



MISSISSIPPI DIVISION OF
MEDICAID

2021 ANNUAL REPORT

STATE FISCAL YEAR 2021

JULY 1, 2020 - JUNE 30, 2021

Dear Governor and Legislators

Governor Reeves and Members of the Mississippi Legislature:

On behalf of the Mississippi Division of Medicaid, it is my pleasure to present you with our Annual Report for state fiscal year (SFY) 2021.

Over the past year, the Division has continued responding to the impacts of the COVID-19 pandemic. Due to the enhanced Federal Medical Assistance Percentage (FMAP) provided by Section 6008 of the Families First Coronavirus Response Act (FFCRA), the Division was able to carry forward \$198 million from SFY 2020 into SFY 2021.

At the same time, FFCRA also required that individuals enrolled for benefits at the date of enactment shall be treated as eligible for benefits through the end of the emergency period. As a result, enrollment has increased roughly 16% since February of 2020.

As we prepare for the eventual lifting of the federal Public Health Emergency, the Division will continue to work toward becoming a high-functioning government agency that aims to improve the health and the life outcomes of people it serves, and in turn the state on whole, while optimally managing public funding and public trust to ensure the Medicaid program remains stable and sustainable.

Respectfully,



Drew L. Snyder
Executive Director



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INTRODUCTION

The Mississippi Division of Medicaid (DOM) is a state and federal program created by the Social Security Amendments of 1965 (PL 89-97), authorized by Title XIX of the Social Security Act to provide health coverage for eligible, low-income populations. The Mississippi Legislature enacted the Mississippi Medicaid program in 1969.

All 50 states, five territories of the United States and District of Columbia participate in this voluntary matching program.

Each state runs its own Medicaid program within federal guidelines, jointly funded by state and federal dollars. For Medicaid, the Federal Medical Assistance Percentage (FMAP) is used to calculate the amount of federal matching funds for state medical services expenditures. Currently, Mississippi has the highest FMAP in the country.

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



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

MississippiCAN is administered by three different coordinated care organizations (CCOs), and approximately 65 percent of DOM beneficiaries are enrolled in the program.

WHO WE SERVE

Roughly one in four Mississippians receive health benefits through Medicaid or CHIP. Beneficiaries do not directly receive money from Medicaid for health benefits. Rather, health care providers are reimbursed when beneficiaries receive medical services.

MISSISSIPPICAN

Authorized by the state Legislature in 2011, DOM oversees a Medicaid managed care program for beneficiaries, the Mississippi Coordinated Access Network (MississippiCAN).

FEDERAL MATCH RATE

DOM provides health coverage for 27.7% of the state's population. The FMAP rate for Mississippi for federal fiscal year (FFY) 2021 is 77.76% and increases to 78.31% for FFY2022 (the FFY runs from October through September). An additional 6.2 percentage point increase from the Families First Coronavirus Act was available for one quarter of FFY2020, all of FFY2021 a portion of FFY2022.

The FMAP for state fiscal year 2022 is 79.31%, and this budget assumes the additional 6.2 percentage points will be available through December 31, 2021. The projected FMAP for FFY2023 is 78.35%.

ENROLLMENT | FY21 Medicaid Members by Month

TOTAL ENROLLMENT BY MONTH



The figures above reflect the Medicaid enrollment count for each month of fiscal year 2021; 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>).

FFCRA REQUIREMENTS DRIVE RISE IN ENROLLMENT

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

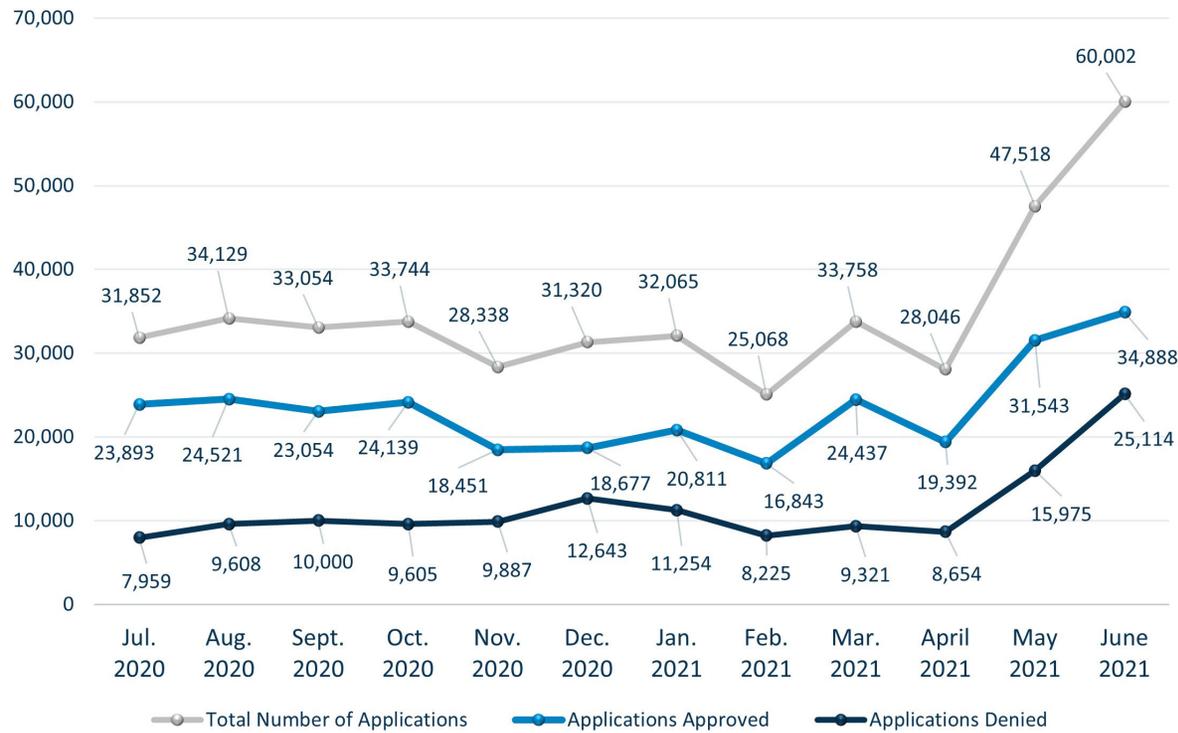
In order to receive that support, states were required to not take any adverse action on those who were eligible for benefits at the beginning of the public health emergency. Adverse actions include termination of eligibility or reduction in benefits.

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

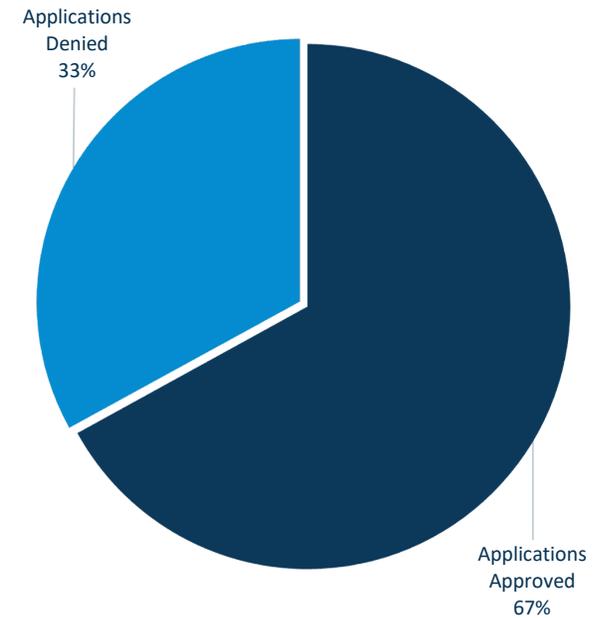
Due to that as well as other factors, Medicaid enrollment increased by approximately 16% since the beginning of the pandemic.

ENROLLMENT | *Medicaid Applications in FY21*

APPLICATIONS APPROVED/DENIED



The figures above reflect the total number of applications received, applications approved, and applications denied for state fiscal year 2021 by month, which ranges from July 1, 2020, through June 30, 2021. These figures include both initial applications and applications for annual renewal.



TOTAL NUMBER OF APPLICATIONS

418,894

APPLICATIONS APPROVED

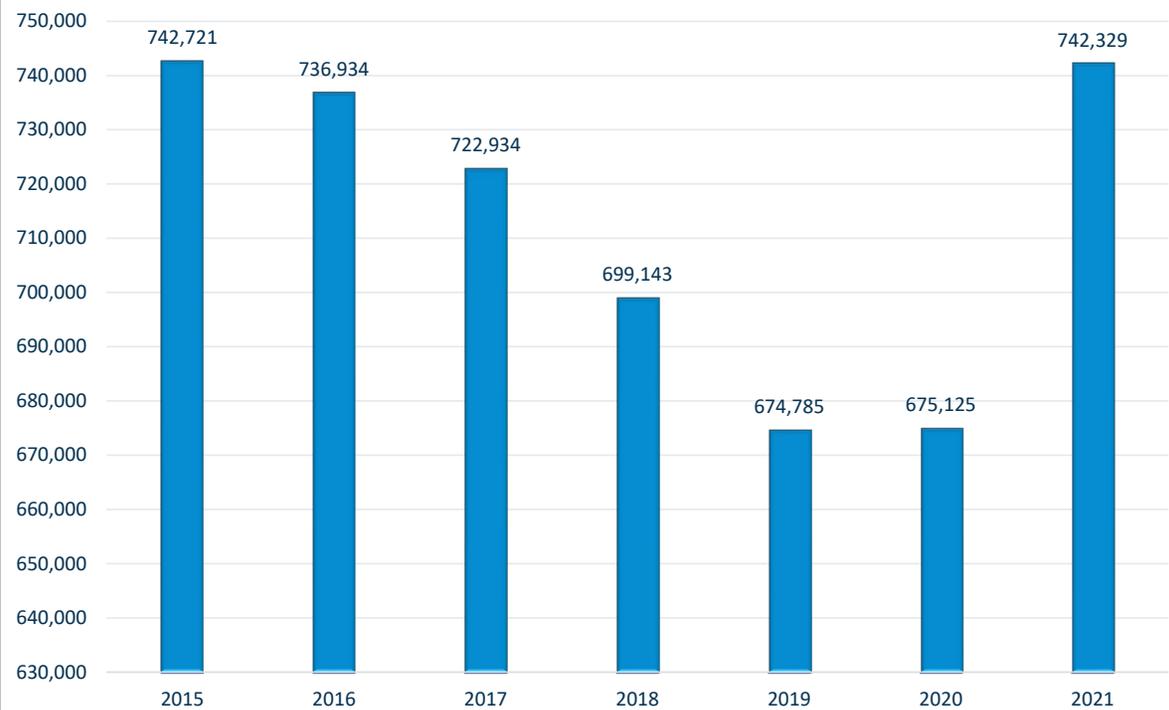
280,649

APPLICATIONS DENIED

138,245

ENROLLMENT | *Medicaid Members Annual Averages*

ANNUAL AVERAGES BY FISCAL YEAR



The figures above reflect the average annual Medicaid enrollment count for each of the past six fiscal years; they do not include CHIP beneficiaries. Enrollment reports are continually updated and available on the Medicaid website under Resources (<http://medicaid.ms.gov/resources>).

FEDERAL POVERTY LEVELS

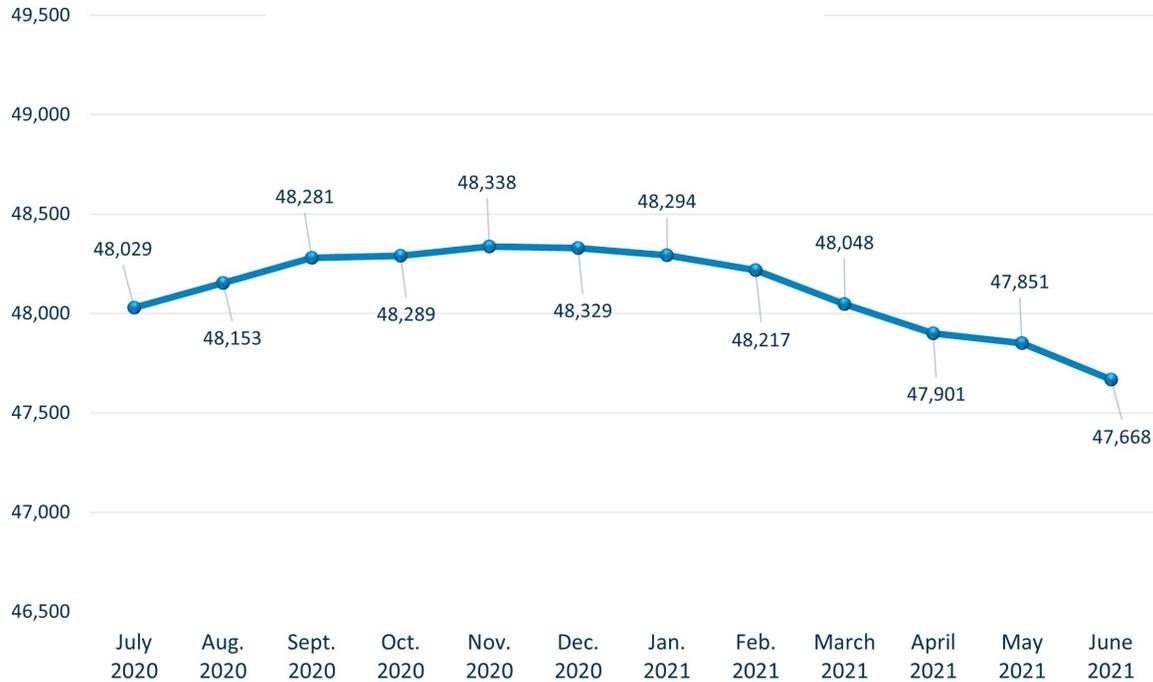
Each state has authority to choose eligibility requirements within federal guidelines. In Mississippi, Medicaid eligibility is based on factors including family size, income, and the Federal Poverty Level (FPL).

- > Infants from birth to age 1 — **194% FPL**
- > Children age 1 up to 6 — **143% FPL**
- > Children age 6 up to 19 — **133% FPL**
- > Pregnant women — **194% FPL**
- > CHIP children up to age 19 — **209% FPL**

Eligibility for people who receive Supplemental Security Income (SSI) and the aged, blind, or disabled are based on additional requirements such as income and resource limits.

ENROLLMENT | FY21 CHIP Members by Month

TOTAL ENROLLMENT BY MONTH



The figures above reflect the Children’s Health Insurance Program (CHIP) enrollment count for each month of fiscal year 2021. Enrollment reports are continually updated and available on the Medicaid website under Resources (<http://medicaid.ms.gov/resources>).

CHIP OVERVIEW

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

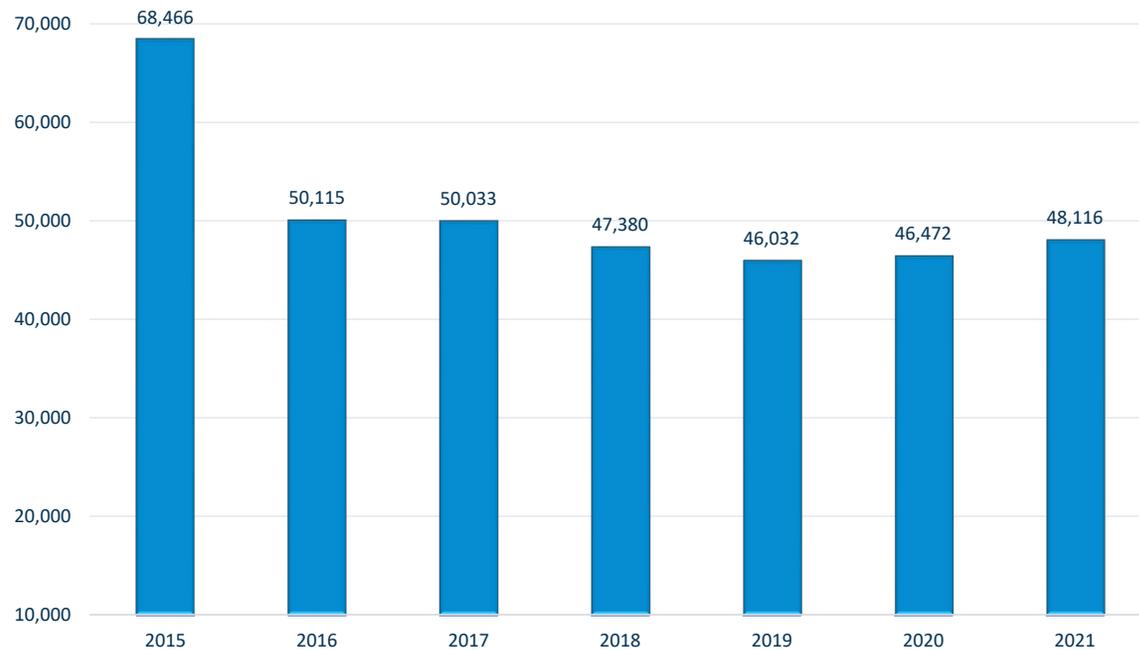
To be eligible for CHIP, a child cannot be eligible for Medicaid. Also, at the time of application, a child cannot be covered by another form of insurance to qualify for CHIP.

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

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

ENROLLMENT | *CHIP Members Annual Averages*

ANNUAL AVERAGES BY FISCAL YEAR



The figures above reflect the average annual CHIP enrollment count for each of the past seven fiscal years. Enrollment reports are continually updated and available on the Medicaid website under Resources (<http://medicaid.ms.gov/resources>).

NEW CHIP CONTRACTS TOOK EFFECT IN 2019

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

- > DOM implemented new three-year contracts for the CHIP on Nov. 1, 2019. Although DOM's managed care program, MississippiCAN, includes three MCOs, CHIP will continue to be administered by two vendors because it has a smaller number of members.
- > Molina Healthcare replaced Magnolia Health as one of the two MCOs. UnitedHealthcare Community Plan will continue to serve as the other CHIP vendor.

ENROLLMENT | FY21 MississippiCAN Members by Month

TOTAL ENROLLMENT BY MONTH



The figures above reflect MississippiCAN enrollment for fiscal year 2021. Enrollment reports are continually updated and available on the Medicaid website under Resources (<http://medicaid.ms.gov/resources>).

MISSISSIPPICAN OVERVIEW

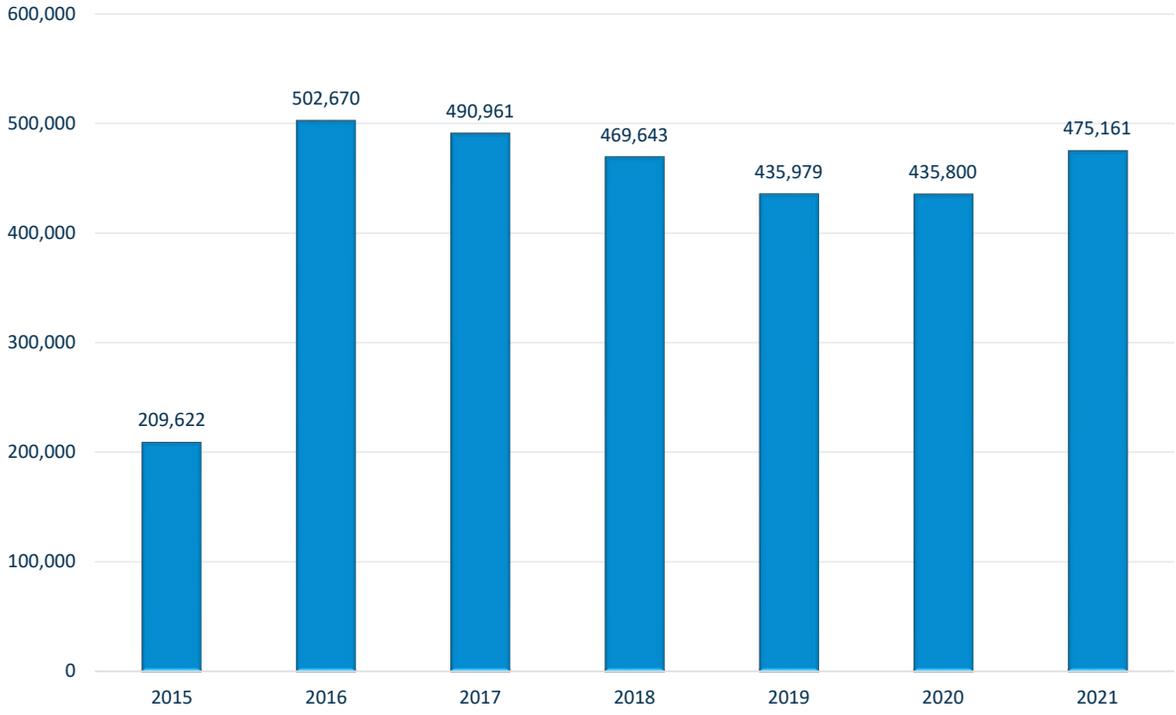
Authorized by the state Legislature in 2011, DOM oversees a Medicaid managed care program for beneficiaries called MississippiCAN.

MississippiCAN is designed to get a better return on Mississippi's health care investment by improving the health and well-being of Medicaid beneficiaries. MississippiCAN is a statewide coordinated care program designed to meet the following goals:

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

ENROLLMENT | FY21 MississippiCAN Members Annual Averages

ANNUAL AVERAGES BY FISCAL YEAR



MISSISSIPPICAN OVERVIEW

MississippiCAN is administered by different managed care organizations (MCOs), and approximately 65 percent of DOM beneficiaries are enrolled in MississippiCAN.

Beneficiaries have the option of enrolling in the MCO of their choice. Health care providers who serve beneficiaries covered by Medicaid or CHIP should verify the beneficiary’s eligibility at each date of service and identify to which network they belong.

The next open enrollment period will be held October through December, 2021.

Providers are encouraged to enroll in all Mississippi Medicaid programs.

The figures above reflect the average annual MississippiCAN enrollment count for each of the past seven fiscal years. Enrollment reports are continually updated and available on the Medicaid website under Resources (<http://medicaid.ms.gov/resources>).

FINANCE | Medicaid Funding by Source

TOTAL

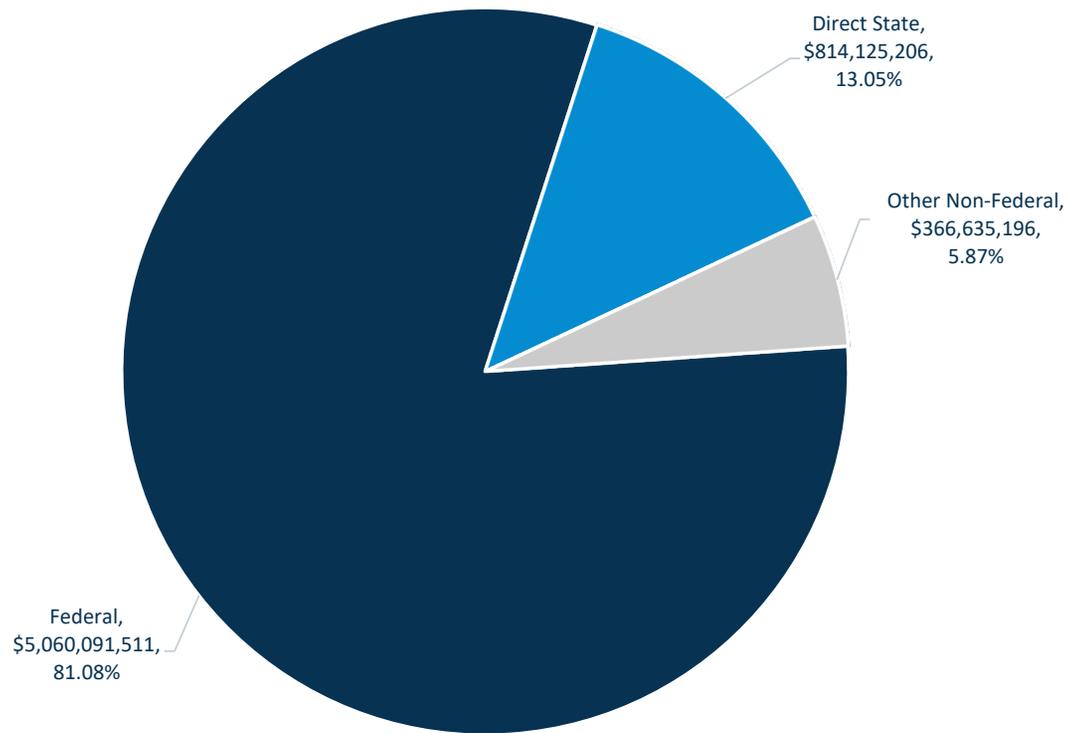
\$6.2 billion

FEDERAL

\$5.1 billion

DIRECT STATE

\$814 million



83.77% > Fiscal year 2021 blended FMAP for Mississippi

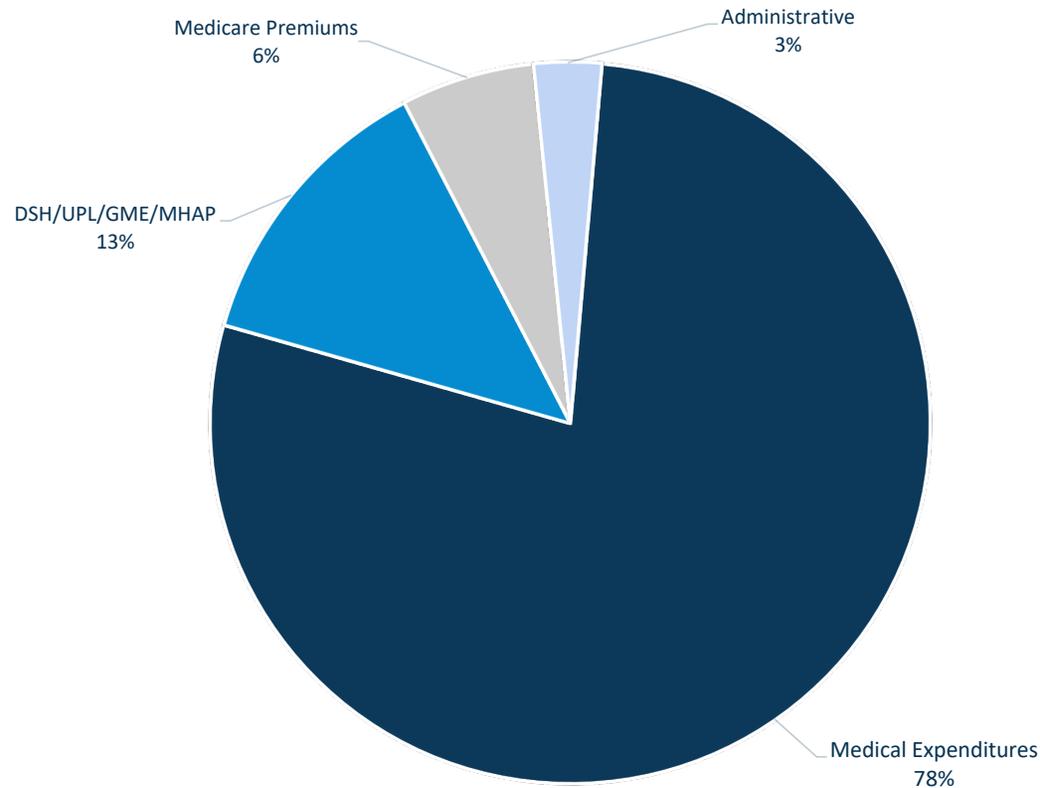
FINANCE OVERVIEW

A significant portion of DOM's annual budget comes from federal matching funds, which is calculated by the Federal Medical Assistance Percentage (FMAP). The Families First Coronavirus Relief Act (FFCRA), passed by Congress in March of 2020 in response to the COVID-19 pandemic, increased Mississippi's FMAP by 6.2 percentage points to 83.96%. Combined with the state's pre-FFCRA FMAP of 77.76%, the blended FMAP for state fiscal year 2021 equates to 83.77%.

- > Of the entire Medicaid budget, more than 97% goes toward reimbursement for health services provided to Medicaid beneficiaries. The cost for administering the program is relatively low when compared to other state Medicaid programs. For fiscal year 2021, administrative expenditures totaled \$186,598,190.
- > Nearly every dollar Medicaid receives is matched with federal funds. Depending on the project and office area, Medicaid matching rates range from 90% federal/10% state to a 50% federal/50% state match at minimum.

FINANCE | Medicaid Expenditures

TOTAL SPENDING



Note: The Medical Expenditures amount includes the Children’s Health Insurance Program (CHIP), MississippiCAN, Long Term Care and Home and Community Based Services. Medicare Expenditures include Part A Premiums, Part B Premiums and Part D.

MEDICAL EXPENDITURES

\$4,899,011,818

DSH/UPL/GME/MHAP

\$801,166,761

MEDICARE PREMIUMS

\$354,075,144

ADMINISTRATIVE

\$186,598,190

FY2021 TOTAL

\$6,240,851,913



SUPPLEMENTAL PAYMENTS AND OTHER TYPES OF CARE AND SERVICES

- > The total amount paid for medical assistance and care in fiscal year 2020 includes supplemental payments and other types of care and services, such as:

\$801,166,761

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

\$4,161,096

- > State grant funding for the Delta Health Alliance project.

\$354,075,144

- > Medicare Premiums

\$433,500

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

\$160,356,889

- > Children's Health Insurance Program (CHIP)

PROGRAM INTEGRITY | *Activites & Audits*

INVESTIGATION REVIEW

The Office of Program Integrity 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 2021, Medicaid had the following activity:

SFY 2021

Total overpayments identified	\$7,647,370.64
Total amount recovered	\$1,649,742.37
Number of Opened Case Investigations	232 cases
Number of Cases Resulting in Corrective Action	127 cases
Number of Cases Referred to MFCU	19 cases
Total recovered by RAC	\$127,838.53
Number of Opened RAC Cases	319 cases
Total PI Recovery SFY 2021	\$1,777,580.90

In addition to performing audits, Program Integrity meets monthly with Qlarant, which is DOM's Unified Program Integrity Contractor (UPIC) partner. Qlarant receives a monthly feed of MMIS claims data and runs the information through its algorithms to detect aberrant claims and providers.

Also, DOM contracts with a Recovery Auditor Contractor (RAC) to perform provider audits. During SFY2021, audits performed by the RAC resulted in \$127,838.53 in recovered funds.

ACTIONS TO COMBAT FRAUD, WASTE & ABUSE

DOM's actions and activities in detecting and investigating suspected or alleged fraudulent practices, violations and abuse are listed below:

Reporting Fraud

- > Fraud reporting hotline
- > Website Fraud and Abuse Complaint Form

Reporting Review and Analysis

- > 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

- > 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

HOW TO REPORT FRAUD & ABUSE

Anyone can report fraud or abuse:

Email: fraud@medicaid.ms.gov

Toll-free: 800-880-5920 | Phone: 601-576-4162

Fax: 601-576-4161

Mailing address: 550 High Street, Suite 1000, Jackson, MS 39201

Report fraud or abuse online: [Secure Online Form](#)

PROGRAM INTEGRITY | *Overview & Insights*

MEDICAID AUDITS

Based on analysis of provider billing patterns that indicate possible overpayments by the Division of Medicaid, the Office of Program Integrity will initiate an audit. The audit can be a desk audit, which is done entirely on the basis of billing records and/or actual claims records, or it can mature into a field audit in which the Medicaid auditor goes to the provider's place of business to conduct the record review and any related interviews of medical staff and providers such as physicians or hospital personnel. If the audit indicates the provider has likely abused the Medicaid system by generating unnecessary costs to Medicaid from excessive or unnecessary services, the auditor will prepare and present 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 possible fraud or abuse include falsifying certificates of medical necessity or plans of treatment, and medical records to justify payment; soliciting or receiving kickbacks; and inappropriate billing practices such as upcoding.

INVESTIGATIVE REVIEW & REFERRAL PROCESS

Often, what began as a routine audit may mature into a full-blown investigation if the auditor suspects that the provider has engaged in conduct beyond mere abuse and committed fraud. Some of these investigations may result only in recovery of funds from the provider for improper claims. However, if the evidence supports a credible allegation of fraud by the provider, then the case is referred to the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General for possible criminal prosecution or civil action.

DATA ANALYSIS & MEDICAL REVIEW

Key to the development of audits is the use of data analysis tools such as algorithms that uncover areas of potential fraud and abuse in the Medicaid system. The algorithms are created through research using multiple means such as Medicare Fraud Alerts, newspaper articles, websites, and other sources. The Division does not have a full-time statistician or data analyst, and this is an addition which could significantly augment and improve the work of Program Integrity. Program Integrity works closely with multiple external

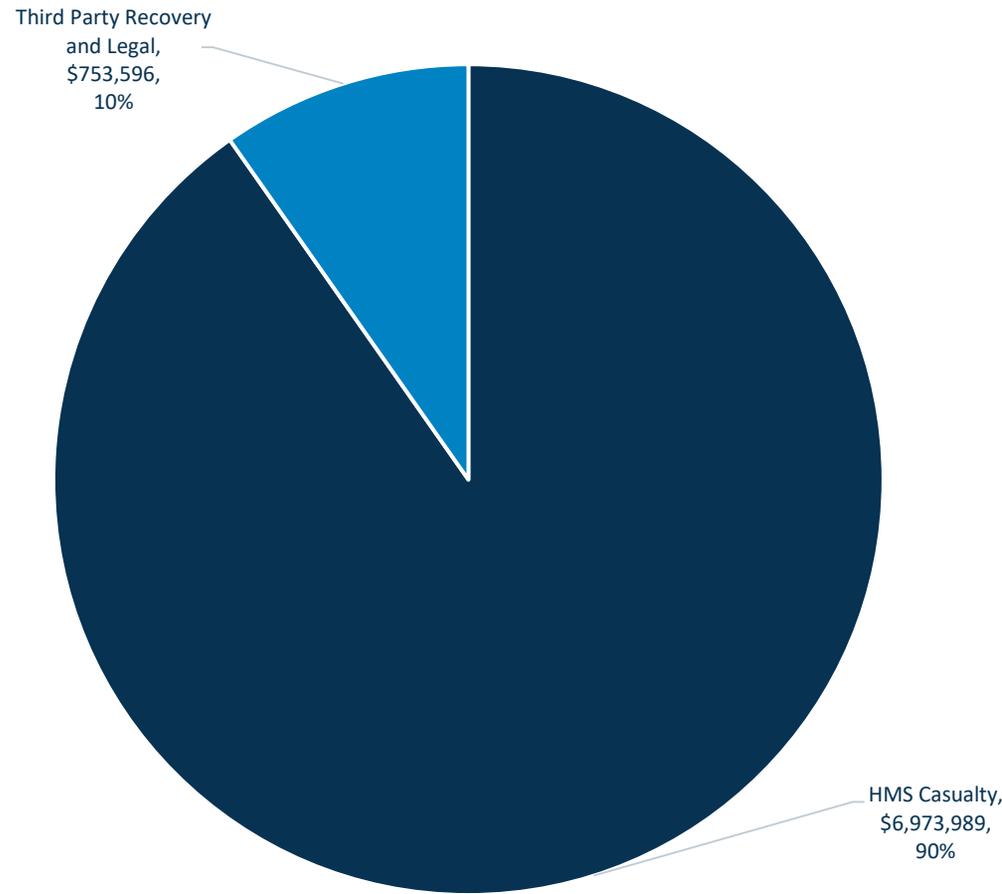
partners and contracted vendors providing a range of different services, such as creating reports, reviewing claims, and providing research for provider reviews.

When investigations involve issues of medical judgment, or the medical necessity of treatment and services, the registered nurses in the Medical Review Division review claims of both providers and beneficiaries to determine the medical necessity and appropriateness of services rendered and to ensure quality to meet professionally recognized standards of health care.

MEDICAID ELIGIBILITY QUALITY CONTROL

Persons initially determined to be eligible for Medicaid may not continue to remain eligible. The team of investigators in the Medicaid Eligibility Quality Control Division regularly verify continued eligibility.

THIRD PARTY RECOVERY | *Amounts Recovered*



RECOVERED FUNDS

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

In collaboration with the Legal staff and HMS Casualty, a breakdown for the funds recovered for fiscal year 2021 are listed below.

THIRD PARTY RECOVERY AND LEGAL

\$753,596

HMS CASUALTY

\$6,973,989

TOTAL FUNDS RECOVERED

\$7,727,585

Waiver	Avg. of participants FY 2021	Waiting list	Fed. authorized slots in FY 2022	Total cost per person FY 2021*	Estimated state cost to fund all slots FY 2022**
Assisted Living	589	14	1,050	\$17,058.72	\$1,733,848.30
Elderly and Disabled	16,393	8,252	22,200	\$16,852.32	\$36,214,961.59
Independent Living	2,326	1,043	5,800	\$21,999.18	\$12,351,219.62
Intellectual Disabilities/ Developmental Disabilities	2,664	2,806	3,900	\$49,412.70	\$18,654,282.50
Traumatic Brain Injury/ Spinal Cord Injury	841	98	1,050	\$28,264.70	\$2,872,824.11
Totals	22,813	12,213	34,000		\$71,827,136.12,

* Total cost per person is based on FY2021 data as of June 30, 2021. Costs may be adjusted based on claims submitted throughout the timely filing period.

** Estimated state cost to fund all slots based on SFY2022 blended FMAP of 90.32%.

HOME AND COMMUNITY BASED SERVICES OVERVIEW

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

SOURCE NOTES

- > The average of number of current participant over the fiscal year is based on data submitted in the monthly legislative report.
- > Number of participants on the wait list as reported in the monthly legislative report for the last month of the fiscal year (June 2021).
- > Total Cost Per Person – D + D' from the monthly 372 ran on the last day of the fiscal year (6/30/2021).

EMPLOYEES | *Program Workforce*



600
Approximate number of employees working in the regional offices



300
Approximate number of employees working in the central office

MEDICAID WORKFORCE

For fiscal year 2021, the Mississippi Division of Medicaid was authorized to have:

FULL-TIME, PERMANENT POSITIONS

979

PART-TIME, PERMANENT

9

FULL-TIME, TIME-LIMITED

23

TOTAL

1,011

TOTAL FILLED AS OF DEC. 15, 2021

885

HIGHLIGHTS | 2021 Developments

SCHOOL-BASED TELEHEALTH COVERAGE EXTENDED

- > With the start of the new school year in the midst of the COVID-19 pandemic, DOM extended its emergency telehealth coverage to include schools as temporary originating site providers. The move makes it possible for schools without school nurses or school-based clinics to utilize telehealth services.
- > Effective Aug. 1, 2020, schools were approved as temporary telehealth originating site providers on the condition that services are facilitated by a telepresenter acting within their scope of license and/or certification.
- > The amended policy allowed any school to serve as the originating site as long as the distant site provider uses a telepresenter who meets the definition of Miss. Admin. Code Part 225, Rule 1.1.D.



MEDICAL CARE ADVISORY COMMITTEE RECONVENES

- > After going on hiatus for more than a year due to the COVID-19 pandemic, the Medical Care Advisory Committee (MCAC) was reconstituted in summer 2021 with newly appointed members. This federally required body tasked with advising DOM about health and medical care services had not convened since Nov. 1, 2019, during the previous administration.
- > The MCAC is made up of 11 members appointed by the governor, lieutenant governor and the speaker of the House of Representatives who are either healthcare providers or consumers of healthcare services. The new committee was officially sworn in on June 25, and on July 30 and they elected Dr. David Reeves as the new chairperson.

GROUND AMBULANCE SERVICE RATES INCREASED

- > Working in cooperation with the Mississippi State Department of Health (MSDH), the Division of Medicaid increased the reimbursement rate for emergency ground ambulance transportation in September 2020.
- > Previously these rates were calculated at 70% of the Medicare rate. A collaborative agreement with MSDH made it possible for those reimbursements to be calculated at 100% of the Medicare rate, resulting in an estimated increase of \$7.8 million per year at no additional cost to the state.
- > By maximizing the use of recurring state funds, DOM is helping to enhance access to a critical service without increasing state spending.



CONTACT US | *More Information*

MORE INFORMATION

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MISSISSIPPI DIVISION OF
MEDICAID