



MISSISSIPPI DIVISION OF
MEDICAID

2019 ANNUAL REPORT

STATE FISCAL YEAR 2019
JULY 1, 2018 - JUNE 30, 2019

Dear Governor and Legislators

Governor Bryant and Members of the Mississippi Legislature:

On behalf of the Mississippi Division of Medicaid (DOM), it is my pleasure to present you with our Annual Report for state fiscal year 2019.

Thanks to a productive partnership with lawmakers and other stakeholders across the state, this agency has been able to successfully operate within its original appropriated budget for the first time in several years, while at the same time increasing access to needed Medicaid services.

In this report we have illustrated enrollment trends over the past five years compared to 2019, and highlighted the services and programs our \$917 million in direct state funding and \$5.9 billion in total funding have supported.

We will continue to face challenges in the coming years as the health care industry evolves, and we work to keep up with advancements in technology, but we will continue to focus on making data-driven decisions that improve health outcomes of the population.

Respectfully,



CONTENTS

1

Program & Basics

2

Enrollment

9

Finance

12

Program Integrity

15

Home and Community Based Services

16

Employees

17

Innovations



MEDICAID | Program & Basics

MEDICAID AT A GLANCE

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. Mississippi created its program in 1969. 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.

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). The Mississippi FMAP for fiscal year 2019 was 76.21%

DOM administers both Medicaid, which includes fee-for-service and managed care, and the Children's Health Insurance Program (CHIP).



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).

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

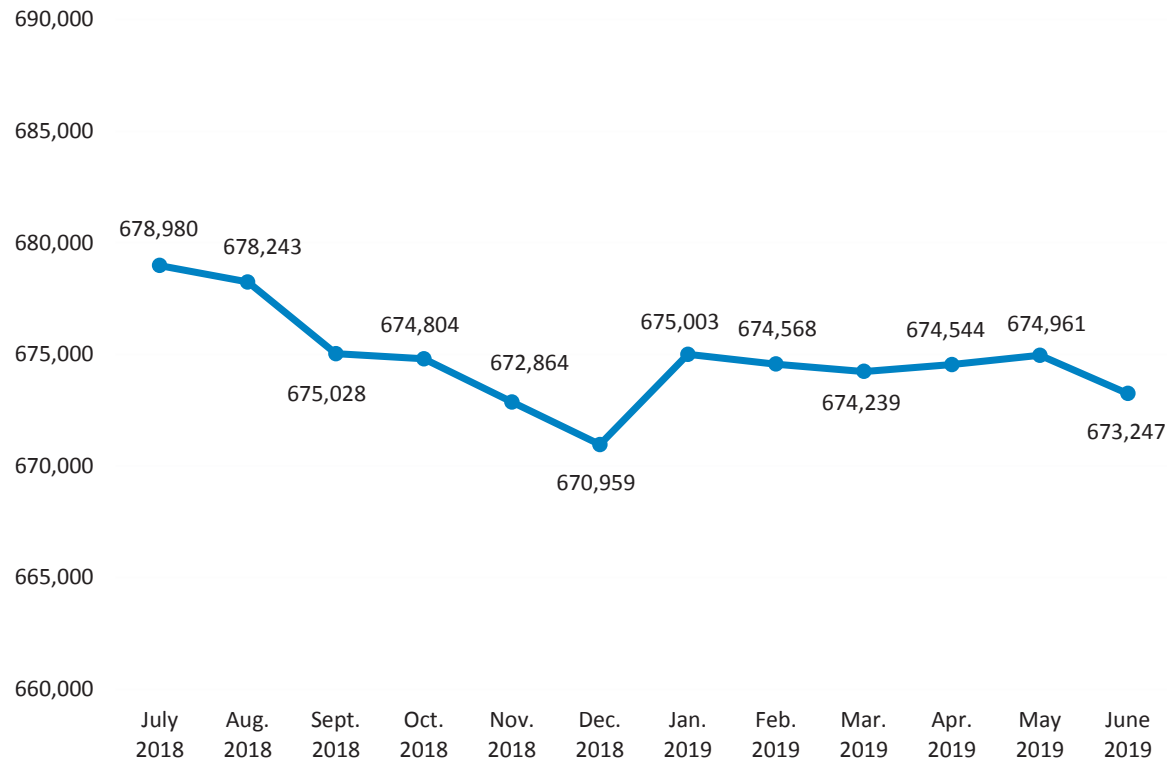
MississippiCAN is administered by three different coordinated care organizations (CCOs), and approximately 65 percent of DOM beneficiaries are enrolled in the program.

MEDICAID vs. MEDICARE

Medicaid: The state administers the program within federal guidelines, receives joint state and federal funding, and 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 primarily serves people age 65 and older, some adults with a disability, and dialysis patients.

ENROLLMENT | FY19 Medicaid Members by Month



The figures above reflect the Medicaid enrollment count for each month of fiscal year 2019; 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>).

BASIC ELIGIBILITY REQUIREMENTS

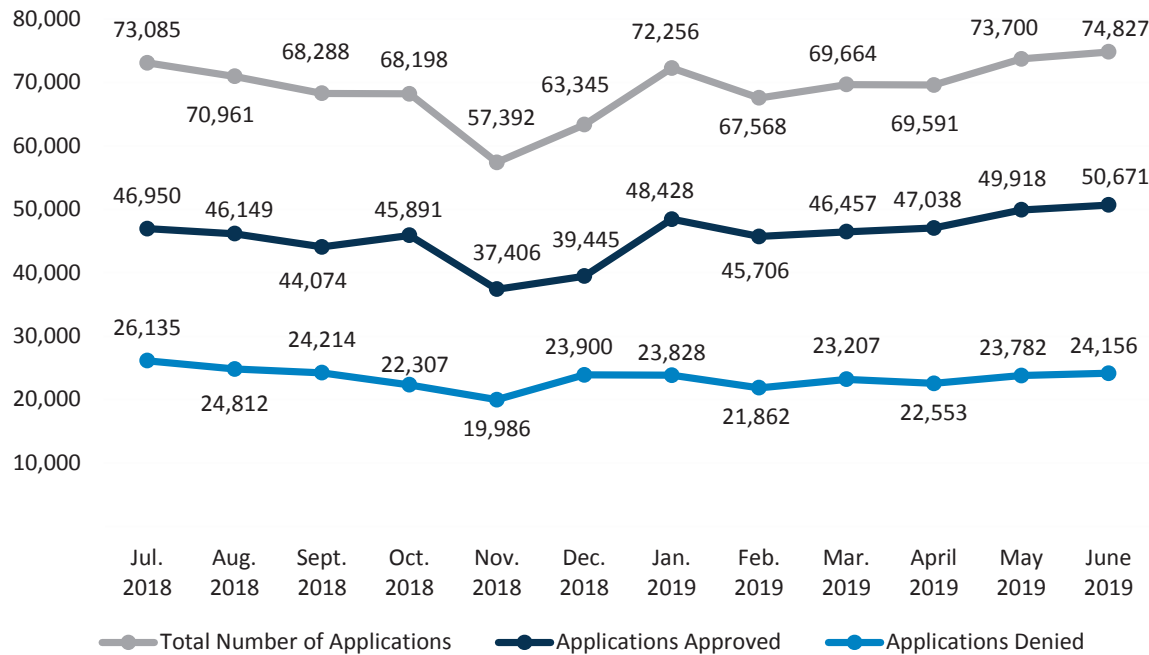
In order to qualify for Medicaid coverage, an individual must complete and submit an application for Mississippi Medicaid health benefits and meet state and federal eligibility requirements.

To qualify for any Medicaid benefits in Mississippi, an individual must:

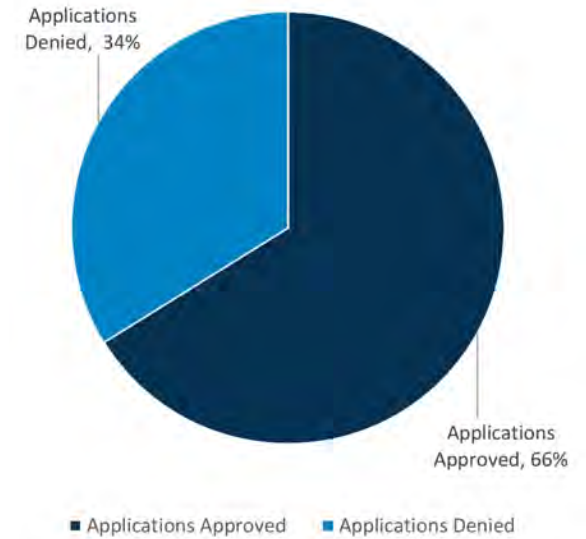
- > be a citizen of the United States or a qualified alien.
- > be a resident of Mississippi.
- > meet requirements for age and/or disability, income and other Mississippi Medicaid eligibility requirements such as resources for certain aged, blind or disabled coverage groups.
- > provide requested verification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

ENROLLMENT | Medicaid Applications in FY19

APPLICATIONS APPROVED/DENIED



The figures above reflect the total number of applications received, applications approved, and applications denied for state fiscal year 2019 by month, which ranges from July 1, 2018, through June 30, 2019. These figures include both initial applications and applications for annual renewal.



TOTAL NUMBER OF APPLICATIONS

828,875

APPLICATIONS APPROVED

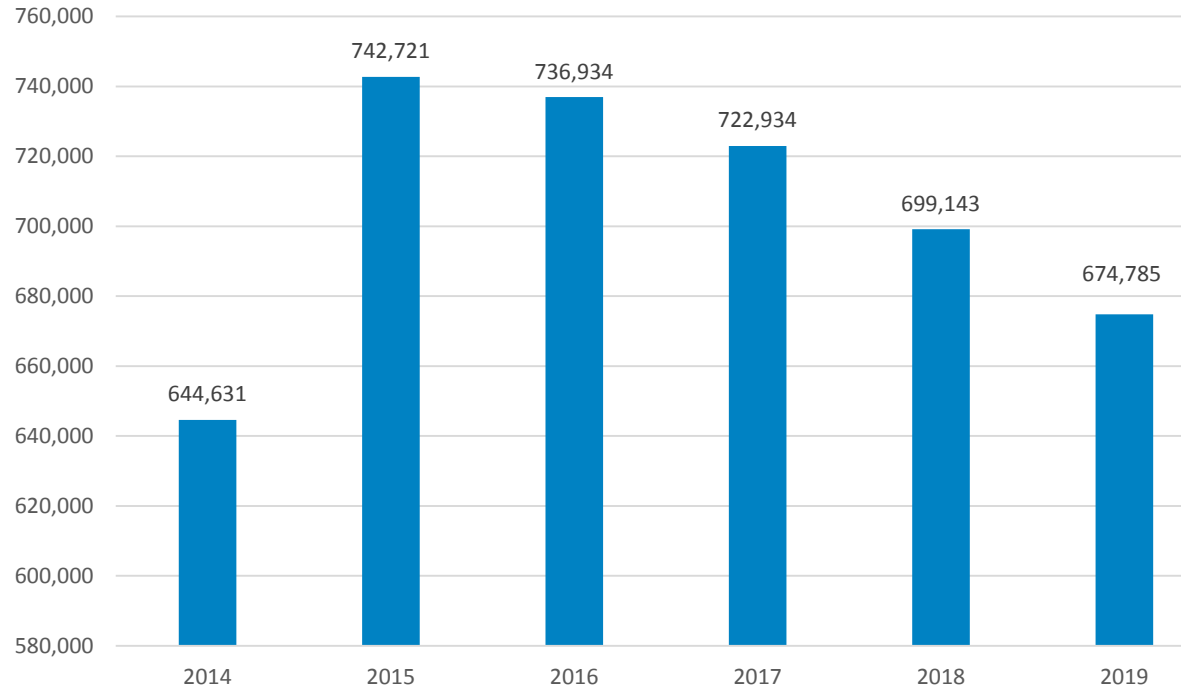
548,133

APPLICATIONS DENIED

280,742

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>).

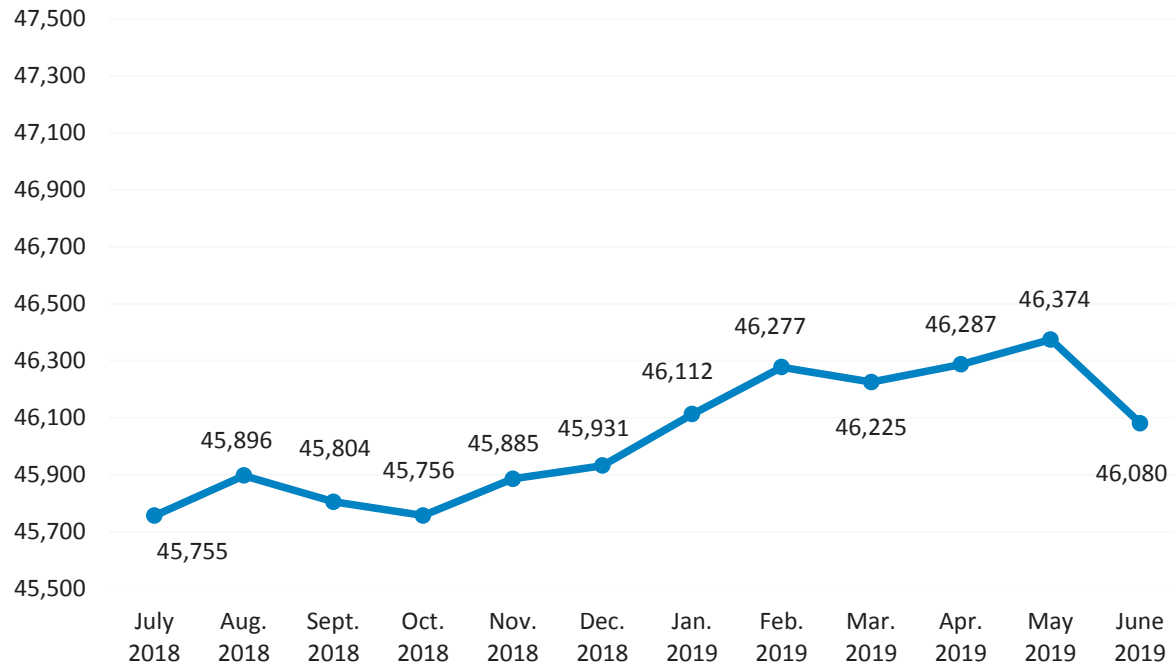
FEDERAL POVERTY LEVELS

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 | FY19 CHIP Members by Month



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).

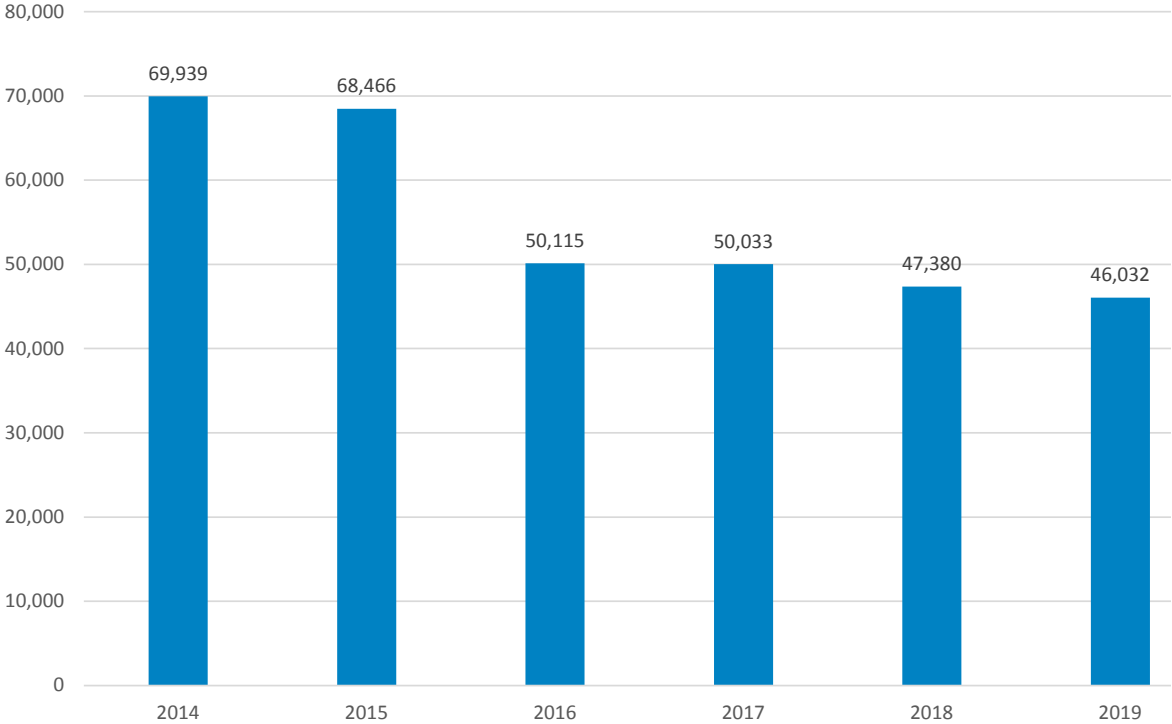
To be eligible for CHIP, a child cannot be eligible for Medicaid. Also, at the time of application, a child cannot be covered by another form of insurance to qualify for CHIP.

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

The figures above reflect the Children’s Health Insurance Program (CHIP) enrollment count for each month of fiscal year 2019. Enrollment reports are continually updated and available on the Medicaid website under Resources (<http://medicaid.ms.gov/resources>).

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 six fiscal years. Enrollment reports are continually updated and available on the Medicaid website under Resources (<http://medicaid.ms.gov/resources>).

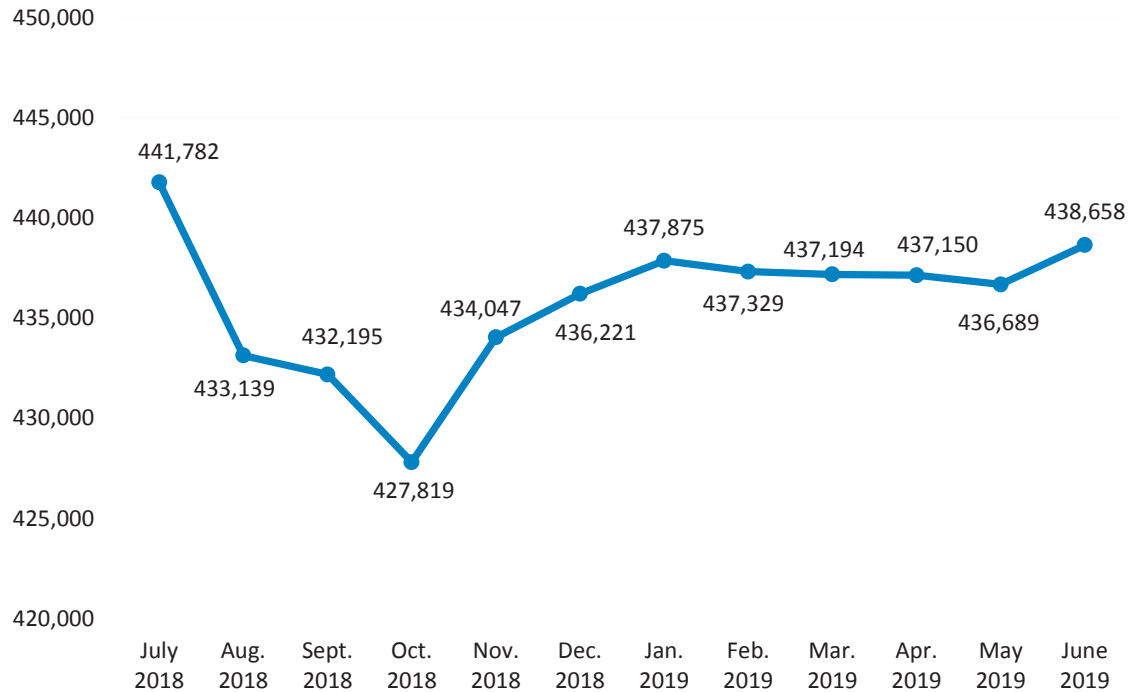
NEW CHIP CONTRACTS TAKE EFFECT NOV. 1, 2019

CHIP is currently administered by two coordinated care organizations (CCOs). New CHIP contracts with Molina Healthcare and UnitedHealthcare Community Plan will take effect Nov. 1, 2019.

CHIP beneficiaries currently enrolled with the outgoing CHIP CCO, Magnolia Health Plan, will receive a letter giving them the opportunity to choose between Molina Healthcare and UnitedHealthcare Community Plan. If a CHIP beneficiary does not respond, they will be assigned to Molina Healthcare.

All CHIP beneficiaries can select a plan during annual open enrollment, which is offered October through December each year.

ENROLLMENT | FY19 MississippiCAN Members by Month



The figures above reflect MississippiCAN enrollment for fiscal year 2019. Enrollment reports are continually updated and available on the Medicaid website under Resources (<http://medicaid.ms.gov/resources>).

MISSISSIPPICAN OVERVIEW

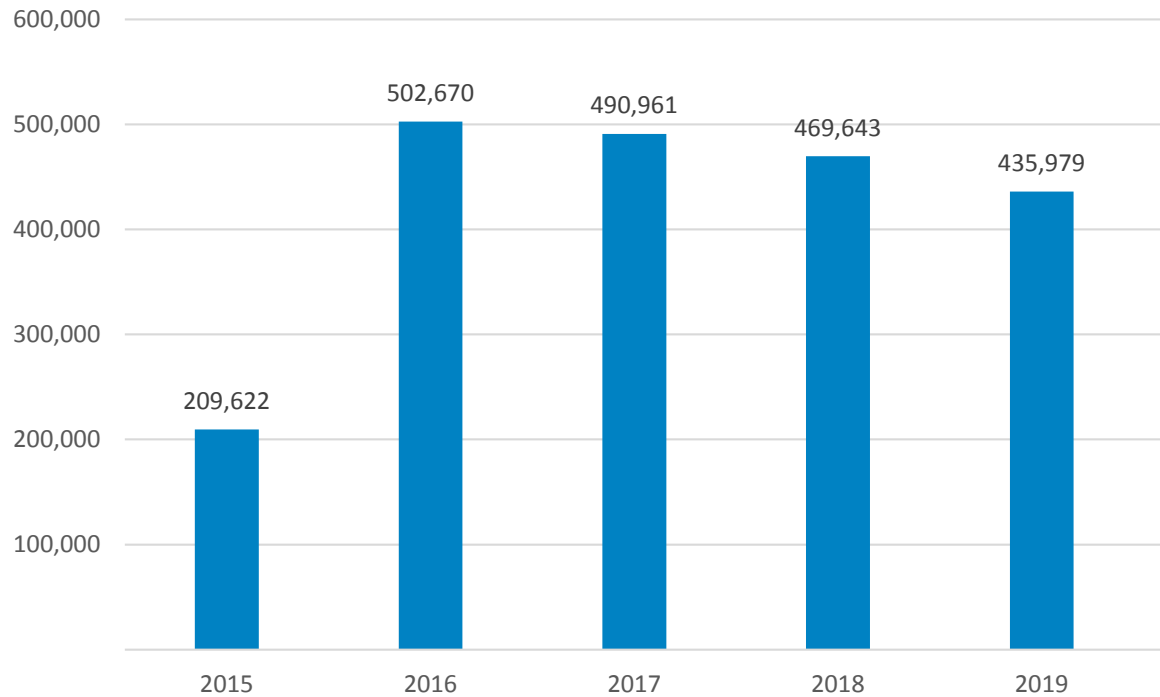
Authorized by the state Legislature in 2011, DOM oversees a Medicaid managed care program for beneficiaries called MississippiCAN.

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 | FY19 MississippiCAN Members Annual Averages

ANNUAL AVERAGES BY FISCAL YEAR



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

MISSISSIPPICAN OVERVIEW

MississippiCAN is administered by different coordinated care organizations (CCOs), and approximately 65 percent of DOM beneficiaries are enrolled 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 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, 2019.

Providers are encouraged to enroll in all Mississippi Medicaid programs.

FINANCE | Medicaid Funding by Source

TOTAL

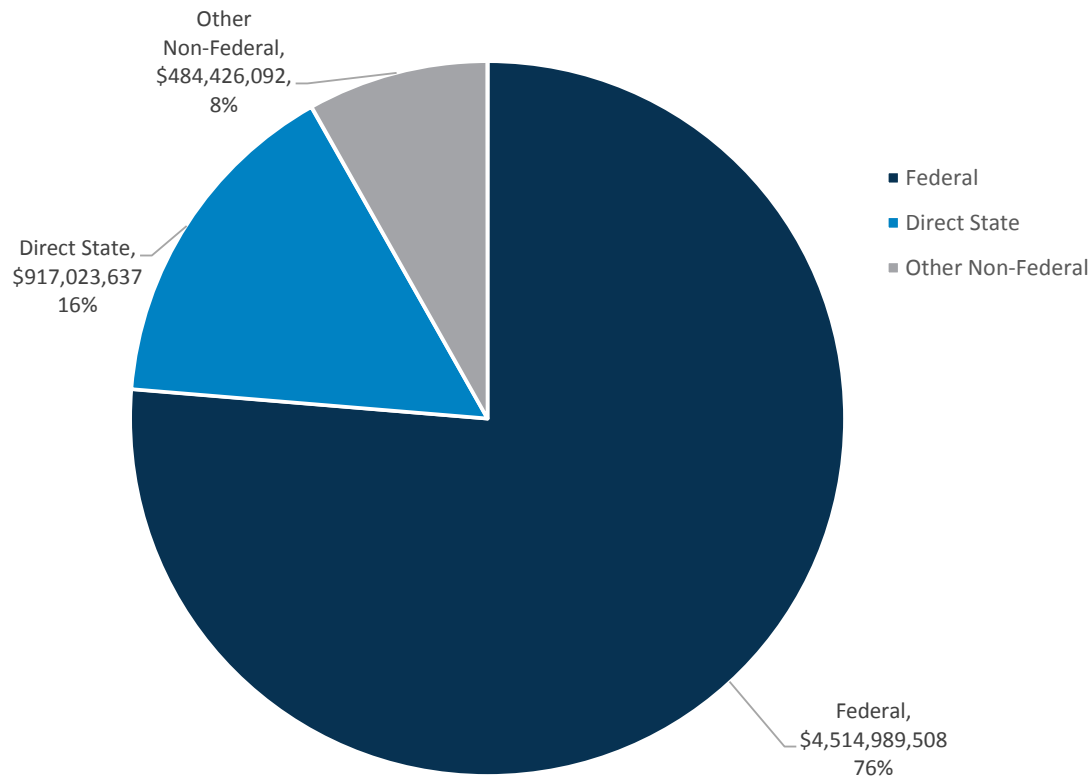
\$5.9 billion

FEDERAL

\$4.5 billion

DIRECT STATE

\$917 million



76.21% > Fiscal year 2019 blended FMAP for Mississippi

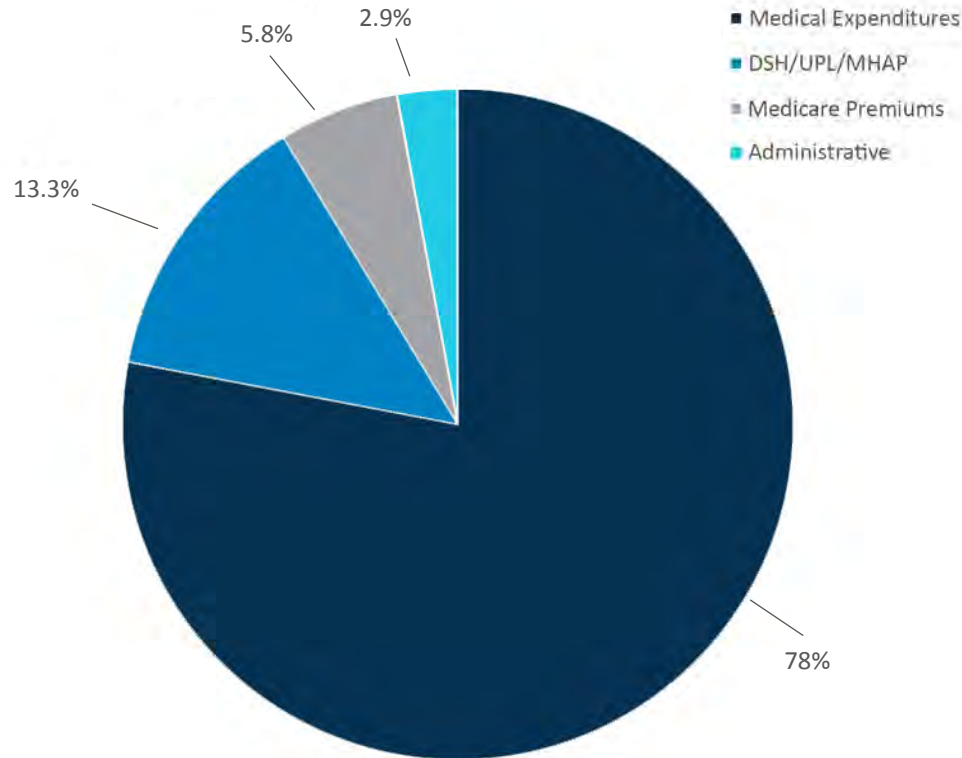
FINANCE OVERVIEW

A significant portion of DOM's annual budget comes from federal matching funds, which is calculated by the Federal Medical Assistance Percentage (FMAP). Mississippi's FMAP for fiscal year 2019 was 76.21%. That means for every state dollar spent on health care for Medicaid the federal government gives DOM approximately three dollars.

- > Of the entire Medicaid budget, more than 95% 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 2019, administrative expenditures totaled \$172,650,041.
- > 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

\$4,613,707,025

DSH/UPL/MHAP

\$788,010,681

MEDICARE PREMIUMS

\$342,071,490

ADMINISTRATIVE

\$172,650,041

FY2019 TOTAL

\$5,916,439,237



SUPPLEMENTAL PAYMENTS AND OTHER TYPES OF CARE AND SERVICES

- > The total amount paid for medical assistance and care in fiscal year 2019 includes supplemental payments and other types of care and services, such as:

\$788,010,681

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

\$3,379,051

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

\$342,071,490

- > Medicare Premiums

\$3,247,000

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

\$156,870,954

- > Children's Health Insurance Program (CHIP)

PROGRAM INTEGRITY | Activities & 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 2019, Medicaid had the following activity:

\$5,550,413

- > Approximate amount recovered through Program Integrity

17 CASES

- > Referred to the Medicaid Fraud Control Unit in the Office of the Attorney General

335 CASES

- > Cases investigated

288 CASES

- > Cases that resulted in corrective action

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. To date, information from our UPIC/Medi-Medi partner has assisted Program Integrity with opening 48 investigations.

Also, DOM contracts with a Recovery Auditor Contractor (RAC) to perform provider audits. During SFY2019, audits performed by the RAC resulted in \$667,782.52 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 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

Online: www.medicaid.ms.gov/contact/report-fraud-and-abuse/

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

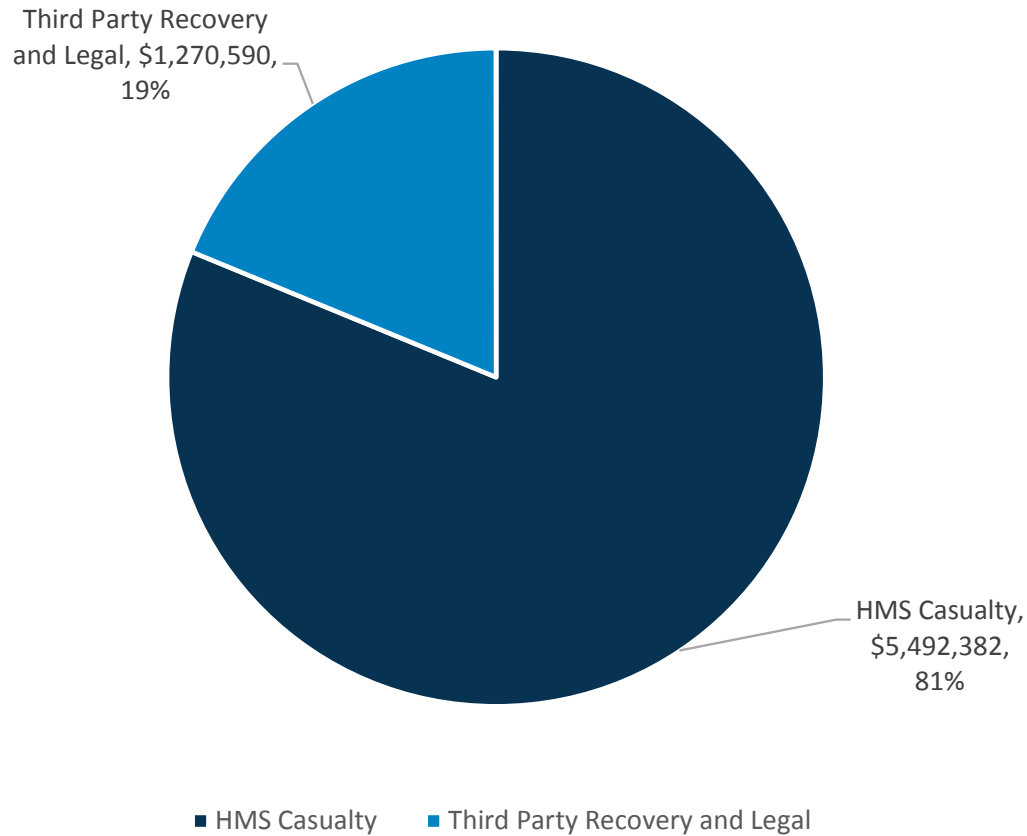
partners and contracted vendors providing a range of different services, such as creating reports, reviewing claims, and providing research for provider reviews.

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 2019 are listed below.

THIRD PARTY RECOVERY AND LEGAL

\$1,270,590

HMS CASUALTY

\$5,492,382

TOTAL FUNDS RECOVERED

\$6,762,972

Waiver	Avg. of participants FY 2019	Waiting list	Fed. authorized slots in FY 2020	Total cost per person FY 2019*	Estimated state cost to fund all slots FY 2020
Assisted Living	592	392	920	\$16,792	\$4,137,935
Elderly and Disabled	16,845	9,268	21,600	\$15,903	\$75,743,998
Independent Living	2,093	990	5,650	\$20,122	\$30,861,251
Intellectual Disabilities/ Developmental Disabilities	2,629	2,095	3,400	\$49,504	\$36,079,300
Traumatic Brain Injury/ Spinal Cord Injury	773	63	3,600	\$26,236	\$21,893,525
Totals	22,932	12,808	35,170		\$168,716,009

* Total cost per person is based on FY2019 data as of June 30, 2019. Costs may be adjusted based on claims submitted throughout the timely filing period.

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 2019).
- > Total Cost Per Person – D + D' from the monthly 372 ran on the last day of the fiscal year (6/30/2019).

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 2019, the Mississippi Division of Medicaid was authorized to have:

FULL-TIME, PERMANENT POSITIONS

997

PART-TIME, PERMANENT

2

FULL-TIME, TIME-LIMITED

37

TOTAL

1032

TOTAL FILLED AS OF JUNE 30, 2019

916

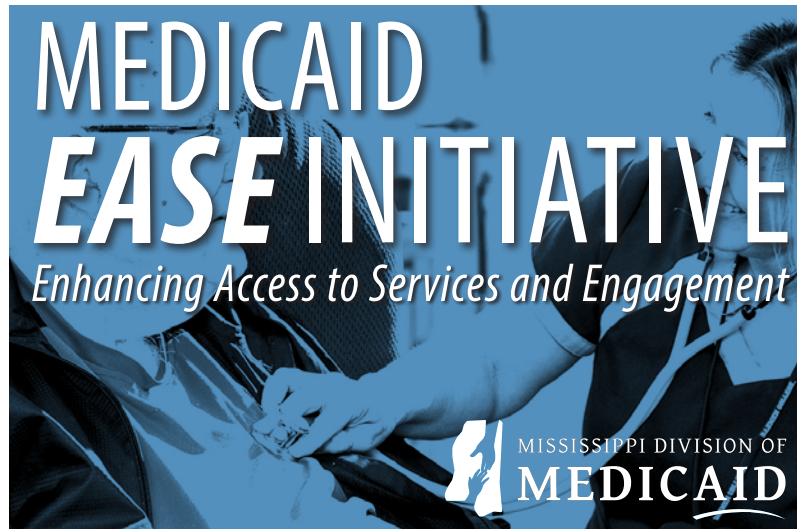
INNOVATIONS | 2019 Highlights

16 VISITS

- > DOM increased the physician visit limit for beneficiaries from 12 to 16

36 VISITS

- > DOM increased the number of home health visits from 25 to 36.

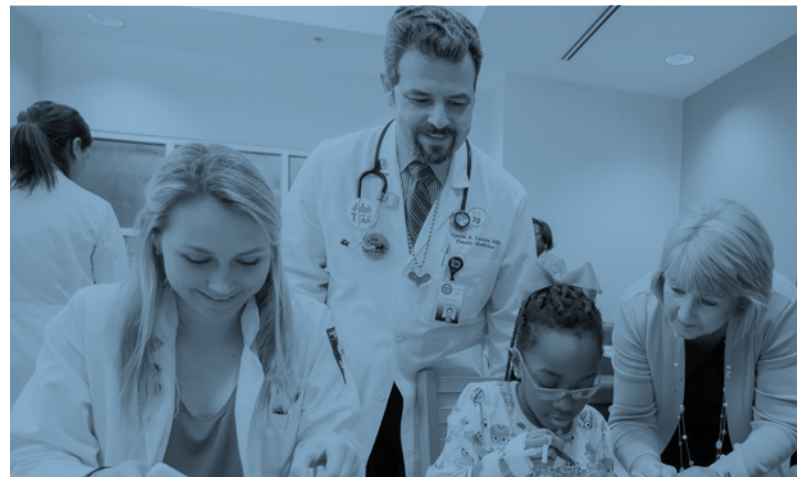


ENHANCING SERVICES

- > Capitalizing on the flexibilities lawmakers granted DOM during the 2018 legislative session, DOM announced the Medicaid EASE Initiative – Enhancing Access to Services and Engagement – in December of 2018 and increased the physician visit limit for beneficiaries from 12 to 16 visits per year.
- > In the second phase, DOM increased the monthly prescription drug limit from five to six prescriptions, and increased the number of home health visits per state fiscal year from 25 to 36. Both changes took effect July 1, 2019.

NEW MEDICAL DIRECTOR

- > Dr. Carlos Latorre was named DOM medical director in November of 2018. A board-certified family physician, Dr. Latorre earned his medical degree at the University of Puerto Rico School of Medicine in 2008, and completed his residency training at the University of Mississippi Medical Center in 2011 while serving as chief resident for the Department of Family Medicine.
- > For the past six years Dr. Latorre has practiced as a family physician in Vicksburg, where he continues to work part time in private practice.



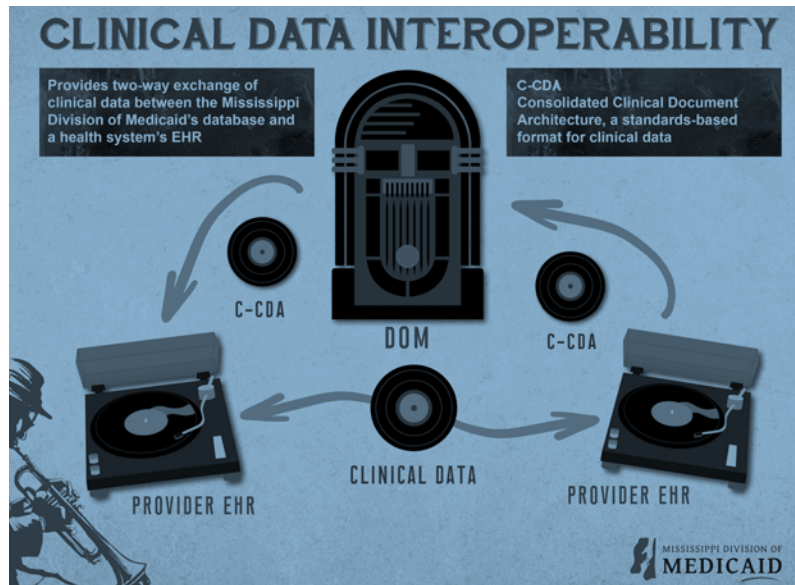
MSMA

- > A board member for the Mississippi State Medical Association, Dr. Latorre was honored with the Dr. James C. Waites Leadership Award by MSMA in August.

INNOVATIONS | 2019 Highlights

380,000

- > DOM receives clinical data information for approximately 380,000 beneficiaries, representing more than half of the agency's 675,000 beneficiaries.



CLINICAL DATA EXCHANGE

- > In the spring of 2019, DOM became the first Medicaid agency in the nation to receive clinical data summaries directly from its managed care organizations (MCOs). This connection, made possible by the technical infrastructure created by health information technology company MedeAnalytics, helps DOM gain insights into its Medicaid population and better understand how therapies or procedures affect health outcomes and the cost of care.
- > DOM has also established interoperability connections with the University of Mississippi Medical Center, Forrest General Hospital, Singing River Health System and Hattiesburg Clinic.

REPORTING DATA

- > As part of an ongoing effort to increase program transparency, DOM developed the Medicaid Vital Signs dashboard, which displays key Mississippi Medicaid metrics, allowing anyone to quickly check specific Medicaid statistics and follow recent program trends. Most of the information presented in Medicaid Vital Signs will be updated on a monthly basis.



76

- > DOM has published 76 reports through Vital Signs since January 2019, including managed care HEDIS scores.

LEADERSHIP

Executive Director

Drew Snyder

Chief Legal Counsel

Patrick Black

Chief Integrity Officer

Bob Anderson

Deputy Administrator for Administration

Jennifer Wentworth

Deputy Administrator for Information Technology

Rita Rutland

Deputy Administrator for Eligibility

Janis Bond

Deputy Administrator for Human Resources

Janie Simpson

Deputy Executive Director

Tara Clark

Medical Director

Carlos Latorre, M.D.

Senior Director for External Affairs

Wil Ervin

MORE INFORMATION

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