MISSISSIPPI DIVISION OF MEDICAID

Annual Report
Fiscal Year 2017

MISSISSIPPI DIVISION OF
MEDICAID

Program History and Basics

The Mississippi Division of Medicaid (DOM) is a jointly funded state and federal government program created by the Social Security Amendments of 1965, providing health coverage for eligible, low-income populations. States are not required to have a Medicaid program, yet all 50 states, five territories and the District of Columbia participate in it.

Mississippi created its program in 1969, at a time when state lawmakers recognized that it made financial sense to take part in a federal health coverage program that came with matching funds.

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

However, the federal government through the Centers for Medicare and Medicaid Services (CMS) supports state programs by matching their Medicaid costs at varying levels. This is called the Federal Medical Assistance Percentage (FMAP).

Although medical services costs and the number of enrolled beneficiaries drives Medicaid expenditures, other cost drivers are provider reimbursement rates, medical service inflation costs and utilization rates for health services. Additionally, the Patient Protection and Affordable Care Act (PPACA) has had lasting impacts on the agency in the form of legal mandates to which DOM must comply.

Mississippi Medicaid health benefits is the umbrella term used to encompass all health benefits programs administered by DOM – regular Medicaid, the Children's Health Insurance Program (CHIP) and the managed care program, MississippiCAN.

Agency Overview

The U.S. census estimates there are nearly three million residents in Mississippi (as of July 2016). DOM serves 1 in 4 Mississippians who receive health benefits through regular Medicaid, CHIP or MississippiCAN. Beneficiaries do not directly receive money from Medicaid for health benefits. Rather, health-care providers are reimbursed when beneficiaries receive medical services. The agency has approximately 1,000 employees located throughout one central office, 30 regional offices and over 80 outstations.

What is MississippiCAN?

Authorized by the state Legislature in 2011, DOM oversees a Medicaid managed care program for beneficiaries, the Mississippi Coordinated Access Network, which is also called MississippiCAN.

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

MississippiCAN is administered by different coordinated care organizations, and approximately 65 percent of DOM beneficiaries are enrolled in MississippiCAN.

Medicaid and Medicare are Different

Medicaid: The state administers the program within federal guidelines, it receives joint state and federal funding, and it targets low-income children, some parents/caretakers, pregnant women, and individuals who are aged, blind or have a disability.

Medicare: This is a federal program that receives federal funding, and it targets people age 65 and older, some adults with a disability, and dialysis patients.

Timeline of Program

July 30, 1965 — President Lyndon B. Johnson signs the Social Security Amendments of 1965 into law, which established both the Medicare and Medicaid programs. Medicaid provides health coverage for eligible, low-income populations.

1969 — The Mississippi Legislature authorizes a Medicaid program for the state.

August 21, 1996 — The Health Insurance Portability and Accountability Act, commonly known as HIPAA, was signed into law.

1997 — The Children's Health Insurance Program (CHIP) was created to provide health coverage for low-income, uninsured children.

March 23, 2010 — President Barack Obama signs the Patient Protection and Affordable Care Act (PPACA) into law, which includes a number of health insurance reforms and mandatory requirements, even if states did not opt-in to Medicaid expansion.

January 1, 2011 - Go Live — 54,500 beneficiaries are enrolled in Mississippi's managed care program, MississippiCAN, including those who receive Medicaid through:

- Supplemental Security Income (SSI)
- Child and Protection Services foster care children
- Disabled child living at home
- Working disabled
- Breast/cervical cancer through Mississippi Department of Health

December 2012 — Behavioral health services transition to MississippiCAN, and 141,800 beneficiaries are enrolled in MississippiCAN, including those who receive Medicaid through:

- Adults on Temporary Assistance for Needy Families (TANF)
- Pregnant women
- Infants age 0-1

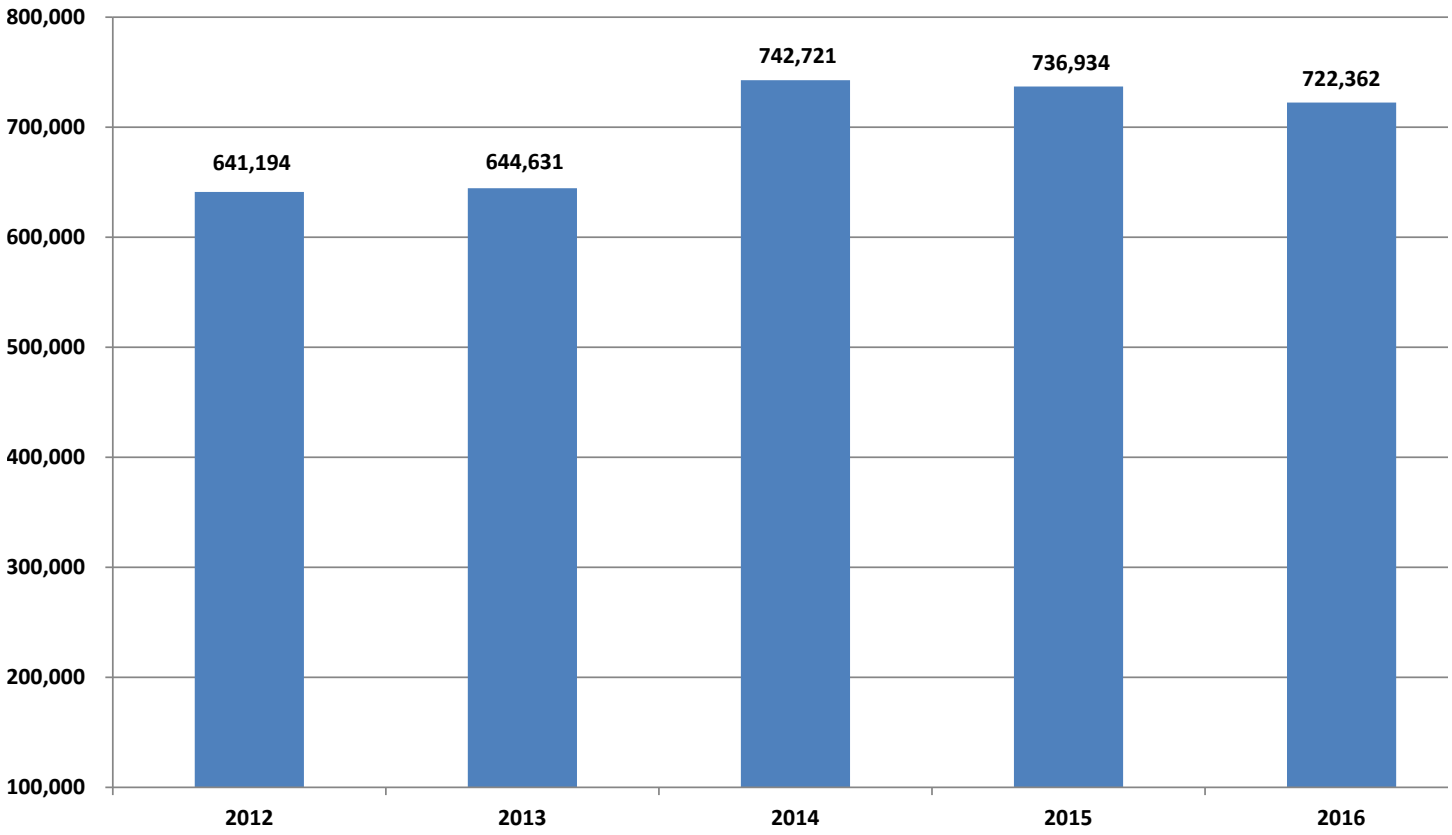
December 2014 — 196,000 beneficiaries are enrolled in MississippiCAN, including those who receive Medicaid through:

- Quasi-CHIP

December 2015 — Inpatient hospital services transition to MississippiCAN, and 550,008 beneficiaries are enrolled in MississippiCAN, including those who receive Medicaid through:

- TANF children

Medicaid Beneficiary Enrollment Annual Averages



The figures above reflect Medicaid enrollment annual averages calculated by calendar year; they do not include Children's Health Insurance Program (CHIP) beneficiaries. Enrollment reports are continually updated and available on the Medicaid website under Resources (http://medicaid.ms.gov/resources).

Medicaid Overview

Medicaid provides health coverage for eligible, low-income populations in Mississippi. These populations include children, low-income parents/caretakers, pregnant women, and individuals who are aged, blind, and or have a disability. Contrary to common perception, the largest population DOM serves is children.

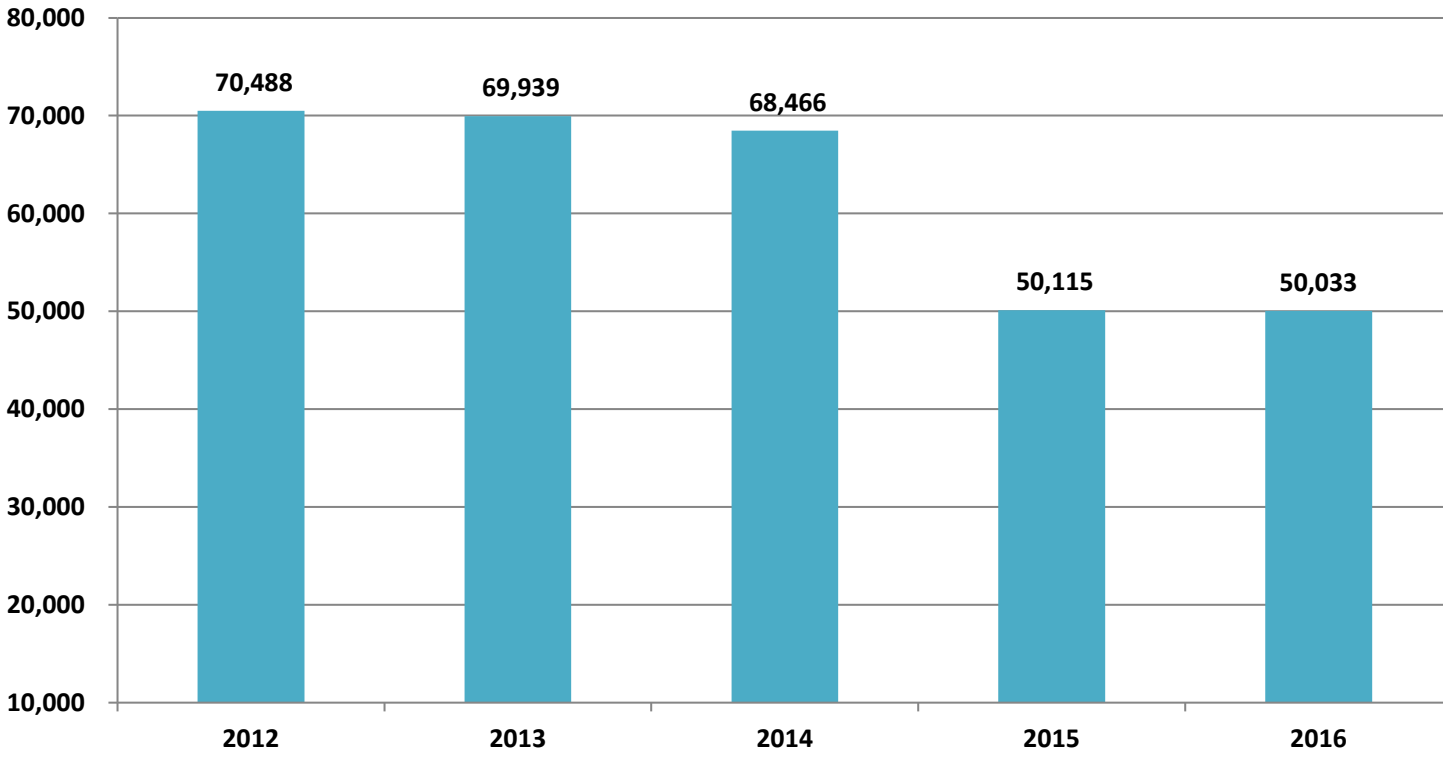
In order to qualify for Medicaid coverage, an applicant must complete and submit an application for Mississippi Medicaid health benefits and meet state and federal eligibility requirements.

Basic Eligibility Requirements

The basic requirements to qualify for any Medicaid benefits in Mississippi are:

- You must be a citizen of the United States or a qualified alien.
- You must be a resident of Mississippi.
- You must meet requirements for age and/or disability, income and other Mississippi Medicaid eligibility requirements such as resources for certain aged, blind or disabled coverage groups.
- You must file an application form.
- You must provide requested verification within the allowed time limits.

CHIP Beneficiary Enrollment Annual Averages



The figures above reflect CHIP enrollment annual averages calculated by calendar year. Approximately 19,000 children moved from CHIP to Medicaid in December 2014, due to income limit changes mandated by the PPACA. Enrollment reports are continually updated and available on the Medicaid website under Resources (http://medicaid.ms.gov/resources).

Children's Health Insurance Program Overview

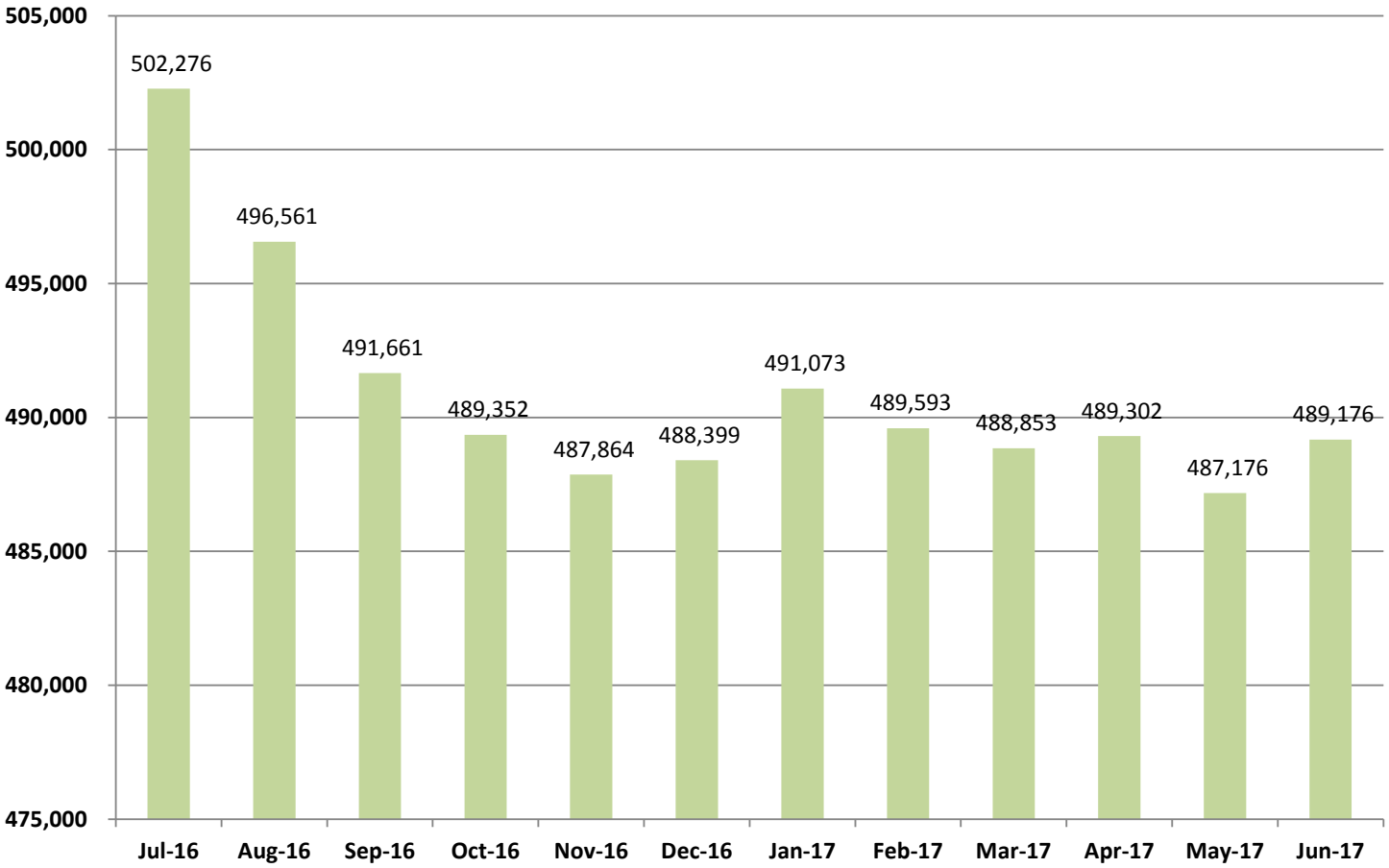
The Children's Health Insurance Program (CHIP) provides health coverage for uninsured children up to age 19, whose family income does not exceed 209 percent of the federal poverty level (FPL).

To be eligible for CHIP, a child cannot be eligible for Medicaid. In other words, CHIP covers children in a higher family income bracket. Also, at the time of application, a child cannot be covered by another form of insurance to qualify for CHIP.

Note, as reflected in the chart above, approximately 19,000 children were transitioned from CHIP to Medicaid (Quasi-CHIP category), due to income limit changes associated with the PPACA.

- ✔ As of July 2016, the U.S. Census estimates Mississippi has nearly **3 million residents.**
- ✔ The largest group on Medicaid is children, or approx. **56 percent** of total enrollment.
- ✔ **Over 25 percent** of Mississippians receive Mississippi Medicaid health benefits.
- ✔ In federal fiscal year 2017, Mississippi's Federal Medical Assistance Percentage was **74.63 percent.**

MississippiCAN Fiscal Year 2017 Enrollment



The figures above reflect MississippiCAN enrollment for fiscal year 2017. Enrollment reports are continually updated and available on the Medicaid website under Resources (http://medicaid.ms.gov/resources).

MississippiCAN Overview

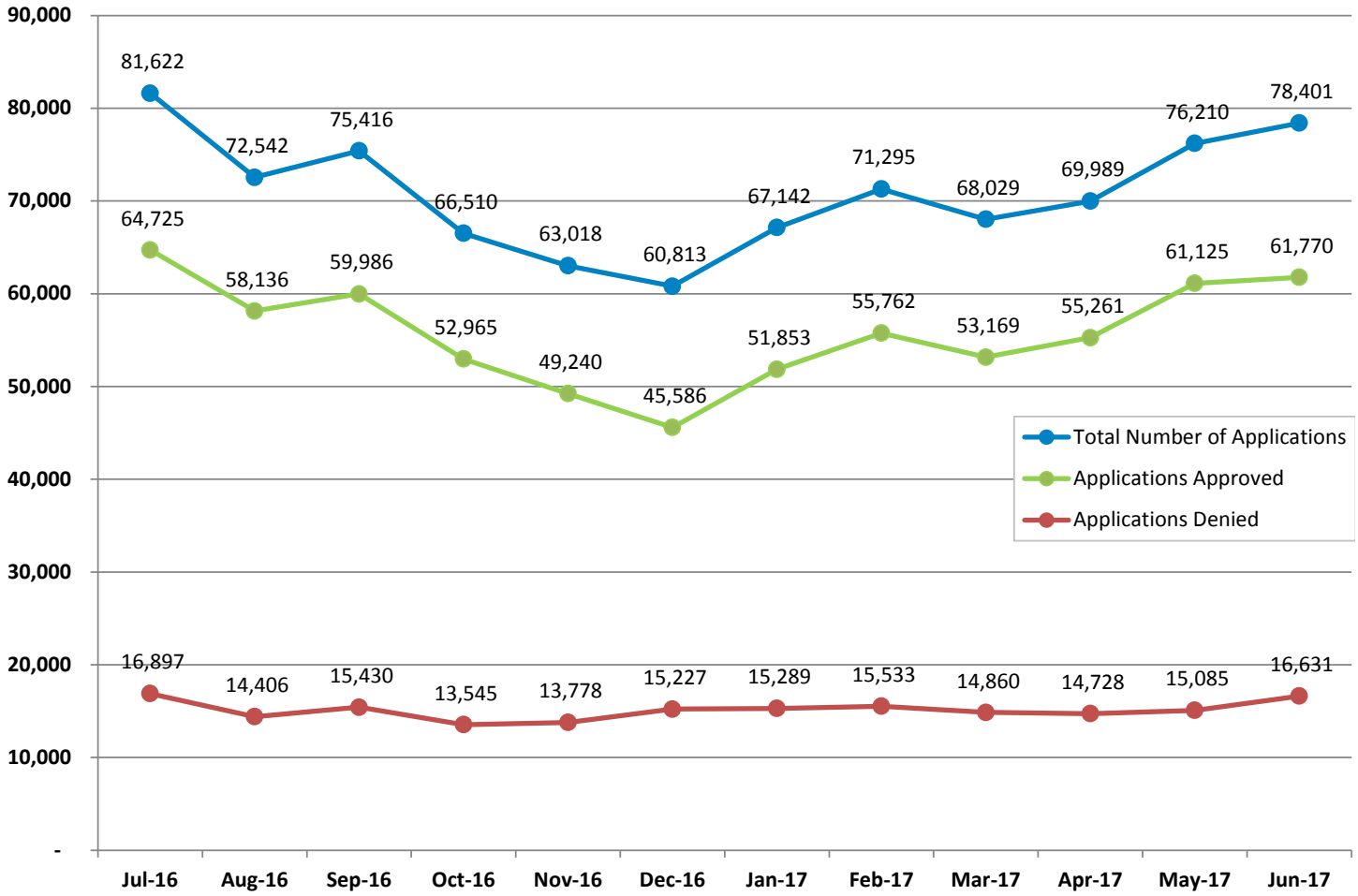
Authorized by the state Legislature in 2011, DOM oversees a Medicaid managed care program for beneficiaries called MississippiCAN. MississippiCAN is administered by different coordinated care organizations (CCOs), and approximately 65 percent of DOM beneficiaries are enrolled in MississippiCAN.

Managed care is an increasingly common approach to providing health benefits for Medicaid programs. According to the Kaiser Foundation, at least 38 state Medicaid agencies now have some type of managed care program.

The agency has contracts with CCOs, that have gone through an extensive requests for proposals process. The CCOs that win the procurement are reimbursed for providing care to beneficiaries in MississippiCAN.

Beneficiaries have the option of enrolling in the CCO of their choice. Health-care providers who serve beneficiaries covered by Medicaid or CHIP should verify their eligibility at each date of service and identify to which network they belong. Providers are encouraged to enroll in regular Medicaid, CHIP and MississippiCAN.

Medicaid Applications



The figures above reflect the total number of applications, applications approved, and applications denied for state fiscal year 2017 by month, which ranges from July 1, 2016, through June 30, 2017.

Total Number of Applications

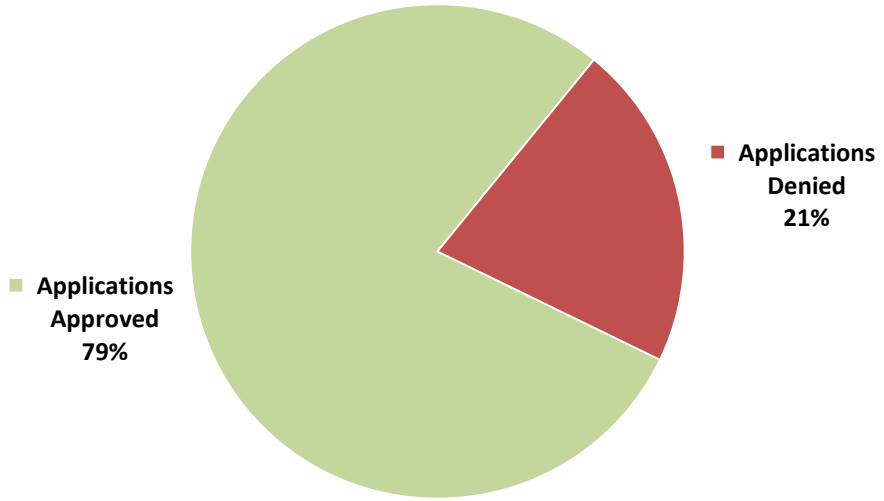
850,987

Applications Approved

669,578

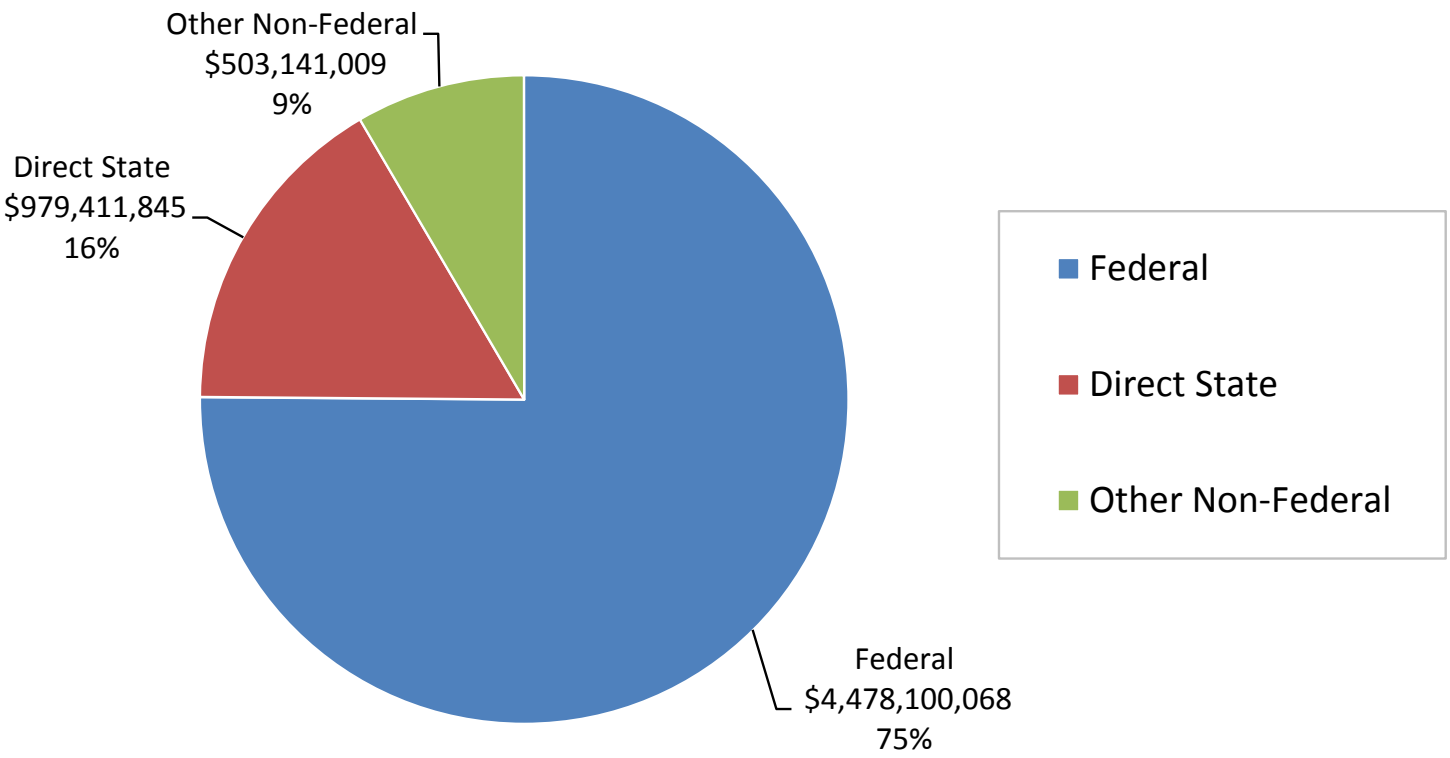
Applications Denied

181,409



Fiscal Year 2017 Medicaid Funding by Source

Total: $6.0 billion | Federal: $4.48 billion | Direct State: $979.4 million

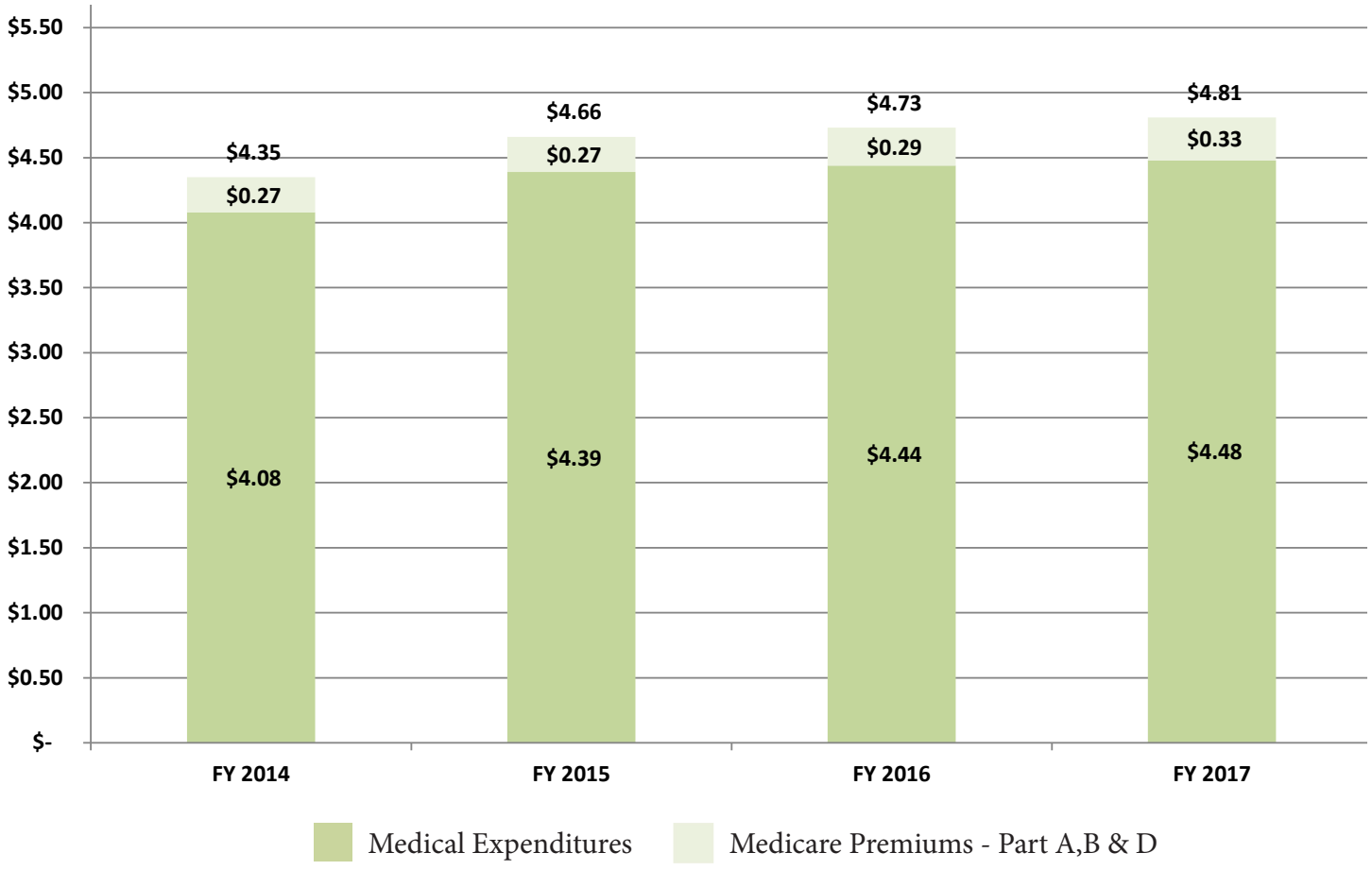


A significant portion of DOM's annual budget comes from federal matching funds, which is calculated by the Federal Medical Assistance Percentage (FMAP). That means for every state dollar spent on Medicaid's health service claims the federal government gives DOM approximately three dollars, and conversely, a loss of one state dollar translates into a loss of three federal dollars for a total loss of four dollars.

Of the entire Medicaid budget, 95 percent goes toward provider reimbursement for health services provided to Medicaid beneficiaries. Medicaid covers approximately 65 percent of all births in the state of Mississippi, and children up to age one. The cost for administering the program is relatively low when compared to other state Medicaid programs. For fiscal year 2017, administrative expenditures totaled $169,370,383, which is $7 million less than the previous year; the agency had 1,067 positions.

Nearly every dollar Medicaid receives is matched with federal funds. Depending on the project and office area, Medicaid matching rates range from 90 percent federal / 10 percent state for the design, development, and implementation of CMS approved information technology services and systems, to a 50 percent federal / 50 percent state match at minimum for general administrative expenditures.

Medical Service Expenditures in Billions



Note: Medical Expenditures exclude Mississippi Hospital Access Program (MHAP) payments, Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) payments. Medicare Expenditures include Part A Premiums, Part B Premiums and Part D. The expenditure figures listed above are in billions.

Medical Assistance and Care

The total amount paid for medical assistance and care under this article is $5,791,072,266; this includes:

$793,215,804
Mississippi Hospital Access Program (MHAP) payments (which has been paid through MississippiCAN since 2016), Disproportionate Share Hospital, and Upper Payment Limit funds

$28,893,587
Health Information Technology (HIT) incentive payments from the Centers for Medicare and Medicaid Services

$153,996,626
Children's Health Insurance Program (CHIP)

$2,000,000
Transfers to other state agencies

Program Integrity

Investigation Review

The Investigation Review Division investigates and audits any type of provider who receives Medicaid payments, to determine whether that provider has committed fraud or abuse. If there is evidence that a provider has committed fraud against Medicaid, then the case is referred to the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General for possible criminal or civil action. If a provider has likely abused the Medicaid system, the Investigation Review Division will prepare and present a formal audit. The provider then has an opportunity to appeal an adverse audit and request an administrative hearing before a Hearing Officer, who will thereafter make a written recommendation to the executive director for a final decision. Should the provider disagree with the executive director's decision, then the provider may file an appeal with the courts.

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

Medicaid Eligibility Quality Control Division

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

Data Analysis Division

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

Medical Review Division

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

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

Program Integrity Activities

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

Looking back over fiscal year 2017, Medicaid had the following activity:

- Approximately $1.6 million recovered through Program Integrity.
- Approximately $3.8 million identified through cost report and waiver program audit recoveries.
- Seven cases referred to the Medicaid Fraud Control Unit in the Office of the Attorney General; DOM has identified $3.1 million as improper billing associated to those cases.
- 464 complaints investigated.
- 209 cases investigated.
- 34 cases that resulted in corrective action.

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

Also, in state fiscal year 2017, DOM completed Recovery Auditor Contractor (RAC) provider audits, which resulted in $218,173 in recovered funds. The Medicaid Integrity Contractor (MIC) is another contractor that is working with Program Integrity to perform provider audits. During state fiscal year 2017, $332,064 was collected on MIC cases.

Actions to Combat Fraud, Waste and Abuse

The actions and activities of the division in detecting and investigating suspected or alleged fraudulent practices, violations and abuse of the program are listed below:

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

Reporting Review and Analysis
- ✔ Fiscal agent weekly reports
- ✔ Claims review software
- ✔ Data-mining

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

Database Reviews
- ✔ Medicare Exclusion Database
- ✔ Provider Enrollment Chain of Ownership System

Training
- ✔ Webinars - recommend current fraud and abuse practices to review
- ✔ National Advocacy Center - offers training on provider reviews, best practices, and latest fraud, waste, and abuse trends

Third Party Recovery

Recovered Funds

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

In collaboration with the Legal staff and HMS Casualty, a breakdown for the funds recovered for fiscal year 2017 are listed to the right.

Third Party Recovery and Legal

$2,432,636

HMS Casualty

$8,447,650

Total Funds Recovered

$10,880,286

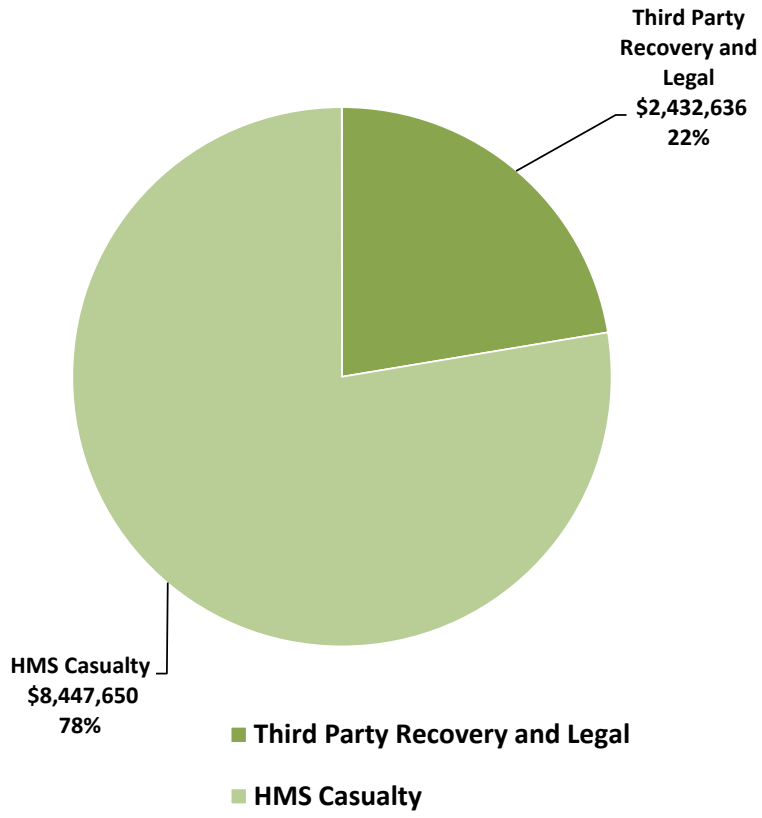
How to Report Fraud or Abuse

Every dollar lost to the misuse of Medicaid benefits, is one less dollar available to fund programs providing essential health services for vulnerable Mississippians.

Anyone can report fraud or abuse by contacting DOM:

Toll-free: 800-880-5920
Phone: 601-576-4162
Fax: 601-576-4161
Mailing address: 550 High Street, Suite 1000, Jackson, MS 39201

Report fraud and abuse by submitting a Fraud and Abuse Complaint form online at http://medicaid.ms.gov.



Contact Information

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