proper and efficient for the administration of MSCAN. The costs must be reasonable and consistently applied across entities within Generally Accepted Accounting Principles ("GAAP"). The costs must also be reasonable under the existing circumstances. The MSCAN contract language prescribes that costs be allocated among plans based on their benefit to the plan and that the costs must be reasonable. The MSCAN contract is less than specific about allowable corporate allocations.

The accounting premise is that costs must be reasonable, comparable, and appropriate under the circumstances. During the audit period of fiscal year 2018, 2019, and 2020, the CCOs were evaluated and compared with plans of a similar nature and size in the District of Columbia, Iowa, Kansas, Pennsylvania, Minnesota, New Mexico, and West Virginia.

The multi-state comparison with MSCAN CCOs reflected a wide variation in administrative costs across the plans, ranging from 4.63% to 13.4%. In Mississippi, the CCOs experienced a low of 8.8% and a high of 14.8% for general and administrative expenses. A review of national norms revealed that these percentages were within acceptable limits, despite the wide variation in percentages.

Discussions with DOM and MSCAN personnel indicated that there was no recurring, periodic system in place by which to adequately review corporate allocations. CCOs submit quarterly NAIC reports which yield significant information and annually submit a comprehensive report reflecting all operations with substantial footnotes. There was no indication that the management agreements executed between parents/affiliate and local plans were reviewed for adequacy, excessive charges, or appropriateness.

Findings and Recommendations for §43-13-117(H)(3)(c)(vii) – Reasonableness of Corporate Allocations

Findings

- During the audit period, the lack of a robust systematic review and approval process for corporate allocations is concerning in that the CCOs, their parents and affiliates have an opportunity to adjust corporate expenses as they wish, without clear oversight by DOM. This has, reportedly, been improved through internal modifications to ensure that costs are a critical piece utilized during the rate setting process.
- These expenditures appeared to be made during the 2018-2020 audit period with fewer constraints imposed by DOM.

Recommendations

- MSCAN should implement at least a quarterly review of corporate allocations on a go-forward basis. This process should be instituted immediately and a review of 2022 allocations should begin. Future reviews should occur consistent with the filing of quarterly and annual NAIC reports.
- The recurring review should include an evaluation of each CCOs corporate allocation on a line-item basis to determine reasonableness when compared with prior periods and when compared with plans of a comparable size.
- Allocations which affect payments to corporate and affiliates should be approved, in advance, as previously discussed here. This places a governor on monies which may be transferred out of state and regulates, to a degree, the general and administrative costs between parties.
- Corporate allocations, general and administrative expenses and contracted medical service costs should be regulated by MSCAN to ensure effective and efficient expenditures. Monies which can be kept in state should be.

- Recommendations is made that the CCO contracts be written to specify what corporate allocations are allowed, which require pre-approval and any limitations on the amounts allocated.
- Oversight of reporting and expenditures at both the medical service cost and general and administrative levels is highly recommended. These reviews should be conducted at least semi-annually or more routine when circumstances dictate.

§43-13-117(H)(3)(c)(viii)—Value-Added Benefits and the Extent to Which They Are Used

Medicaid health plans have been integrating services for beneficiaries for many years because of the operational, social services, and non-health requisites of beneficiaries across the United States. Innovative plans, faced with increased costs of care, along with non-health related mandates, have faced pressure to expand beyond traditional services and products while addressing member needs with a more focused approach to the allocation of plan resources.

Often, beneficiaries face a combination of poor conditions, whether it is a chronic physical, behavioral, cognitive, or non-medical condition such as poverty with a lack of social or environmental opportunities. These determinants have dramatic impacts on health outcomes, which has led to policymakers and health plans developing efforts to include those as an elemental component of outcomes measurements. Most health plans' goals are to provide health care with reduced spending whether beneficiaries are high-risk, high-need, or moderate users of care.

Mississippi's MSCAN CCOs have adopted various approaches to value-added benefits to deliver targeted services to Medicaid beneficiaries. CCOs are not paid extra for the provision of value-added services, as these add-ons are excluded from all rate-setting calculations. Plans offer these services because it is expected that, in so doing, health outcomes will be improved while costs are mitigated. State Medicaid agencies have been influential in encouraging health plans to deploy value-added services. In a May 2016 report, the Centers for Medicare & Medicaid Services ("CMS") stated that managed care organizations have the latitude to provide value-added services and products, and it recognized that the costs of those services are to be excluded from the rate setting and CCO payment process.

Some states push contracted health plans to provide value-added services, but others leave the decision about value-added services to the discretion of the plans. Those states that play a larger role often have a more prescriptive methodology for the offering.

Those plans that are left with discretion tend to offer a broader range of services when determining the overall allocation of state-paid resources and those structure the value-add around the beneficiaries, their families, and beneficiaries of the care teams; allowing the list of services to be designed to best meet the needs of the populations enrolled. The discretionary selection of services seems best when describing the latitude accorded MSCAN CCOs. Each CCO has developed its own selection of value-added services which are afforded to each CCOs' enrolled populations in Mississippi.

A representative list of value-added services offered by each Mississippi CCO includes, but is not limited to:

- Well-child benefits including low- or no-cost sports physicals,
- Dollars for child immunizations, well-child check-ups, and follow-ups for select issues,
- Breast and cervical cancer advance screening payments,
- Well-care rewards for issues such as diabetes, immunizations, and other important issues,
- Reward for pre-natal and post-natal care, including vitamins and related baby products,
- Smartphones for routine communication, including discounted internet services,
- Home care visits using telehealth,

- Opioid treatment services,
- 24-hour nurse advice services,
- Nutrition counseling and assistance,
- Weight management services,
- Smoking cessation services,
- Prepaid gift cards for EPSDT, childhood immunizations, breast cancer exams, maternal-fetal care,
- Enhanced vision care benefits,
- Select behavioral health services,
- Healthy behaviors gift cards,
- Mammograms,
- Diabetic treatments and care, including eye exams,
- Fresh vegetables for beneficiaries, and
- Diaper days and baby showers for expectant mothers.

Commonly Deployed Value-Added Benefits, Nationally

A survey of Medicaid health plans across the United States shows that, in addition to the above list of goods and services, plans often include the following as value-added benefits:

- Daily pre-cooked, home-delivered meals for a specified period of days/weeks,
- Breast pumps for female beneficiaries (often given once every one to two years),
- Breast pump rentals if neonatal stays are required,
- Infant and child car seats for each pregnancy,
- Online GED programs to facilitate educational opportunities,
- Housing assistance, with limited dollar amounts, utility payments,
- Moving expenses,
- Trailer Park and lot rents,
- Circumcision for newborns (through one year of age),
- Over-the-counter products and medicines,
- Additional inpatient assistance when it involves mental health or drug related issues,
- Additional in-home obstetrics support,
- Healthy play for children,
- Assistance for those who suffer from asthma,
- Additional physician visits for select needs,
- Hearing related matters,
- Vision support in addition to required benefits,
- Transportation assistance outside normal non-emergency transportation services, and
- Expanded dental visits and services.

The benefits are, as reported, designed around the populations served and vary widely by plan and by state. Each CCO has the discretion to implement and manage its own set of value-added services with measurements as to the inherent value received through each of the benefits offered following closely with performance measure results that are routinely reported to DOM. Because not every member avails themselves or their children of every value-added benefit, comprehensive and exact measurements of positive results is difficult at best on an individual or even population basis.

Findings and Recommendations for §43-13-117(H)(3)(c)(viii)—Value-Added Benefits and the Extent to Which They Are Used

Findings

- The benefits offered through the existing CCOs are expansive and appear to be consistent with the populations being served.
- The value-added benefits are in keeping with the performance metrics prescribed by DOM for each CCO.
- DOM via MSCAN does not mandate periodic reporting as to health outcome improvements achieved through the offering of value-added benefits.
- DOM, via MSCAN, does not mandate periodic reporting about the mitigation of healthcare and non-healthcare costs achieved through the offering of value-added benefits.
- Total discretion is left to each CCO to design value-added benefits around the beneficiaries served and those benefits are intended to both attract beneficiaries from both enrollment and health improvement perspectives.
- As reflected above, there are a sizable number of additional value-added benefits which could be incorporated into the operations of any CCO, should those be determined to be viable for inclusion in the offerings to beneficiaries.

Recommendations

- DOM could incorporate a periodic, formalized reporting structure for the recurring use of each level of value-added benefits provided by the CCOs, to evaluate the extent to which these services and products are used.
- DOM could encourage the CCOs to expand the offerings of value-added benefits for its member populations, to further improve health outcomes.
- Each CCO should continually review the value-added benefit offerings to determine the potential for increasing or modifying existing service/product offerings.
- DOM should continue and perhaps enhance its reporting requirements related to compliance with performance metrics and improved outcomes.
- Coordination between DOM and the CCOs about benefit offerings could bring improved outcomes, cost mitigation, and provide DOM needed assurances that the most appropriate and beneficial value-added benefits are available.

§43-13-117(H)(3)(c)(ix)—The Effectiveness of Subcontractor Oversight, Including Subcontractor Review

Based on a review of CCO subcontracts, policies, procedures, corrective action processes, subcontractor requirements and associated information from each of the CCOs along with federal and state laws and regulations, and associated information has allowed for the determination of the effectiveness of subcontractor oversight. This report details the specifics developed by each Mississippi CCO, as well as the contractual requirements within DOM, including requirements for the CCOs to oversee and manage the performance of and fees paid to related parties.

Section 15 of the Contract allows the CCOs to contract for the "provision or purchase of services for and from third parties" which are not parties to MSCAN. Each CCO was allowed to subcontract for services under MSCAN from 2018 through 2020. DOM has the responsibility to ensure all contract terms are fulfilled and compliance is maintained. Subcontractors are required to comply with any delegated activity with related reporting requirements, though it is ultimately the CCOs' responsibility to ensure compliance. DOM may impose remedies on a CCO if the agency determines that the subcontractor has not satisfactorily performed and the CCO has done nothing to correct the issue.

DOM has provided each CCO a checklist of specific requirements which must be included in every subcontract supporting MississippiCAN. DOM must pre-approve all subcontracts and also retains the right to review or audit compliance. Additionally, corrective actions and terminations must be submitted to DOM. All agreements are contractually required to be submitted to DOM for approval no less than thirty (30) days in advance and all activities contracted must be delineated. DOM may approve or disapprove of the proposed agreements and traditionally coordinates with the CCOs to achieve a positive outcome ultimately directed towards beneficiaries' health and optimum operational processes. However, it appears that even with all these contractual requirements, the CCOs may not always submit subcontract for prior approval to DOM. This may be because they do not always consider non-related parties to be covered under MSCAN requirements. This report recommends further evaluation of this issue.

The subcontractor, irrespective of their relationship with the CCO, must agree to comply with the delegated activities and reporting requirements in accordance with the CCO's obligations. The subcontracts do not, in any way, limit the CCOs responsibility for compliance with their MSCAN contract.

Additionally, any subcontractor's activities and performance must be monitored by DOM and are subject to annual reviews and audits. The results of such CCO reviews have to be included in the contractually required Annual Quality Management Program Evaluation they have to send to DOM. If contract noncompliance occurs, the CCO is required to take corrective action that includes, but may not be limited to, modification of activities, corrective action plans (CAP) or subcontractor termination. CCOs are obliged to warrant that all subcontractors completely and adequately report on activities and contract breaches.

The subcontracts are to be maintained at the offices of each CCO and be available for review, upon request, by DOM. All remedies are available to DOM for any breaches which may occur and for which DOM determines are significant and uncorrectable. The CCOs have implemented oversight policies and procedures relating to contracts to ensure compliance, such as:

CCO #1 incorporates an oversight program for third parties into their operations. This applies to any contracted third party for the purpose of fulfilling contractual obligations. Performance standards are outlined along with reporting requirements and mandates for compliance with all state, federal, and NCQA requirements, as applicable. The program allows contracting with local, national, and related party entities. The guidelines provide that suppliers, providers and vendors must abide by all regulatory contracts and laws. This includes meeting required reporting deadlines, adhering to monitoring mandates and the provision of audit reports, tracking of activities, maintaining minutes of meetings, training, and education as appropriate and documentation of performance issues and requests.

CCO#2 has adopted policies and procedures associated with performance monitoring and oversight of delegated entity contracts and relationships. The CCO has the option of delegating a host of services to third parties under the auspices of a governing board which ensures that the Subcontractors maintain compliance with contract requirements, including monthly and quarterly reporting of delegated activities coupled with an annual audit. The oversight board has a policy of constant monitoring of activities along with a mandate of consistent reporting on a monthly basis. Corrective action for noted deficiencies is provided as are annual audits, internally, of third-party contracts. The described oversight board makes decisions as to the continuation or termination of Subcontractors, at its discretion.

CCO#3 also implemented written protocols for the management and oversight of Subcontractors. These provide for an oversight board to ensure compliance and allows for contracting with Subcontractors whether or not related. The policies mandate performance under contract terms along with continual reporting requirements. The reporting requirements are reasonable yet rigorous for the subcontractors. Deficiencies may be met with corrective action plans or termination if not satisfactorily rectified. The policies require compliance with all federal and state regulations along with directives through its agreement with DOM. In addition, the CCO may

contract with local, national, or related entities, without limitation if the entities are not excluded from participation with Medicare or Medicaid. The policies delineate the procedures related to compliance, directives, and reporting. Reporting is required on an annual basis, along with monthly accounts varying based on the type of subcontract.

Findings and Recommendations for §43-13-117(H)(3)(c)(ix)—The Effectiveness of Subcontractor Oversight, Including Subcontractor Review

Findings

- Each subcontract entered for each of the three CCOs has been reviewed for consistency in language related to compliance with the Contract, reporting requirements, and any other issues which are mandated through the CCO Contract with DOM. There are a multitude of DOM approved subcontracts which involve a host of Medicaid managed health plan services and goods, none of which appears out of line with the MSCAN contract or with normal CCO operations.
- DOM has crafted a professionally written Contract for MSCAN and the CCOs. The requirements for Subcontractor agreements allows for the CCO to enter into these contracts at will, with the advance, written approval of DOM. The CCO may delegate any activity or duty under its Contract if: 1) The activities are specified in writing in the Subcontractor agreement, 2) The Subcontractor agrees to fulfill the subcontracted activities, 3) There exists a revocation clause which allows for the remedy of any deficiency or termination, 4) The Subcontractor agrees to allow DOM, CMS, HHS/OIG or the Comptroller General to audit and inspect any and all associated records, 5) The Subcontractor must make available all records as requested under 42 CFR Section 438.230 and 6) The right to audit/inspect exists for a period of ten (10) years.
- Any subcontract to be executed must be submitted to DOM for advance written approval by the CCO.
- The subcontracts must be maintained locally and available for inspection upon request by DOM, its agents, and auditors.
- The Contractor must require periodic reporting and include such reporting requirements in the subcontractor agreements.
- DOM's reporting requirements are outlined in the Contract itself and the Subcontractor reporting requirements must be included in each subcontractor agreement.
- Each CCO has mandated monthly, quarterly, and annual reporting for each Subcontractor and these reporting mandates are included in every subcontract agreement reviewed.
- The detailed policies and procedures employed by the CCOs appear both relevant and detailed at a level sufficient to ensure oversight effectiveness, given the magnitude of the ramifications if the Subcontractors fail to deliver, including termination of the subcontracts, sanctions and penalties levied against the CCOs leading to the possible termination of the CCO contract if the failures are incurable and of significant magnitude.
- The provisions included in the Contract with the CCOs by DOM are sufficiently flexible to allow for the variations in CCO operations and the services/goods which are contracted. The provisions are also regimented sufficiently to ensure that DOM has significant insight into the CCO and Subcontractor operations and service offerings which would enable DOM to address any deficiencies within a month to a calendar quarter period of time.
- There are generally three ways to measure contract effectiveness: 1) Does it save time? 2) Does it save money? and 3) Are reporting requirements met with relative ease? In the instant case, the Subcontracts are entered by the CCOs with the anticipation of saving time, money and being able to provide required reporting on an at will/as needed basis. The Contractor and Subcontractor oversight prescribed by DOM, using both the language in the Contract itself and the subcontract agreements enables DOM to save time, money and gain the reports necessary to maintain legal, operational, and financial efficiencies.
- DOM has determined that not all contracts have been properly submitted, in advance, as contractually required and that some have been executed and put into place without that process being honored.

Recommendations

- As part of its continuing efforts to enhance and improve operational and financial efficiencies, the three CCOs must continue to oversee and manage each Subcontractor relationship, irrespective of whether it is a local, national, or related party.
- The CCOs must ensure timely and accurate reporting of all Subcontractor activities, as required in the subcontract, and as prescribed in the Contract with DOM. This should include consistent monthly, quarterly, and annual reports provided internally for analysis and opportunities to improve as well as in meeting the obligations of the CCO itself.
- The CCOs should establish and maintain consistent reporting by and between all subcontractors which are associated with the three CCOs. The reports should be required on a monthly basis where it is most appropriate and quarterly should the reporting be too cumbersome.
- Because it was determined that not all subcontractor agreements were properly submitted for approval to DOM in advance, DOM should ensure that its reporting requirements are sufficient to ensure Contract compliance and effectiveness provided that the reports are consistently reviewed, and any action required taken within a reasonable amount of time to avoid any MSCAN interruptions.
- There should be a less than annual review prescribed by DOM for the Annual Quality Management Program Evaluation; perhaps a semi-annual report to address any potential issues or areas of concern enabling DOM to act if necessary.
- It is recommended that DOM institute a systematic set of procedures, communicated to each CCO in the strongest of terms, which direct CCOs to comply with the contract submission requirements and that penalties for failure to follow the contract be considered.

§43-13-117(H)(3)(c)(x) –Whether Health Outcomes Have Been Improved

Outcome measures are defined by the World Health Organization as a "change in the health of an individual, group of people, or population that is attributable to an intervention or series of interventions." These measures revolve around quality and the costs of care which health plans, among others, are undertaking to improve. The more effective the care, the lower the ultimate costs and the better for the patients in the short and long-term. The improvement of beneficiary care and reduced costs benefit all involved stakeholders. Outcomes are routinely reported to CMS and other groups.

Patients may rely on health outcomes data to enable decision-making about their healthcare. Transparency is critical when measuring outcomes for both the patients/beneficiaries and the managed health organization, as well as with Medicaid agencies. Health plans rely on health outcome data to improve care delivery methodologies and to mitigate costs.

Plans and providers can be agents of change when it comes to health quality and improvement. As change agents, to achieve best results and institute best practices, they are routinely asking:

1) What is quality,
2) What measured indicators will return the greatest benefit,
3) How can we achieve optimum outcomes for our patients and beneficiaries, and
4) What can we do to continually improve results?

The questions should lead to innovative ideas and variations on current practices with the same goals.

With MSCAN, DOM has instituted contractual requirements of the CCOs that stress the need for enhanced health outcomes and the results have been generally positive. The performance measures allow DOM and the CCOs to uncover spaces where different treatments could improve care, identify alternative care methods,

reveal evidence which can improve care for individuals with select conditions or even populations, and relate different treatments that have varying levels of effectiveness. Through reporting and oversight, DOM can see when improvements are occurring. For each of the three current CCOs, outcomes are reported below. The review of health outcomes period does include at least a portion of the COVID pandemic time. The CCOs all had some setbacks from their expected improvements during this time. However, despite the pandemic, CCO#1 reflected marginal, yet positive improvements in its reporting. COVID-19 had a significant impact on CCO#2, with lower-than-expected outcome findings during the pandemic year in number of areas. For CCO #3, twenty (20) of sixty-eight (68) outcomes measures reflected increases over the 2020-2021 period (used to make up for the absence of historical data in the 2018 and 2019 audit periods), so they too were unable to show improvements through the pandemic.

The importance of measuring outcomes cannot be overstated given the rising costs of healthcare, the poor health many Medicaid beneficiaries find themselves in and the limited funds available to care for and manage each population.

Ultimately, the goals may be universally described as:

- Improving the healthcare experience for the beneficiaries,
- Improving the health of all populations within DOM and MSCAN,
- Mitigating the costs of healthcare on a per member and per population basis, and
- Mitigate staffing costs, staff turnover and even staff burnout from treating sicker populations.

Measurement is a critical component of implementing positive change. Outcome measures communicate whether improvements are in care and/or costs. Medicaid providers are the ones who must confront and manage issues to ensure continuity of care. The CCOs appear to be increasingly focused on outcomes.

Efforts to improve the delivery of health care services and outcomes depends on a well-defined approach to performance measurement. A guiding light to improvement involves the value of care delivered. Value may be measured by the health outcomes realized on a per dollar expended basis to deliver that care. This result is presented in the form of a ratio that considers the acuteness of a beneficiary's condition divided by the monies expended to address or treat that condition. When value is enhanced, the result stems from a cost-to-care ratio. The monies expended are often more quantifiable than the severity of the condition. The point is to focus on value of the care delivered and the result of that care rather than costs alone.

Health outcomes are increasingly important in Mississippi as a result of the State ranking at the bottom or near the bottom in almost every key health outcome, as compiled by the Mississippi State Department of Health. This is a continuing trend that has existed for a significant period of time. Both in the State and on a national basis, health inequalities have been worsened for those who face hurdles to adequate care either because of their geographic location, religion, ethnicity, race, socio-economic condition, and even sexual orientation, among others. The consequence of these issues culminates in a disproportionate segment of Mississippi's population facing poor health conditions. As a result, the quality of care can be negatively impacted while associated costs increase unnecessarily and disproportionately.

Each CCO must comply with DOM's Quality Management to improve the mandates related to health care outcomes for all beneficiaries. The CCOs have agreed to provide, pursuant to the contract with DOM, an annual independent audit of health outcomes and submit them to DOM for review, analysis, and to promote a collaborative relationship geared to improving beneficiaries' health. DOM may, in coordination with the CCOs, modify performance measures based both on CCO results and ever-changing beneficiaries' health. The performance measures described in the MSCAN contract are primarily centered on the Healthcare Effectiveness Data and Information Set (HEDIS®). CCOs are required to utilize standardized methodologies as outlined in Volume 2, *HEDIS® Technical Specifications*, in order to properly calculate performance. CCOs are also

obligated to undergo an annual audit of their rates by a Certified HEDIS® firm, and provide the audit report to DOM, including HEDIS® rates for all Performance Measures.

Despite their efforts, the pandemic took a major toll on the CCOs and their ability to address needed health outcomes. The pandemic caused a loss of between six to nine months of the CCOs having an ability to intervene in care and make a difference. Each CCO reported this impediment to what had been continuing improvement. Exhibit F of the MSCAN contract details nineteen (19) health outcome measurements across seven (7) categories, including:

1) Obesity,
2) Asthma,
3) Well-Child and Early Periodic Screening, Diagnostic and Treatment (EPSDT),
4) Diabetes,
5) Congestive Heart Failure,
6) Maternal and Child Health, and
7) Member Satisfaction.

These are all within CMS categories of measures and address the most significant health issues facing MSCAN beneficiaries.

CMS generally outlines twenty-six (26) measures across six (6) categories, including: 1) Prevention and health promotion, 2) Management of acute conditions, 3) Management of chronic conditions, 4) Family experience with care, 5) Care coordination and care transition, and 6) Availability of care. Within the seven DOM categories of overall outcome measurements, included are outcomes for:

Obesity-
BMI for Adults
BMI-weight assessment, nutrition and physical activity for children and adolescents
Asthma-
Use of appropriate medications to control asthma
Asthma-related ER visits
Avoidable asthma-related rehospitalizations
Well-Child and EPSDT-
EPSDT screening
Lead screening for children
Childhood immunizations—% of EPSDT eligible beneficiaries with up-to-date immunizations
Well-child visits in first 15 months of life
Diabetes-
Nephropathy screening
Blood sugar poorly controlled in people with diabetes
Blood sugar well-controlled in people with diabetes
Congestive Heart Failure-
Ace inhibitor therapy
Congestive heart failure
Maternal and Child Health-
Pre- and post-natal complications
Pregnancy outcome for beneficiaries enrolled throughout pregnancy
Prenatal and postpartum care
Member Satisfaction-
Member satisfaction-improve overall rating of health plan
Improve percentage of Beneficiaries reporting they received needed care

CCO#1 Reported Outcomes

CCO#1 reported performance measures for the audit period 2018 – 2020 based on HEDIS® effectiveness of care methods. The data reported was comprehensive and reflected improvement in approximately twenty (20) categories, when the entire audit period is evaluated.

Key areas of improvement for CCO#1 are reported to include childhood immunizations, lead screenings for children, nephropathy screenings, blood sugar poorly controlled and blood sugar well controlled for diabetics, cancer screenings and utilization. Results reflected small improvements from just over 3% to over 16% in eleven areas identified and listed by DOM as key. Behavioral health measures reflected improvements along with asthma measures. Cardiovascular care demonstrated more small positive gains specifically in the area of diabetes and behavioral health improvement for the entire audit period. Measurable losses in 2020 were noted in key categories when there had been positive gains in 2018 and 2019, though the losses were, overall, fewer than the gains. Of note, access to care and utilization suffered the most during the pandemic.

As a part its program to improve health, while effectively managing costs, CCO#1 has allowed for the development of education and management programs to address key elements of beneficiaries' health. CCO#1 has implemented programs addressing behavioral health and physical health, obesity and cardiovascular health, nutrition and maternal/child health, and pre-term pregnancy. They have reported an emphasis on care coordination to improve overall health as well as ensure continued work with child immunizations. Their increased focus on reducing emergency department visits appears to show improvement in the number of required visits stemming from cardiovascular and obesity conditions. They reported that care coordination and management services have resulted in improved hospitalization statistics, down substantially in 2020. However, even though it is a positive trend, a lack of clear explanations for reduced hospitalizations that may stem from the COVID-19 timeframe. Cost containment efforts to curb emergency department visits and hospitalizations resulted in both monetary savings and improved health outcomes over the audit period.

Of the approximate forty (40) HEDIS® measures tracked by CCO#1, fourteen (14) have shown less than positive trends over the audit period, with the majority of negative changes occurring in the COVID-19-year 2020. Twenty-three (23) outcomes reflected positive changes over the audit period involving well-child measures, women's health outcomes, behavioral health, diabetes, and access to care. Ten of those measures met with the 75th percentile NCQA quality, which demonstrates strong positive trends. Five of the downward trends were in the area of Well-Child and EPSDT categories.

Two negative outcomes occurred in 2020, related to asthma management and the use of medications for control, though the results were negligible and understandable given the COVID-19 difficulties. Behavioral health trends were positive with two minor exceptions, again occurring in 2020. Two downward trends occurred in 2020 involving pre-natal care and well-child visits, which have been previously disclosed as problematic during the COVID-19 pandemic. The effects of the pandemic/COVID-19 cannot be fully determined at this time, and while there was a loss of forward progress during that time, some outcomes saw improvement.

CCO#1 developed initiatives to evaluate population characteristics, specifically addressing critical health areas identified by DOM, including cardiac measures, maternal/child health, diabetes and obesity, emergency department utilization, well-child metrics, among others extending to community development and outreach, care coordination and management. A review of the HEDIS Audit Reports for each year across the audit period revealed a significant list of measures followed with the goal of continued improvement year-over-year going forward.

CCO#2 Reported Outcomes

CCO#2 has reported performance measures for the audit period 2018 – 2020 based on HEDIS® effectiveness of care methods. Using HEDIS® measures CCO#2 submitted its required annual independent audit to DOM for review and analysis. The outcomes reported followed DOM measures outlined in Exhibit F—Performance Measures of the contract.

COVID-19 had a significant impact on CCO#2, as well. Outcome measures and normal health care protocols suffered as a result of the pandemic in the general areas of decreased preventive care and office visits, changes in inpatient and outpatient care categories, increased telehealth episodes, along with mounting cases of depression/anxiety. Generally, outcome measures saw improvement across 2018 and 2019, leading into the pandemic year. The 2020 outcomes which saw positive improvements over 2018/2019 were limited in number. Of the approximate thirty-six (36) measures reported as a component of the MSCAN performance measures, eight reflected positive improvement, while the others remained unmet, based on CCO#2's goal of meeting the Quality Compass® 50th percentile.

CCO#2 instituted a forward-facing plan of quality improvement for 2021 and beyond. As a result of 2020, they began initiatives that were intended to improve outcomes across the entire scope of measures. Included in the plan were intentions to enhance member engagement, coordination of care to reduce emergency department visits, normalize utilization across key categories, improve preventive measures designed to address obesity, diabetes, chronic illness, improved mother and well-childcare, and child immunizations. Improved focus on maternity and pre-natal care along with well-baby care were foremost, given Mississippi's history of poor pre-natal and maternity care. Attention to EPSDT and immunizations will see specific programs designed to improve outcomes. Chronic disease programs have been designed to address asthma and COPD, medication adherence, diabetes related problems, and overall care/case management.

Provider and patient engagement resources were developed to address quality measures, make beneficiaries aware of available testing and screenings to aid in diagnosis and subsequent care while education and provider incentives target best practices and support for providers. Home wellness visits were instituted for wellness checks and patient education and to encourage further contact with beneficiaries' primary care provider for any problems noted. Communications related to medications, blood pressure, chronic illnesses, diabetes, and heart associated ailments are heavily utilized to improve outcomes.

CCO#3 Reported Outcomes

CCO#3 reported performance measures for the audit period from the 2018 through 2020 audit period based on HEDIS® effectiveness of care methods. Using HEDIS® measures, CCO#3 submitted its required annual independent audit to DOM for review and analysis. The outcomes reported followed DOM measures outlined in Exhibit F—Performance Measures. The goals stated for CCO#3 include meeting HEDIS® benchmarks described in the Quality Compass® with stated intentions to achieve outcomes in the 67th percentile. As with the aforementioned CCOs, the outcome measurements, while improving, saw negative trends because of the COVID-19 pandemic.

The overall goal for outcomes measures was not met during the audit period. Twenty (20) of sixty-eight (68) outcomes measures reflected increases over the 2020-2021 period, which was examined due to the absence of historical data in the 2018 and 2019 audit periods. There were measures which improved over the periods at issue, including the effectiveness of care and medication management. Preventive care visits declined due to the pandemic, along with episodes of pre-natal and post-natal care, which were often unavailable, well-child visits and care declined, along with emergency department visits (which did achieve positive results in the 67th percentile). Obesity and weight assessment services, asthma and COPD, cardiac care and high blood pressure, and related areas did not achieve positive outcome improvements year-over-year.

However, the measures which did experience positive improvements included: 1) Statin therapy for HBP, 2) Cardiac rehabilitation, 3) Kidney evaluation and diabetic therapy, 4) Behavioral health depression treatment, 5) Behavioral health follow-up for children, 6) Pharmacotherapy for opioid use, 7) Access to preventive care, 8) Select pre- and post-natal care, 9) Emergency department visits, and 10) Inpatient utilization. There were other related improvements over the course of the audit period, but the majority were not met with either positive improvement or significant positive improvement.

CCO#3, along with CCO#1 and CCO#2, has determined the impediments to achieving opportune outcomes for MSCAN beneficiaries. CCO#3 has developed a forward-facing plan, as well, which reflects the opportunities for outcome improvements across its entire MSCAN population. The measures follow those prescribed by DOM in Exhibit F-Performance Measures and have been categorized in order of importance within that framework. The performance plan began in 2019 and continue beyond the audit period. The plan for improvement reflects those measures not previously achieved and those which have seen marginal improvements towards those which would be significant and have a long-term positive impact on MSCAN beneficiaries.

Combined Data

The CCOs are equally aware and responsive to the outcomes measures prescribed for two principal reasons: 1) Improve the health of their beneficiaries and 2) Achieve outcomes to aid in reducing the cost of care in the healthcare environment experiencing rising costs in an inflationary economy where Medicaid dollars are at some level of risk. The combination is a positive for each CCO, the beneficiaries of MSCAN and for DOM and the State of Mississippi.

The Quality Team at DOM focuses on the outcomes measures and on improving both care and overall health. The team works in collaboration with each CCO with the overarching aim of improving outcomes. The comprehensive outcomes measures experienced by each CCO are reported on an annual basis, along with the HEDIS® Audit Report. Each organization has developed its own plan, which addresses the needs and issues facing the population it serves. The performance measures remain the same with adjustments made, as appropriate, to address the conditions reported by the beneficiaries enrolled with each CCO. Periodic reviews of quality measures correlating to each performance measure prescribed by DOM do not appear to occur with regularity, if at all. A more collaborative and coordinated approach to outcomes during the measurement year could result in improved results.

Findings and Recommendations for §43-13-117(H)(3)(c)(x) –Whether Health Outcomes Have Been Improved

Findings

- While the Quality Team works continuously throughout the year, an annual report may be lacking in terms of adjusting or improving during the measurement period.
- Consistent review and reporting by the Quality Team are imperative to achieving maximum outcomes.
- More frequent reporting and analysis of outcomes during the year can aid in reducing costs and addressing key issues for correction.
- Each CCO has reported differing goals when addressing the Quality Compass percentiles for outcomes.
- DOM did not set goals for outcomes measurements as per the Contract between CCOs and DOM. The performance measures are set forth, but the desired levels of achievement are not. However, in SFY 2020, a quality program was instituted by DOM at 1% withhold of capitation rates. The withhold differs from established goals set by DOM for each CCO to achieve.
- Each CCO reports its performance measures and HEDIS results in a different manner when it provides data to DOM.

Recommendations

- More frequent reporting of results than on an annual basis (E.g., monthly, or quarterly) would enable each CCO and DOM to address aberrant conditions and health issues which require more immediate attention for the benefit of MSCAN beneficiaries.
- The Quality Team should meet in conjunction with its receipt of interim quality data from the CCOs, whether monthly or quarterly. This should not preclude a comprehensive annual meeting, with and without the CCOs, during which time each of the DOM prescribed Performance Measures are evaluated and compared.
- Reporting the results of DOM's Quality Team's evaluation should be shared with the CCOs towards improvements for the following year.
- DOM should mandate that the reports provided by the CCOs be consistent in presentation, quality, and quantity to foster comparisons and analysis.
- DOM should prescribe a range of quality outcome goals for the CCOs, with an eye towards ensuring a continuing improvement among MSCAN beneficiaries; measured consistently.
- The reports provided by each CCO differ from one another, impeding the ability to make appropriate comparisons between plans. This can inhibit a comprehensive analysis by DOM and thereby its ability to set new outcomes measurement goals and objectives for the following year.

§43-13-117(H)(3)(c)(xi)—The Most Common Claim Denial Codes to Determine the Reasons for the Denial

After analysis, the top claims denial reasons, based on claim denial codes and the associated denial reasons on a per CCO basis are:

Coordinated Care Organization #1
Claim Denial Reasons and Related Number of Claims

Reason	Claim Count		
	2020	**2019**	**2018**
Exact duplicate claim/service	16,881	37,017	4,571
The procedure code is inconsistent with the modifier used.	12,685	13,278	1,425
Precertification/authorization/notification/pre-treatment absent.	12,073	20,546	1,799
Not covered when performed for the reported diagnosis	8,947	10,793	789
Missing EOB (Coordination of Benefits or Medicare Secondary Payer).	8,422	73	-
Not covered when performed in this place of service	7,858	301	1,264
Service/equipment/drug is not covered under the patient's current benefit plan	7,131	6,781	660
Missing/incomplete/invalid diagnosis or condition	6,314	239	-
Rendering NPI Issue	15,597	17,715	-
The time limit for filing has expired	465	16,734	2,428
Missing/incomplete/invalid replacement claim information	415	7,521	818
Drug/service/supply is not included in the fee schedule/contracted fee arrangement	203	13,171	-
Incorrect billing	-	10,794	1,597
Unbundled services	-	118	477
Provider not eligible to be paid for service on the service date	-	-	667

**Spaces without claims data is not indicative of those claims not being present, only that they were not within the top denial reasons.*

Coordinated Care Organization #2

Claim Denial Reasons and Related Number of Claims

Reason	Claim Count		
	2020	2019	2018
Exact duplicate claim/service	117,420	172,717	195,295
The procedure code is inconsistent	23,015	30,243	34,162
Precertification/authorization/notification/pre-treatment absent.	15,342	16,944	188,989
Not a covered service	238,511	256,509	208,073
Missing EOB (Coordination of Benefits or Medicare Secondary Payer).	43,746	42,381	52,030
Administrative void-Insufficient information to process claim	29,518	89,721	150,433
Rendering NPI registered, but not effective on DOS	43,870	62,566	126,794
The time limit for filing has expired	94,334	102,265	151,563
Missing/incomplete/invalid claim information	239,931	295,408	463,661
Resubmit required, with EOB where previous payment was made by the primary insurer	156,474	182,433	174,055
Incorrect billing	12,408	51,195	72,481
Unbundled services	21,619	42,324	65,590
Provider not eligible to be paid for service on the service date	36,705	54,290	64,622

Coordinated Care Organization #3

Claim Denial Reasons and Related Number of Claims

Reason	Claim Count		
	2020	2019	2018
Exact duplicate claim/service	23,053	33,234	19,549
The procedure code/diagnosis code invalid	3,574	3,329	7,966
Precertification/authorization/notification/pre-treatment absent.	33,522	39,871	39,234
Not covered service	5,186	6,218	2,803
Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	34,283	33,455	19,454
Not covered when performed in this place of service	6,964	6,464	4,251
This service missing modifier/invalid modifier	3,430	3,745	1,395
Missing/incomplete/invalid diagnosis or condition	2,127	3,683	3,426
The time limit for filing has expired	11,072	30,184	12,763
Missing/incomplete/invalid replacement claim information/medical records required	8,599	4,744	4,392
This drug/service/supply is not included in the fee schedule or contracted fee arrangement	3,293	2,398	-
Member termination	36,089	51,357	26,952
Maximum benefits exceeded	-	6,035	5,212

** Spaces without claims data is not indicative of those claims not being present, only that they did not fall within the top denial reasons.*

A review of the denial reasons reveals comparable results between the plans. Each was asked to provide the top fifteen (15) denials over the three-year audit period from 2018 through 2020. Duplicate provider claims were one of the most frequent denial codes amongst all three CCOs. This occurs when multiple claims are received for the same service on the same dates by the same provider. Providers frequently submit duplicate claims when the initial claim has not been reimbursed or when there is an attempt to influence payment a second time.

Providers may believe that submitting a second claim is easier than having staff contact the CCO and address the reasons behind a lack of payment receipt. Providers generally pursue this course of action due to the ease with which claims may be re-submitted.

One other common claim denial reason is an all-encompassing incorrect claim category, which includes a myriad of reasons which cause a claim not to be paid initially. Several other claim denial reasons observed at all three CCOs, include:

- Inconsistent/inappropriate use of procedure, diagnosis and/or modifier codes,
- Lack of pre-authorization for the services rendered,
- Rendering of services without appropriate provider information,
- Services rendered are not covered under the CCO MSCAN contract,
- The timely filing of claims was not met. Providers have one-year to file claims,
- Invalid information contained on the claim forms submitted,
- Claim may be resubmitted with additional information (e.g., medical record, EOB)
- Services are not payable based on the place where rendered,
- Member/beneficiary was terminated before claim was filed, and
- Claims do not contain all the required information necessary for payment

CMS maintains information related to claims and claim denials and they report upwards of one hundred (100) denial reasons. Among this extensive list are reasons which mirror what has been reported in Mississippi. The benefit is that it can allow DOM to compare nationwide statistics against current MSCAN experience. This information does not solve the denials which occur on a recurring basis, but it does give insight into the fact that CCOs are experiencing equivalent results, without exception.

Each CCO maintains its own claims management system and implements its own set of requirements and rules with which providers must abide when submitting claims for reimbursement. These claims are tracked for analysis. It is incumbent on providers to learn, understand, and implement processes to ensure the proper submission of claims for reimbursement. The CCOs report on denied claims towards an improvement in submission by providers.

Each CCO implements its own provider education system whereby the parameters for claims submission are set forth, claim manuals are developed and distributed / made available and routine provider seminars, memoranda and notifications are held to aid providers in the submission of clean claims. Educational efforts are recommended and should continue.

MSCAN CCOs volunteered processes and continuing provider education programs directed towards the submission of “clean” claims, which may be paid upon receipt. Providers are made aware of these efforts, according to the data submitted by the CCOs. However, because of the nuances required when completing claim forms and the significant amount of included information, it is not plausible to believe that all claims will ultimately be one hundred percent correct. DOM involvement is critical to reducing abrasion between providers and the CCOs. The education process involves DOM and CCO personnel on all matters affecting MSCAN contract requirements.

DOM coordinates with the CCOs regarding claim denials and works to improve the submission process, explain coverages, and contractual requirements in an attempt to improve DOM/CCO/provider relations. DOM reviews measures, provider communications, and issues related to the CCOs. There is a recurring need to further the education of existing and new providers as requirements change. The CCO tracking mechanisms for denied claims is a positive for the providers so that education efforts may be tailored to the specific denial reasons. The total of the top-15 claim denials exceeds 6.2m over the 2018, 2019, and 2020 audit period. The claims, by year, for the identified reasons, exceeded 2.6M in 2018, 2.1M in 2019 and 1.6M in 2020.

Findings and Recommendations for §43-13-117(H)(3)(c)(xi)—The Most Common Claim Denial Codes to Determine the Reasons for the Denial

Findings

- A key finding in the evaluation of denied claims is that because the CCOs track claims payment, denials and resubmissions, comparisons may be made, and education efforts may be structured towards the mitigation of claims issues.
- The analysis of denial trends on a year-over-year basis is indicative of positive trends across the top denial reasons.
- There is a positive trend across denied claims, using the reasons revealed by the CCOs, with a downward adjustment by approximately 500,000 annually.
- The reduction in denied claims is a positive upon which future claims results can be investigated and issues mitigated.
- Because of the CCO education efforts and provider efforts to comply, the result is that more claims are being paid correctly and timely, when compared year over year. This is good news for the providers who are profiting from the education efforts offered by the CCOs through improved claim processing.

Recommendations

- As a part of the education process, CCOs should continue their established tracking efforts of denied codes towards pinpointing future education for providers. Providers should be encouraged to participate and raise issues to foster more accurate claim submissions and timely payments.
- MSCAN CCOs should continue reporting denials to providers as part of the educational process on all denials, not just those which represent those at the top.
- DOM should continue its efforts to coordinate with CCOs, Providers and internal processes which fosters positive relationships with all involved in the delivery of care to MSCAN beneficiaries.
- DOM should continue to work with the CCOs to aid in mitigating potential provider issues regarding the submission of claims.
- Continued coordination between all affected parties involved with MSCAN should continue based on 2018, 2019 and 2020 information.
- There is a need for a continued, consistent review of MSCAN activities designed to measure results, population statistics, program success and rates leading to most effective rate setting and program design.

Appendix A:

OBJECTIVE, SCOPE, AND METHODOLOGY, BY MANDATE

§43-13-117(H)(3)(c)(i)—The Financial Benefit of the Managed Care Program to the State of Mississippi

The objective of this review was to evaluate the financial benefits resulting from the implementation of MSCAN to the State of Mississippi, on a cumulative basis from inception in 2011 through 2022.

The scope was to review prior audits and data to determine cumulative program savings for each of the CCOs from 2011 through 2022. Savings have been measured by the difference between actual MSCAN expenditures and projected fee-for-service expenditures.

The review relied on the methodologies employed by Milliman in previous years, and as utilized herein, are based on actuarial, statistical, and actual information and calculations across multiple categories. Savings are measured, by Milliman, on a comparison of actual program expenditures with projected fee-for-service expenditures. Annual adjustments are made to include an evaluation of member populations, nuanced issues such as COVID-19, changing CMS regulations and related data.

§43-13-117(H)(3)(c)(ii)—The Difference Between the Premiums Paid to the Managed Care Contractors and the Payments Made by Those Contractors to Health Care Providers

The objective of this audit was to evaluate the premiums paid by DOM to each CCO and, in turn, evaluate the payments made by each CCO to its contracted providers, ensuring appropriateness at each step.

The scope was to specifically address the legislatively mandated aspects of fees received and paid over the audit period from 2018 through 2020, as part of ensuring federal and state compliance within MSCAN and with each CCO.

The methodology of determining the amount of premiums paid by DOM to CCOs included comprehensive review of all sources of monies available for distribution to CCOs for care; careful evaluation of contracts and agreements executed by the CCOs and related parties as well as the calculations underpinning the allocations; a seven-state comparison of corporate allocations to determine reasonableness within MSCAN; and a detailed investigation into the costs incurred and classified by CCOs to provide for proper accounting and reporting.

§43-13-117(H)(3)(c)(iii) –Compliance with Performance Measures Required Under the Contracts

The objective of this audit was to determine whether the CCOs were following the performance measures described in Exhibit F of the MSCAN contract and whether they were meeting the reporting requirements.

The scope was to identify and evaluate the prescribed performance measures associated with MSCAN beneficiaries. A review of the measures, by category and in detail was compared with performance measures described by CMS in various publications. This review and evaluation covered the audit period from 2018 through 2020.

The methodology employed for this review centered on information provided by DOM and with reports issued by the CCOs and by CMS, with a focus on performance towards improving the health of beneficiaries and maximizing expenditures.

§43-13-117(H)(3)(c)(iv) —Administrative Expense Allocations

The objective of this audit was to determine whether or not the administrative expense allocation methodologies employed by each CCO and their parents/affiliates consistent in application and approach. Each CCO utilizes its own approach to allocations between related parties which can create barriers when attempting to make reasonable comparisons so additional work was performed to aid in alleviating some of those issues.

The scope was to evaluate the allocation methods used during the audit period to ensure that they were within normal limits experienced by other Medicaid agencies, reasonable for the size of plans and populations served, and appropriate for Mississippi.

The methodology employed involved a detailed review of each CCO's related and unrelated parties and its rational and systematic approaches to allocating costs among the various entities. A careful evaluation of contracts and agreements executed by the CCOs and related parties as well as the calculations underpinning the allocations, a seven-state comparison of corporate allocations to determine reasonableness within MSCAN and a detailed investigation into the costs incurred and classified by CCOs to provide for proper accounting and reporting.

§43-13-117(H)(3)(c)(v) —Whether Non-Provider Payments Assigned as Medical Expenses Appropriate

The objective of this audit was to determine whether or not CCO non-provider payments classified as medical costs were categorized appropriately. The rules are specific as to what may and may not be included in the calculation of the MLR. The scope of the audit included a review of all categories of costs, both general and administrative and medical, along with Myers & Stauffer audit reports of Medical Loss Ratio (MLR) calculations across the audit period 2018-2020.

The methodology involved the review of significant data provided by the CCOs, the Myers & Stauffer audit reports, as described, the related calculations of what may and may not be included, and information supplied DOM in order to determine whether medical costs were appropriately categorized.

§43-13-117(H)(3)(c)(vi) –Capitated Arrangements with Related Party Subcontractors

The objective of this audit was to identify related party Subcontractor relationships and to evaluate those agreements for both substance and essential services, with a dive into the payments made under these agreements over the audit period 2018-2020.
The scope was to evaluate and examine MSCAN contract provisions and whether or not the CCOs provided transparency into related party subcontractors. The related party subcontracts cover the overwhelming majority of the subcontracts executed by the CCOs, primarily in monetary terms and, in most instances, in operational areas as well.

The methodology employed in this review include thorough review of the MSCAN contract and subcontract process to ensure that they are being followed and are based on the Code of Federal Regulations and the CMS, which oversees all aspects of the Division of Medicaid as a critical element of the State/Federal partnership that allowed for the creation of Medicaid agencies. It also included review and analysis of each related party subcontract, financial statements, notes to the annual financial statements and NAIC annual reports to confirm both the relationships and the financial ties. Finally, determination was made through research and investigation as to which subcontractors were related parties.

§43-13-117(H)(3)(c)(vii) – Reasonableness of Corporate Allocations

The objective of this audit was to review CCO data, NAIC information, and supplied statistics to determine if the corporate allocations made were within normal limits for health plans of similar size and with similar populations while evaluating the services contracted.

The scope included a detailed review, over the audit period 2017-2020, of all expense allocations made by the CCOs during each audit year to evaluate methods employed, reasonableness with comparable plans, and compliance with the provided agreements, consistent with NAIC filings.

The methodology involved reviews and comparisons of calculations made by the plans, the varied expenses which were allocated and a determination as to effectiveness and appropriateness within DOM. Each CCO provided details of how expenses are allocated, and those narratives and explanations were compared with actual calculations to ensure consistency in application and reasonable under the circumstances.

§43-13-117(H)(3)(c)(viii)—Value-Added Benefits and the Extent to Which They Are Used

The objective of this audit was to evaluate the value-added benefits offered through CCOs and determine the extent to which they have been utilized for MSCAN beneficiaries. The CCOs have unilateral authority and ability to create and offer benefits as they determine most appropriate for the populations they serve, with just a few exceptions spelled out in the MSCAN contract. Each CCO provides varying degrees of value-added benefits to improve beneficiaries' health and non-medical conditions within the populations they serve.

The scope was to determine what value-added services and products are being offered and to understand the extent to which those benefits have been utilized during the audit period and under the allowances of the MSCAN contract. The flexibility offered by the CCOs enables each to evaluate the unmet needs of its enrolled beneficiaries with the overarching goal of improving beneficiaries medical and non-medical health.

The methodology employed and utilized in this review is based on actual value-added benefits deployed and consumed with the associated CCO tracking on a beneficiary basis.

§43-13-117(H)(3)(c)(ix)—The Effectiveness of Subcontractor Oversight, Including Subcontractor Review

The objective of this audit was to determine if MSCAN contract provisions and CCO activities provide both transparency into the subcontractors and the oversight required.

The scope was to identify subcontractor relationships held by each CCO and to evaluate the effectiveness of oversight by DOM that would ensure the most effective service delivery for beneficiaries across the audit period of 2018 through 2020. Both DOM and the CCOs have an obligation to ensure continual and adequate oversight of subcontracts.

The methodology employed in this review included review, evaluation, and analysis of the MSCAN contract and subcontract process by the CCOs, analysis of operations activities to ensure that the activities adhere to requirements that may be found in the Code of Federal Regulations and by CMS as well as approved requirements of the Mississippi Division of Medicaid.

§43-13-117(H)(3)(c)(x) –Whether Health Outcomes Have Been Improved

The objective of this audit was to determine whether or not the MSCAN contract provisions and activities of the CCOs provide required transparency with a view towards improved outcomes. The majority of the health care services provided involve a combination of local plan operations and related-party service subcontractors, across the board.

The scope included the identification and evaluation of the results of health outcomes for MSCAN beneficiaries in accordance with CCO obligations. It also included a compliance review to ensure that requirements and outcomes are being met. This review and evaluation covered the audit period 2018 through 2020.

The methodology for this review included a review of the MSCAN contract and subcontract process to ensure activities are following the Code of Federal Regulations and CMS with a focus on HEDIS® measures as a critical component of measurable outcomes. The related party subcontracts were reviewed for the services contracted as well as those with unrelated subcontractors.

§43-13-117(H)(3)(c)(xi)—The Most Common Claim Denial Codes to Determine the Reasons for the Denial

The objective of this audit was to determine the reasons for denial and the volume of claims affected by the selection of the top codes. Each denial code and explanation was evaluated and measured against the codes within the CCO and between the CCOs to determine consistency, aberrances, and potential issues. The analysis also was compared with data provided by CMS for evaluation across nationwide claims processed.

The scope was to gather all available information related to the claims' submission processes through MSCAN. The claims are submitted by participating providers to each CCO for reimbursement. Each CCO was asked to provide their top fifteen (15) denial codes and associated reasons for analysis and evaluation across the audit period 2018 through 2020.

The methodology employed for this review involved analysis and evaluation of actual claim denials, volumes, and statistical analysis between CCO claims denials. The review identified several key points for consideration, future education, and cooperation between providers, CCOs and DOM.

Appendix B:
MSCAN BACKGROUND

Beginning in 2011, the Mississippi Division of Medicaid implemented its managed care program called Mississippi Coordinated Access Network ("MSCAN") with the goal of improving financial returns on Mississippi's health care investments by improving the health and well-being of Medicaid beneficiaries.

MSCAN is a statewide coordinated care program designed to meet the following objectives:

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

Mississippi implemented its Medicaid managed health program to increase the predictability of spending and improve the coordination of care for beneficiaries.

Coordinated care organizations ("CCOs") are those managed care organizations that contract with DOM, and ensure the provision of appropriate medical services and care to those enrolled through DOM. The CCOs that currently administer the MSCAN program are:

- Magnolia Health Plan (a Centene Company),
- UnitedHealthcare Community Plan, and
- Molina Healthcare

Each of these companies is responsible for establishing a provider network whose healthcare providers are contracted to provide prescribed services for beneficiaries and are, in turn, reimbursed by the CCOs.

Appendix C:
HISTORY OF MEDICAID

The Centers for Medicare and Medicaid Services ("CMS") serves as the pivotal point for all program and policies related to Medicaid. Medicaid services millions of those who are most vulnerable, including families, pregnant women and children, adults, seniors, and those who are disabled.

Medicaid was created under Social Security Act Title XIX in 1965, along with Medicare to provide health coverage for certain eligible, low-income populations The Mississippi Legislature enacted Medicaid for the State of Mississippi in 1969. States are not required to adopt a Medicaid program, yet every state, including the District of Columbia and United States territories, has its own Medicaid program, designed in accordance with and approval through CMS rules and regulations, with an overall design of providing health coverage for those eligible, low-income populations.

Although each state manages its own program, beneficiary eligibility is determined by household income and Supplemental Social Security Income (SSI) status, based on the Federal Poverty Level (FPL) and family size, with FPL being established by the United States Department of Health and Human Services (HHS).

The Medicaid program is funded through a matching program wherein CMS matches state Medicaid costs at varying levels through the Federal Medical Assistance Program (FMAP). The Mississippi FMAP for the audit period 2018-2020 was 75.65%, 76.21% and 76.98% respectfully. DOM administers Medicaid fee-for-service and MississippiCAN, as well as the Children's' Health Insurance Program (CHIP).

Medicaid is a federal-state partnership whereby the Federal government sets forth guidelines and parameters for the programs, which are then administered by each state in accordance with that state's approved plan. Every state Medicaid program is different which results in variations of coverage across the country. The Federal government, under the Federal Financial Participation ("FFP") conditions, provides for a federally funded contribution coupled with the states' share.

Historically, Medicaid has been central to the improvement in reducing the number of uninsured Americans. With increasing enrollment comes an increased need for additional state and federal funds, placing additional pressures on state budgets, which will extend long past the pandemic experienced in the United States.