Mississippi Medicaid 101

House Medicaid Committee

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MISSISSIPPI DIVISION OF MEDICAID

Drew L. Snyder
Executive Director
Office of the Governor Division of Medicaid

Outline

Origin of Medicaid	Eligibility	Benefits & Services	Fee-for-Service vs. Managed Care
Home and Community Based Waiver Programs	Overview of State and Federal Financing	Resources	

Mississippi's Medicaid Program

- Medicaid was created as part of the Social Security Amendments of 1965 to provide health coverage for certain eligible, low-income populations.
- Mississippi Legislature authorized a Medicaid program in 1969 special session; began operations January 1, 1970
- Medicare is separate and distinct from Medicare, although some people can be enrolled in both.
- State government's largest budget item
- Largest health insurance program in the state
- Along with Children's Health Insurance Program (CHIP), covers 25-30% of the state's population
- Medicaid members do not receive direct payments. Providers are paid for services to Medicaid members.
- Administered primarily through Mississippi Division of Medicaid, with other state agencies (e.g., Dept. of Mental of Health, Dept. of Rehabilitation Services, Dept. of Health, Dept. of Child Protection Services) also playing role

Medicaid's Major Stakeholders

- Members and their families
- Mississippi and American taxpayers
- State elected officials
- Federal policymakers and regulators (Congress & Centers for Medicare and Medicaid Services)
- Clinicians and other health service providers
- State Medicaid agency; state health agencies and other agencies
- Advocates
- Contractors

"Political pressure connected with the program can be intense from professional groups representing hospitals, nursing homes and physicians and recipients concerned about benefits. Further, legislative appropriations to run the program have turned into annual battles among lawmakers concerned about its increasing cost." Watkins, Lynn (1984, June 17). Allain will shoulder Medicaid burden, Clarion-Ledger.

Eligibility

- Must be a resident of Mississippi; must apply; must meet requirements for household income and/or age, and for certain aged, blind, or disabled coverage groups, must have medical need and/or limited assets.
- Some people, including most individuals who receive social security income and children who are in foster care, qualify for Medicaid by virtue of their participation in those programs. Others must meet financial criteria that vary by group and by state.
- Federal law also requires periodic renewal, or redetermination, of eligibility.
- Medicaid is generally the payer of last resort. That is, the other insurance pays for the expenses it covers and then Medicaid wraps around to provide additional services that are covered by Medicaid but not the primary insurance.
- Medicaid also pays for certain cost sharing amounts charged to enrollees by their primary insurance.
- Eligibility groups are mandated by federal law and others may be covered at state option.

Fee-for-Service vs. Managed Care

- Under fee-for-service model, the state pays providers directly for each covered service received by a Medicaid beneficiary.
- Under managed care, the state pays a fee to a managed care plan for each person enrolled in the plan. In turn, the managed care plan pays providers for all of the Medicaid services a beneficiary may require that are included in the plan's contract with the state.

Primary Eligibility Pathways

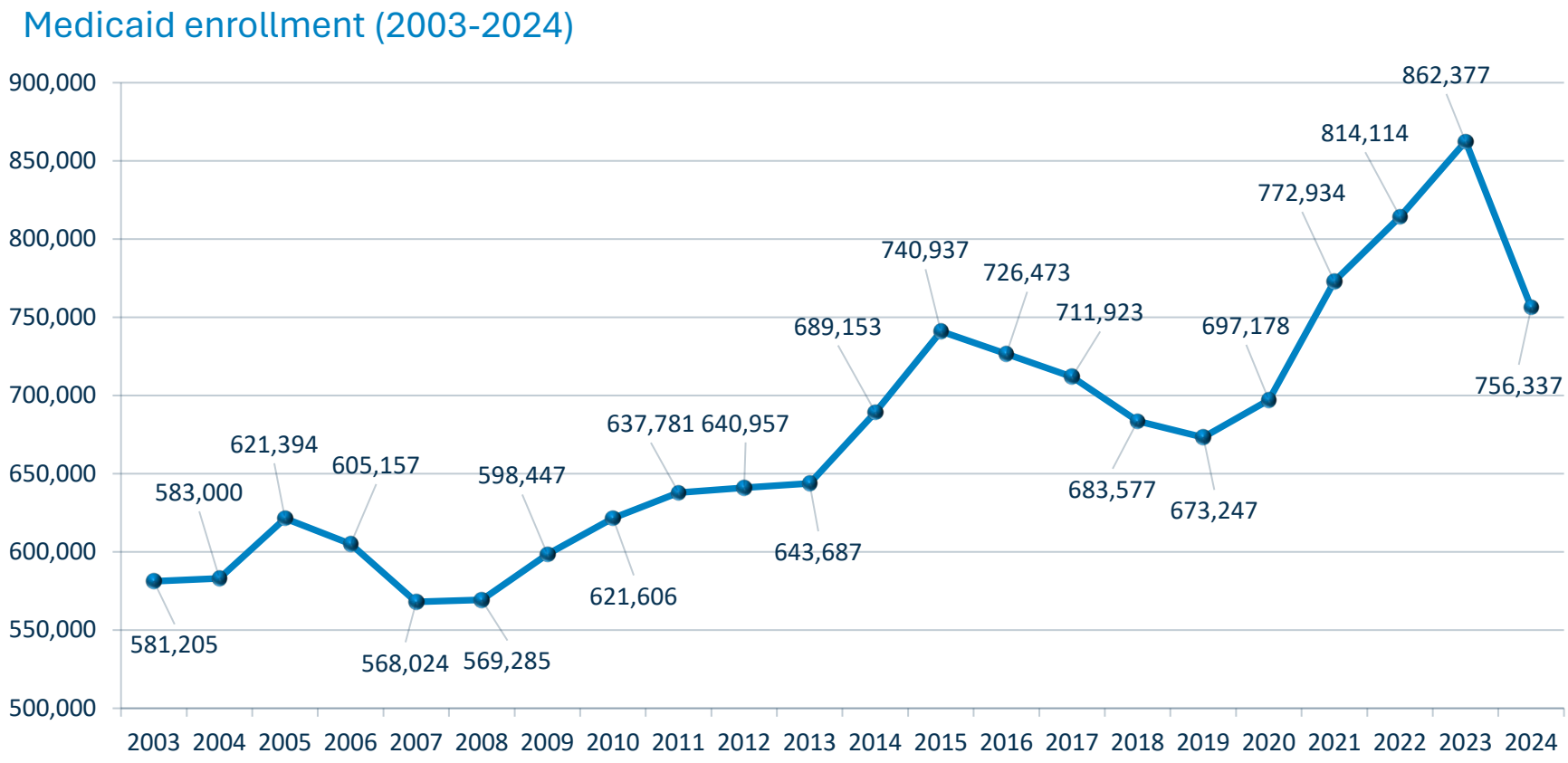
- Modified Adjusted Gross Income (MAGI)
- Examples:
  - Pregnant women
  - Low-Income parents
  - Infants and children
  - CHIP children

- Non-MAGI
- Based on old age, disability, and/or medical need
- Examples:
  - SSI Enrollees
  - Institutional Long-Term Care
  - HCBS Waiver Populations
  - Dually Medicare/Medicaid Eligible
  - Katie Beckett Children

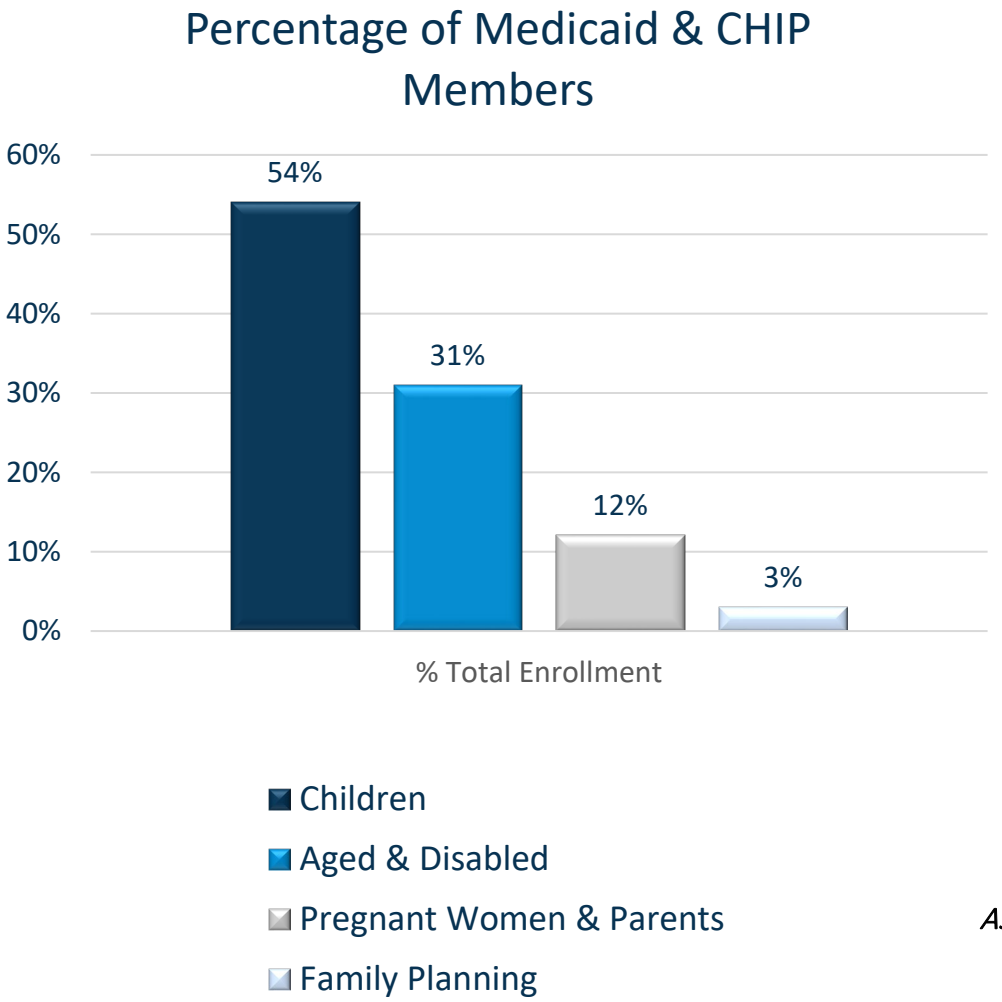
Annual Household Income Limits (MAGI)

		Pregnant Women; Infants to age 1; Family Planning	Children 1 to 5	Children 6 to 19	CHIP Children	Parent & Caretaker Relatives
Household Size	**100% FPL**	**199% FPL**	**143% FPL**	**138% FPL**	**209% FPL**	**24% FPL**
1	$14,580	$29,028	$21,588	$20,124	$31,212	$3,456
2	$19,720	$39,252	$29,184	$27,216	$42,204	$4,656
3	$24,860	$49,488	$36,804	$34,320	$53,208	$5,856
4	$30,000	$59,700	$44,400	$41,400	$64,200	$7,044

Mississippi Medicaid Historical Enrollment



Who is Enrolled?



756,337
Medicaid members

46,192
CHIP members

802,529
Total enrollment

As of December 31, 2023

Benefits

Mandatory and optional benefits are defined in federal statues and regulations to include a range of items and services as well as specific provider types. State statutes (e.g., Section 43-13-117) also articulate the types of covered benefits.

Federally-Mandated Medicaid Benefits		"Optional" Benefits	
Inpatient Hospital	EPSDT*	Prescription Drugs	Clinic services
Outpatient Hospital	Nursing Facility Services	Dental services	Occupational therapy
Physician Services	Home Health Services	Speech	Physical Therapy
Rural health clinic	FQHC services	Eyeglasses	Chiropractic Services
Laboratory and x-ray services	Family planning services	Hospice	Personal Care (in waivers)
Non-emergency transportation	Nurse midwife services	Case Management (in waivers)	Intermediate care facility for individuals with intellectual disability
Certified pediatric and family nurse practitioner services	Freestanding birth center services (when licensed)	State Plan Home and Community Based Services	
Tobacco cessation counseling for pregnant women			

Waiver Operations

The Mississippi Division of Medicaid has five (5) 1915(c) home and community-based service waivers, which are operated as follows:

- **Assisted Living (AL) Waiver** - Administered and operated by DOM. Case management is provided as an administrative function by DOM staff. Targeted to qualifying individuals 21+ living in Medicaid enrolled AL facilities.
- **Elderly & Disabled (E&D) Waiver** - Administered and operated by DOM. Case management is provided as a service by a statewide network of ten Area Agencies on Aging/Planning and Development Districts within defined catchment areas. Targeted toward qualifying individuals 21+ who are elderly or disabled.
- **Independent Living (IL) Waiver** – Administered by DOM and operated by the Mississippi Department of Rehabilitation Services (MDRS). Case management is provided as an administrative function by MDRS staff. Targeted toward qualifying individuals 16+ who have neurological or orthopedic impairments.
- **Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver** - Administered by DOM and operated by the Mississippi Department of Rehabilitation Services. Case management is provided as an administrative function by MDRS staff. Targeted toward qualifying individuals with traumatic brain or spinal cord injuries.
- **Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver** - Administered by DOM and operated by the Mississippi Department of Mental Health (DMH). Support coordination is currently provided by DMH's four Regional Centers within defined catchment areas. Targeted toward qualifying individuals with intellectual or developmental disabilities.

Home and Community Based Services (HCBS) Overview

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

Waiver	Unduplicated Enrollment January 2024	Waiting List January 2024	Total Cost per Member for Services FY2023*
Assisted Living	776	188	$11,742.96
Elderly & Disabled	18,128	9,093	$18,535.15
Independent Living	2,602	654	$17,418.35
Intellectual Disabilities/ Developmental Disabilities	2,699	2,814	$49,364.70
Traumatic Brain Injury/Spinal Cord Injury	825	24	$16,334.22

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

Mississippi Medicaid Law

- "Big Three" Medicaid Statutes
  - Section 43-13-115 (groups of recipients)
  - Section 43-13-117 (types of care and services; managed care; reimbursement; other provisions)
  - Section 43-13-145 (hospital and long-term care facility assessments)

Financing

- Financing is a shared responsibility of the federal government and the state.
- States that operate Medicaid within federal guidelines are entitled to federal reimbursement for a share of Medicaid program costs. Formal approval process for federal financial participation is through a document called the Medicaid State Plan.
- Federal share for most Medicaid service costs is determined by the federal medical assistance percentage (FMAP), which is based on a formula that providers higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa).
- The FMAP for Mississippi is **77.27%** and will decrease to **76.9%** in October.
- Federal share for Medicaid administrative functions is generally 50 percent but certain administrative functions receive a higher federal share. However, amounts paid to a managed care plan to cover administrative functions are matched as a medical assistance cost at the applicable FMAP, not as an administrative cost.
- Higher administrative match rates are provided for expenditures that meet certain conditions (e.g., services provided by a quality improvement organization)

Resources

- Medicaid & CHIP Payment and Access Commission (MACPAC)
  - www.Macpac.gov