MISSISSIPPI DIVISION OF MEDICAID

Annual Report

Fiscal Year 2018

July 1, 2017 - June 30, 2018

MISSISSIPPI DIVISION OF
MEDICAID

Dear Governor and Legislators:

It is my pleasure to submit to you the Mississippi Division of Medicaid Annual Report for fiscal year 2018.

This agency gratefully acknowledges the many contributions made by our partners in state government, which have helped make this a successful year of transition for the Medicaid program.

In addition, we acknowledge the continued commitment of our providers. Together we are carrying out our mission to responsibly provide access to quality health coverage for vulnerable Mississippians.

Keeping Medicaid recipients healthy is an investment in our state's future. By providing quality health-care services to our most vulnerable citizens, we better enable them to achieve long-term health and financial stability. Additionally, ensuring Medicaid recipients are healthier now further strengthens the sustainability of the program for those who may need assistance in the future.

On behalf of the 729,729 Mississippians who were enrolled in the Medicaid program at the close of fiscal year 2018, we wish to thank you for your continued support of this important program.

Respectfully,

Drew Snyder

**Drew L. Snyder
Executive Director**

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Program History & 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.

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).

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

Medicaid Overview

DOM serves roughly one in four Mississippians who 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. The agency has over 900 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 (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 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.

Program Timeline

July 30, 1965
President Lyndon B. Johnson signs the Social Security Amendments of 1965 into law, establishing 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.

1984
The Legislature transferred responsibilities of the Mississippi Medicaid Commission to the Office of the Governor, and the Division of Medicaid became the single state agency tasked with administering the program.

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.

President Lyndon B. Johnson signs the Social Security Amendments of 1965, establishing Medicare and Medicaid.

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 for states did not expand Medicaid coverage.

January 1, 2011
54,500 beneficiaries are enrolled in Mississippi's managed care program, MississippiCAN, including:
- Supplemental Security Income (SSI)

- Child and Protection Services foster care children
- Disabled child living at home
- Working disabled
- Breast/cervical cancer through the Mississippi State 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
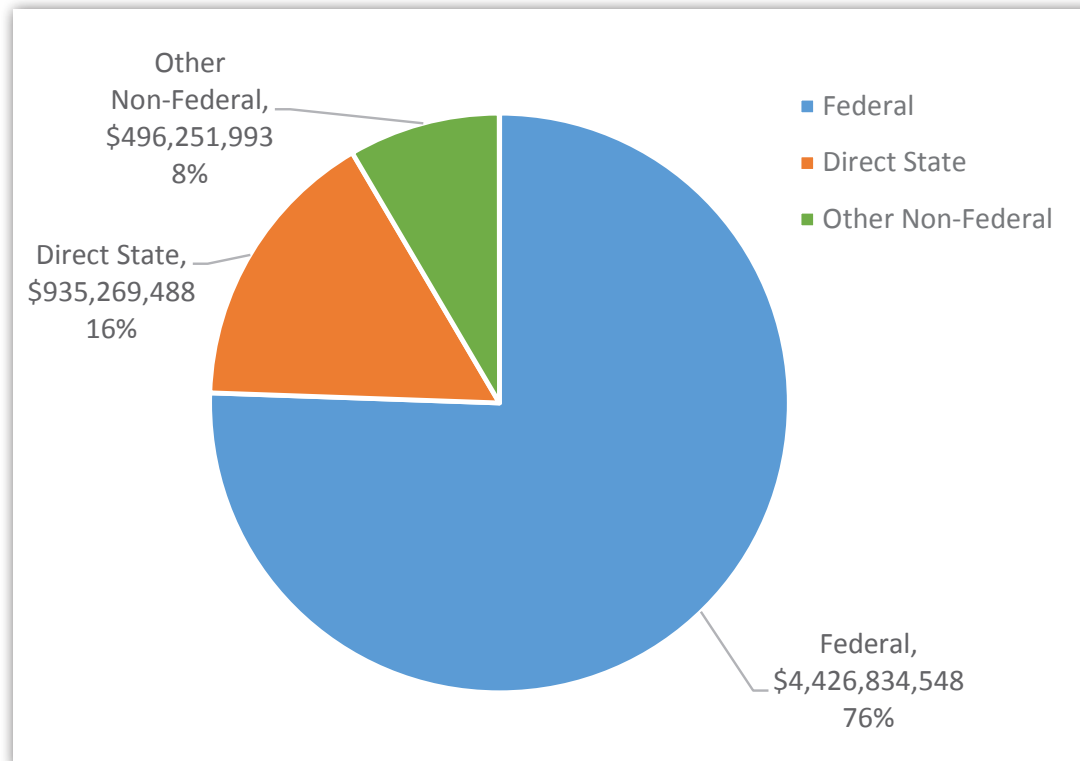- Infants age 0-1

December 2014
196,000 beneficiaries are enrolled in MississippiCAN, including those enrolled in the Quasi-CHIP category of eligibility.

December 2015
Inpatient hospital services transition to MississippiCAN, and 550,008 beneficiaries are enrolled in MississippiCAN, including those enrolled in the TANF children category of eligibility.

Finance | *Medicaid Funding by Source*

Total: $5.85 billion | Federal: $4.4 billion | Direct State: $935 million

Other
Non-Federal,
$496,251,993
8%

Direct State,
$935,269,488
16%

- Federal
- Direct State
- Other Non-Federal

Federal,
$4,426,834,548
76%

76.20% *The fiscal year 2018 FMAP for Mississippi*

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. 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, about 95 percent goes toward provider 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 2018, administrative expenditures totaled $171,867,834.

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.

Finance | *Medicaid Service Expenditures*

Medical Service Expenditures in Billions
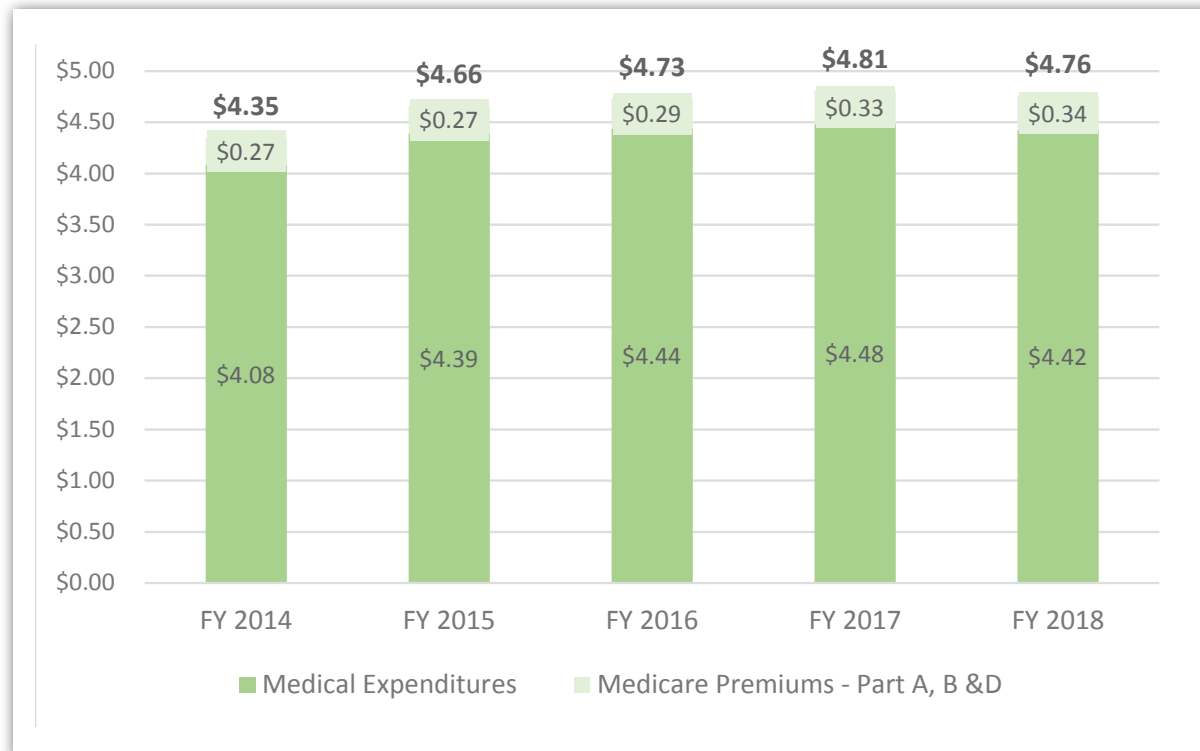
Medical Expenditures

$4,417,542,514

Medicare Premiums

$339,143,728

FY2018 Total

$4,756,686,242

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.

Finance | *Medical Assistance and Care*

Supplemental Payments and Other Types of Care and Services

For fiscal year 2018, the total amount paid for medical assistance and care was $5,686,488,196; this includes supplemental payments and other types of care and services such as:

$782,396,120

Mississippi Hospital Access Program (MHAP) payments (which has been paid through MississippiCAN since 2016), Disproportionate Share Hospital, and Upper Payment Limit funds
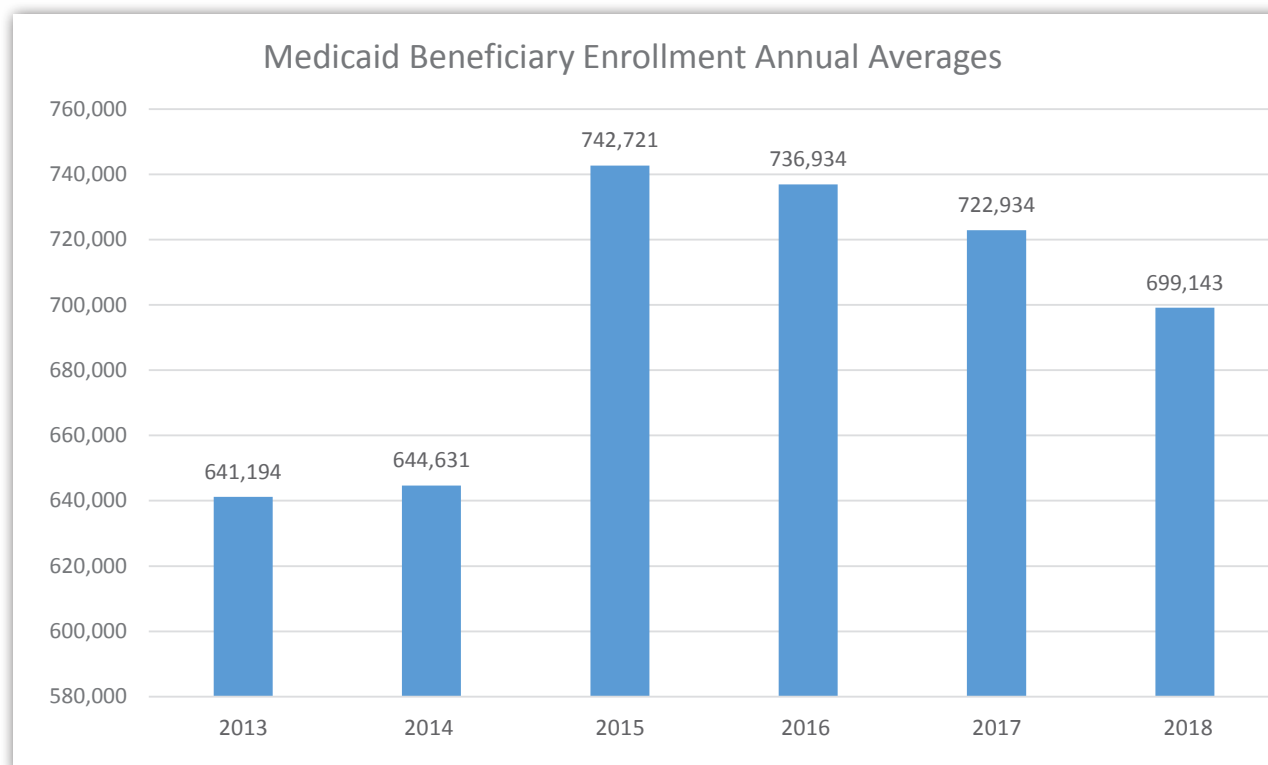
$339,143,728

Medicare Premiums

$2,000,000

Transfers to other state agencies

$11,126,030

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

$134,279,804

Children's Health Insurance Program (CHIP)

Enrollment | *Medicaid Beneficiary Annual Averages*

Medicaid Beneficiary Enrollment Annual Averages

Year	Enrollment
2013	641,194
2014	644,631
2015	742,721
2016	736,934
2017	722,934
2018	699,143

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).

65% *Approximate percentage of all births and children up to age one covered by Medicaid*

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.

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.

Enrollment / *CHIP Beneficiary Annual Averages*

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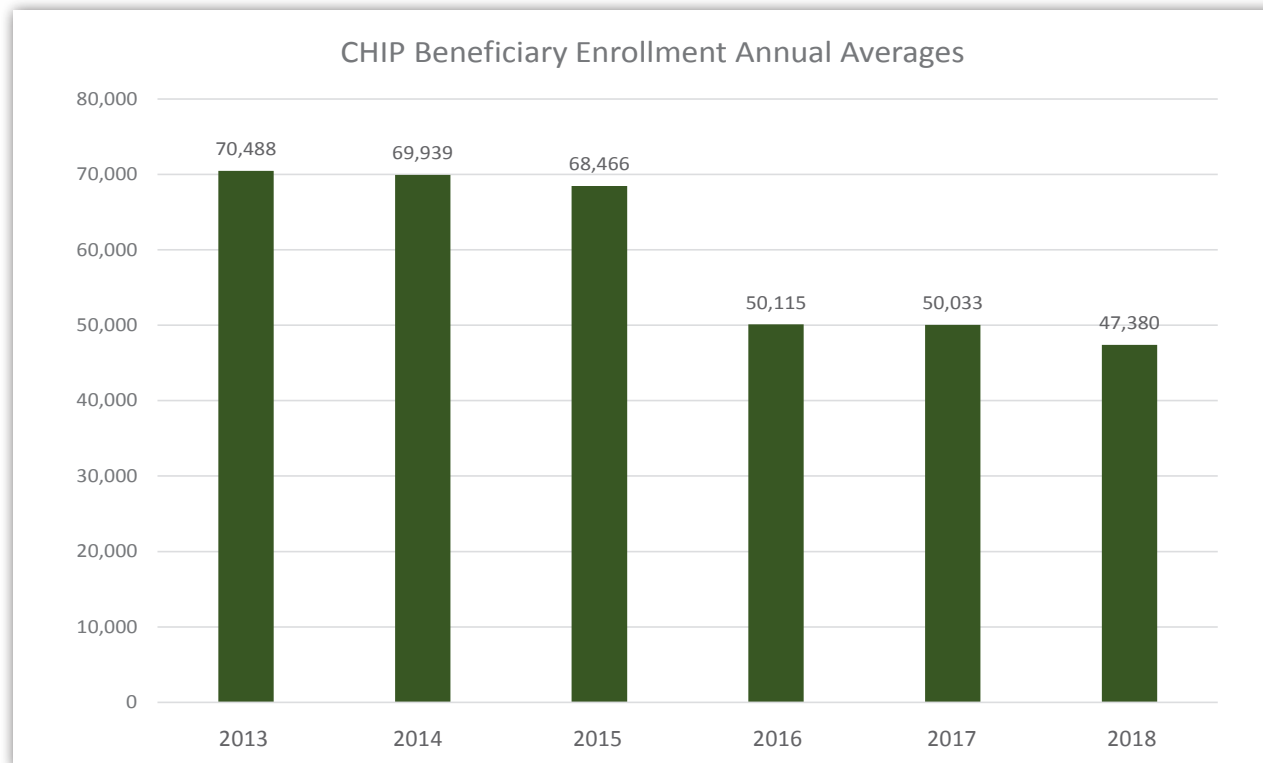
The figures above reflect CHIP enrollment annual averages calculated by calendar year. Approximately 19,000 children moved from CHIP to Medicaid in December 2014, due to income limit changes mandated by the PPACA. Enrollment reports are continually updated and available on the Medicaid website under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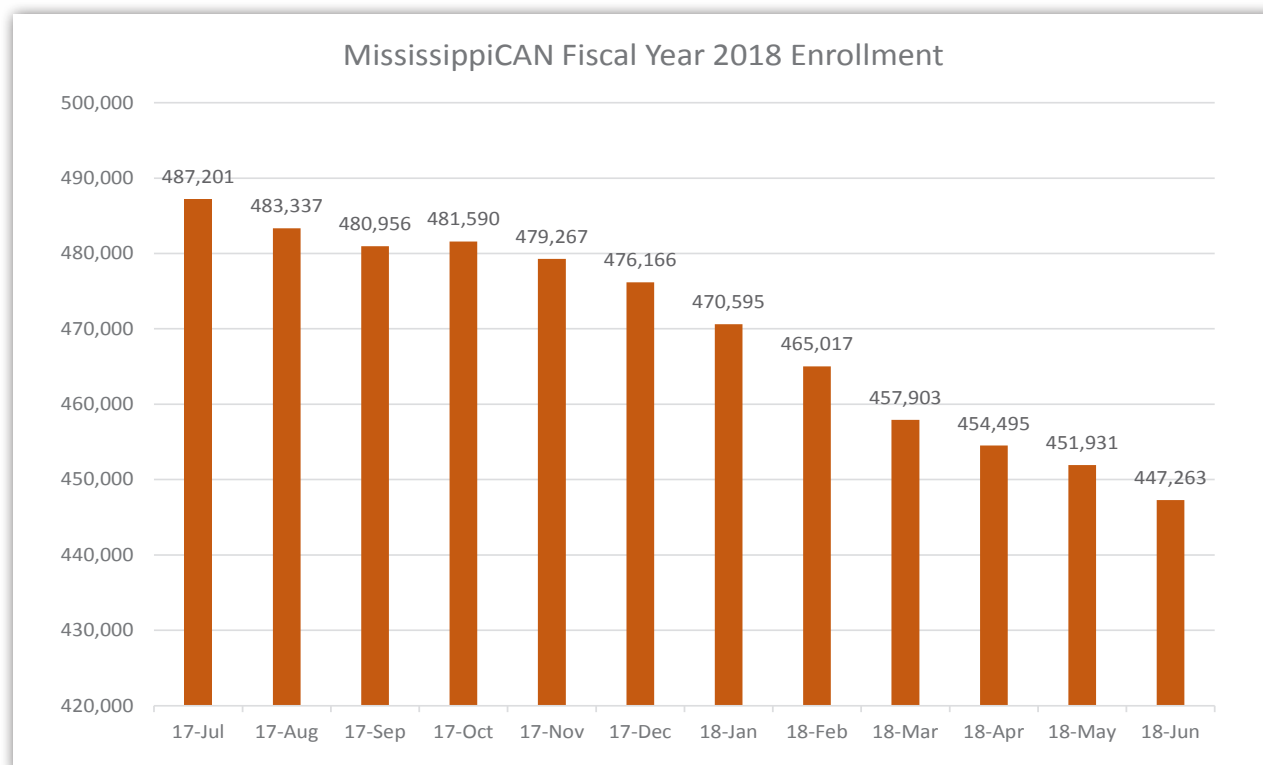
Children's Health Insurance Program Overview

The Children's Health Insurance Program (CHIP) provides health coverage for 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.

Note, as reflected in the chart above, approximately 19,000 children were transitioned from CHIP to Medicaid (Quasi-CHIP category) in 2015, due to income limit changes associated with the PPACA.

Enrollment / *MissississippiCAN FY2018 Enrollment*

MississippiCAN Fiscal Year 2018 Enrollment

Month	Enrollment
17-Jul	487,201
17-Aug	483,337
17-Sep	480,956
17-Oct	481,590
17-Nov	479,267
17-Dec	476,166
18-Jan	470,595
18-Feb	465,017
18-Mar	457,903
18-Apr	454,495
18-May	451,931
18-Jun	447,263

The figures above reflect the total number of applications, applications approved, and applications denied for state fiscal year 2018 by month, which ranges from July 1, 2017, through June 30, 2018.

MississippiCAN Overview

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

The agency has contracts with CCOs that are awarded through an extensive requests for proposals process. The CCOs that win the procurement are responsible for providing care and services to Medicaid beneficiaries in MississippiCAN.

Beneficiaries have the option of enrolling in the CCO of their choice. Health-care providers should verify eligibility at each date of service. Providers are encouraged to enroll as fee-for-service Medicaid providers and contract with each of the CCOs administering services through the MississippiCAN and CHIP programs.

Managed Care / *MissippiCAN Implementation*

New Managed Care Contracts

After a careful procurement process, DOM announced on June 15, 2017, that the new managed care contracts would be awarded to Magnolia Health, Molina Health, and UnitedHealthcare Community Plan.

For the first time, beneficiaries will have three managed care plans to choose from. The contracts were submitted to the Centers for Medicare and Medicaid Services (CMS) on Sept. 22, 2017, and the lengthy implementation of the new contracts began.

The three CCOs completed their Readiness Reviews during the summer of 2018, and a special enrollment period was held from July 1-Aug 31, 2018. The go-live date, Oct. 1, 2018, is the first day the CCOs are responsible for beneficiary care under the new contracts.

54,500

Number of beneficiaries enrolled in MississippiCAN when the program first went live on Jan. 1, 2011

447,263

Number of beneficiaries enrolled in MississippiCAN as of June 30, 2018

Oct. 1 2018

The new contracts for the three CCOs take effect

Home and Community Based Services

Waiver	Avg. of participants FY 2018	Waiting list	Fed. authorized slots in FY 2019	Total cost per person FY 2018	Estimated state cost to fund all slots FY 2019
Assisted Living	599	262	1,100	$18,474	$4,864,930
Elderly and Disabled	16,444	8,534	21,500	$14,985	$77,129,672
Independent Living	2,202	2,725	6,500	$24,516	$38,148,863
Intellectual Disabilities/ Developmental Disabilities	2,578	1,794	2,900	$43,869	$30,456,302
Traumatic Brain Injury/ Spinal Cord Injury	786	355	3,500	$28,562	$23,932,041
Totals	**22,608**	**13,670**	**35,500**		**$174,531,808**

Home and Community Based Services Overview

Home and Community Based Services (HCBS) Programs offer in-home and/or community-based services instead of institutional care. These demonstration waiver programs provide more specialized services, above and beyond the State Plan. Individuals eligible for these programs are the most vulnerable and severely ill, such as: the elderly and disabled, Supplemental Security Income (SSI) recipients, disabled children living at home, and those with a traumatic brain injury/spinal cord injury.

Program Workforce

Employees at the Philadelphia regional office

600
Approximate number of employees working in the regional offices

300
Approximate number of employees working in the central office

Employees in the Office of Long Term Care at the central office

Medicaid Workforce

For fiscal year 2018, the Mississippi Division of Medicaid was authorized to have:

1,027

Full-time, permenant positions

2

Part-time, permanent

37

Full-time, time-limited positions

1,066

Total positions

931

Total positions filled as of June 30, 2018

Fiscal Prudence

Cost-Containment Examples in FY 2018

$200,731

Cost avoidance resulting from 32.3% reduction in in-state agency travel in FY18.

$94,321

Cost avoidance resulting from 58.2% reduction in out-of-state agency travel in FY18.

$4,429,206

Estimated state savings resulting from the new pharmacy reimbursement implementation

$265,450

Amount of liquidated damages assessed and collected, which went to reducing the cost of the contract Non-Emergency Transportation contract.

$139,321

Converted the quarterly Provider Bulletin newsletter from a printed and mailed publication to an electronic provider subscription, saving an estimated $139,321 annually

Program Integrity / *Overview*

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.

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. Examples of beneficiary fraud include doctor/ pharmacy "shopping" to inappropriately obtain unnecessary medications or services, or "lending" a Medicaid identification card to someone to obtain services.

Program Integrity / *Activities*

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 2018, Medicaid had the following activity:

- Approximately $4.8 million recovered through Program Integrity.
- Three cases referred to the Medicaid Fraud Control Unit in the Office of the Attorney General.
- 464 complaints investigated.
- 155 cases investigated.
- 88 cases that resulted in corrective action.

In addition to performing audits, the Office of Program Integrity meets monthly with Qlarant, which is our 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 43 investigations.

Also, DOM contracts with a Recovery Auditor Contractor (RAC) to perform provider audits. During SFY2018, audits performed by the RAC auditor resulted in $7,698.82 in recovered funds.

Actions to Combat Fraud, Waste and Abuse

DOM's actions and activities 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
- 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 and Abuse

Anyone can report fraud or abuse by contacting DOM:
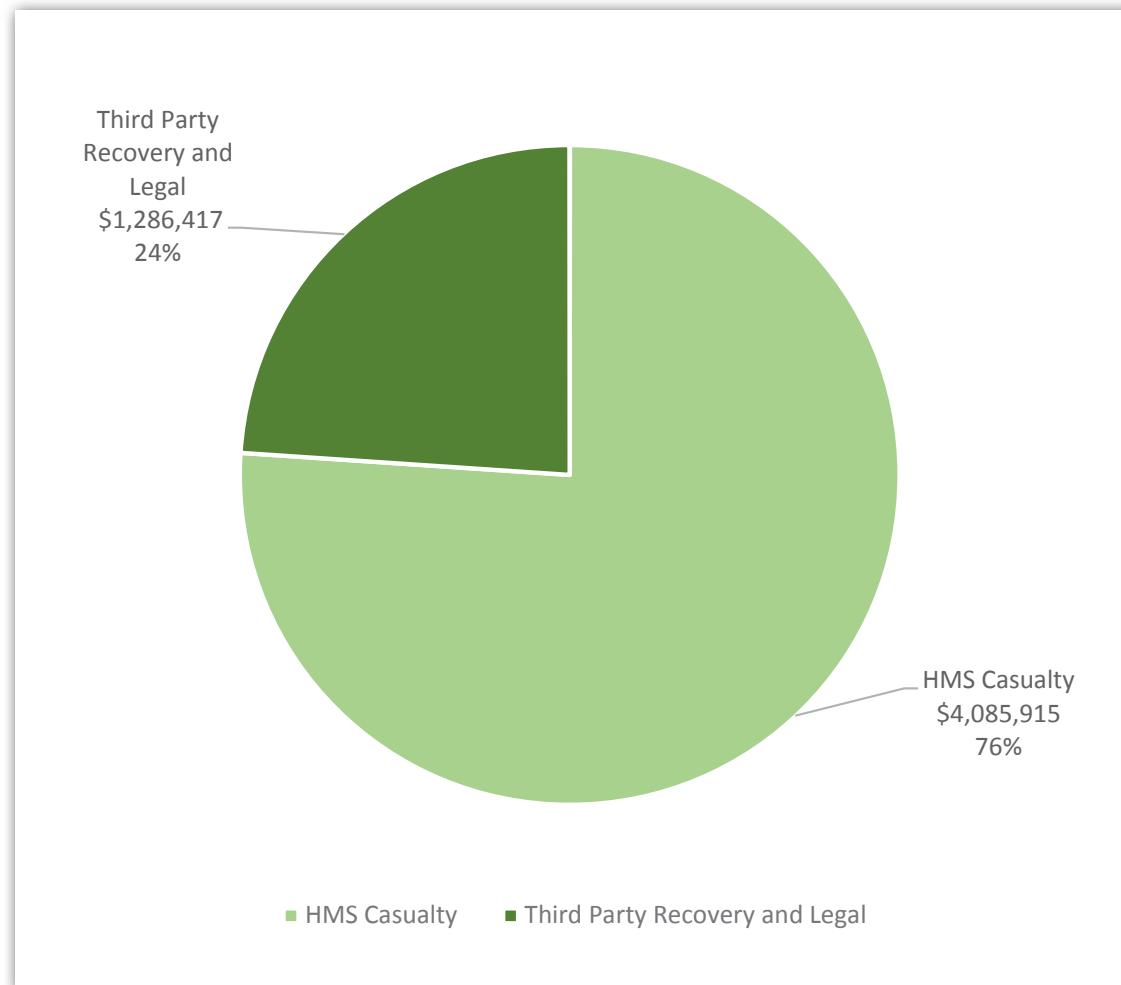
Toll-free: 800-880-5920
Phone: 601-576-4162
Fax: 601-576-4161
Mailing address: 550 High Street, Suite 1000, Jackson, MS 39201

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

Third Party Recovery

Third Party Recovery and Legal
$1,286,417
24%

HMS Casualty
$4,085,915
76%

■ HMS Casualty   ■ Third Party Recovery and Legal

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 2018 are listed below.

Third Party Recovery and Legal

$1,286,417

HMS Casualty

$4,085,915

Total Funds Recovered

$5,372,332

Innovations / *Projects and Milestones*

Complex Pharmacy Care Program Ensures Drugs Used Effectively

In its first year of implementation, a new pharmacy program at the Mississippi Division of Medicaid (DOM) aimed at ensuring the effective use of complex, expensive medications has already prevented $4.6 million in unnecessary spending.

DOM launched the Complex Pharmacy Care Program (CPCP) in October of 2016, a concept that devotes a Mississippi-licensed pharmacist to work closely with beneficiaries undergoing treatment for targeted disease states, such as Hepatitis C.

Read more at https://medicaid.ms.gov/medicaid-pharmacy-program-saves-4-6-million-in-first-year/

CMS Grants First 10-Year Waiver Renewal

In late December, 2017, the Centers for Medicare and Medicaid Services (CMS) granted Mississippi Medicaid the nation's first 10-year waiver extension for our Family Planning Waiver. In announcing the extension, CMS cited a new commitment to allowing states more flexibility with which to operate and administer their Medicaid programs.

Innovations / *Projects and Milestones*

ALL SECTIONS **E-EDITION** **OBITS** **JOBS** **AUTOS**

Medicaid receives March of Dimes grant

By Michaela Gibson Morris Daily Journal   Jun 5, 2018   Comments

JACKSON – Mississippi Medicaid and March of Dimes are working together to get more Clay County moms to full term.

The March of Dimes is providing an $11,050 grant to the Division of Medicaid to promote strategies to reduce risk of premature birth and streamline their access to providers so they get the most out of their prenatal visits.

March of Dimes Partnership Targets Preterm Births

By promoting the use of progesterone and encouraging birth spacing among women with a history of prior preterm births, DOM and the March of Dimes hope to curtail the rate of preterm births in Mississippi.

The March of Dimes awarded DOM a grant to support a new project, which focuses on Clay County and could be a model to be applied in other areas of the state.

The Mississippi Community Grants Program, part of the larger March of Dimes Prematurity Campaign, helps to fund projects aimed at improving outcomes and reducing the risk of preterm births.

Read more at https://medicaid.ms.gov/march-of-dimes-joins-with-medicaid-to-reduce-preterm-births-in-mississippi/

Clinical Data Interoperability Program

In August of 2017, DOM established connections with Hattiesburg Clinic Singing River Health System, establishing an automated system for sharing clinical data in real time, equipping clinicians with enhanced medical-history information about their Medicaid patients. This approach, known as the Clinical Data Interoperability Program, provides two-way communication between DOM's database and the provider.
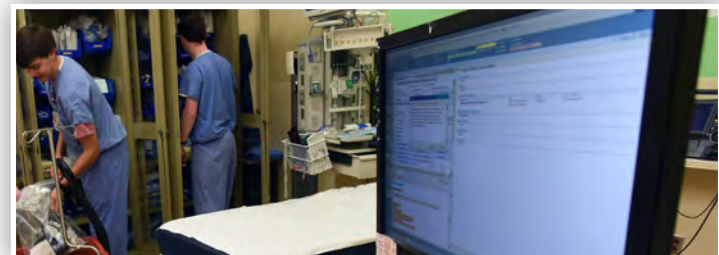
Outreach / *Provider, Beneficiary Workshops*

DOM's Cindy Brown explains Medicaid basics with Hinds Behavioral Health Services staff during a health fair on May 30.

DOM Activities Inform Beneficiaries and Providers in the Community

During fiscal year 2018, the offices of Coordinated Care and Provider Beneficiary Relations (PBR) hosted a series of beneficiary and provider workshops around the state to share information and details about Medicaid, MississippiCAN and CHIP services and changes.

Alongside the beneficiary and provider workshops, Coordinated Care and PBR conducted training workshops for regional office employees. In addition to these outreach activities, PBR is routinely invited to attend community health fairs across the state.

DOM's Marlene Franklin (left) visits with Rhemalyn Lewis, Service Coordinator for United Church Homes, during a health fair and Flag Day celebration organized for the Jackson Run residential community in Jackson on June 13.

Representatives from DOM's Office of Long Term Care (from left) Gail Townsend, Patricia Berry, Paulette Johnson and LaShunda Woods were on hand for the Civil Money Penalty Grant training session on May 1, 2018.

Leadership | *Contact Us*

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
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