



Governor's Office – Division of Medicaid (328-00)

The Mississippi Division of Medicaid in the Office of the Governor (DOM) is a state and federally funded program that pays for health care services provided to eligible beneficiaries. Approximately one quarter of Mississippi's population is enrolled in Medicaid and the Children's Health Insurance Program (CHIP). As of June 2026, enrollment in the two programs totaled 694,432, a decrease of 1.1% compared to June 2025. DOM's annual expenditures are highly contingent upon enrollment, utilization trends, reimbursement rates, and changes to state and federal laws and regulations.

Total expenditures are currently projected to be \$9,411,137,052, and the total direct state support request for FY2028 is \$1,348,784,459. There is no projected carry forward of cash into FY2028. DOM carried \$27,790,101 million into FY2027 from FY2026. DOM anticipates using up the cash balance during FY2027 and is expecting a shortfall of state funding of \$34,216,337. Because state funds are used to match federal funds, the shortfall of state funds will create a total spending shortage of over \$150 million.

Medicaid has worked with its contracted actuary to provide the best estimate of expenditures available at this time. The estimate for FY2027 and the request for FY2028 include fluctuations in costs due to utilization of services and membership levels. These expenditures attempt to account for:

- Medicaid enrollment changes;
- Changes in capitation rates for managed care enrollees;
- Changes in pharmacy benefit costs;
- Changes in service utilization per member;
- Changes in provider reimbursement caused by Medicare rates, federal and state policy, and other factors impacting healthcare; and
- Changes to Medicaid benefits and reimbursement methodology.

The budget projection will be updated in December 2026 and again in March 2027. New data, changes due to eligibility projections and federal and state mandates will be incorporated into those projections as they can be reasonably estimated. The direct state support changes, as reported in the budget submission, are summarized by program area and shown in the table to the right.

Change in State Support	2027 to 2028
Administrative Services	\$ 7,763,675
Medical Services	159,232,152
CHIP	1,169,087
Home & Community Based Services	10,522,730
Total Change Amount	\$ 178,687,644

Administrative services expenditures represent less than 3% of the total agency support spending projection. The state share need for administrative spending is \$91 million, and the total state share need for medical expenditures is \$1,258.7 million. The direct state support need is \$1,348,784,459, which is an increase of \$178.7 million over the projection for FY2027.

Summary of Significant Changes

New CMS Regulations

In calendar year 2024, CMS finalized rule changes that will reshape the federal regulatory landscape for Medicaid and CHIP. These proposed rule changes have implementation requirements beginning in FY2024 and extending up to seven years after. In calendar year 2025, the Working Families Tax Cut (WFTC) legislation contained even more widespread changes for Medicaid. DOM is responsible for tracking and implementing these changes. DOM is working to incorporate the new regulations into a roadmap for the agency. These regulations will impact payment methodologies, state directed payments, provider assessments, waiver and nursing facility provider requirements and require increased oversight of access to care. Links to the most significant rule changes are below:

Working Families Tax Cut Legislation: <https://www.medicaid.gov/resources-for-states/working-families-tax-cut-legislation>

Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F): <https://www.cms.gov/newsroom/fact-sheets/medicaid-and-childrens-health-insurance-program-managed-care-access-finance-and-quality-final-rule>

CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F): <https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f>

Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule (CMS 3442-F): <https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-minimum-staffing-standards-long-term-care-facilities-and-medicaid-0>

Administrative Simplification; Adoption of Standards for Health Care Claims Attachments Transactions and Electronic Signatures Final Rule (CMS-0053-F): <https://www.cms.gov/newsroom/fact-sheets/administrative-simplification-adoption-standards-health-care-claims-attachments-transactions>

2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule (CMS-0062-P): <https://www.cms.gov/newsroom/fact-sheets/2026-cms-interoperability-standards-prior-authorization-drugs-proposed-rule>

Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes Proposed Rule (CMS-2452-P): <https://www.cms.gov/newsroom/fact-sheets/amending-indirect-hold-harmless-threshold-health-care-related-taxes-proposed-rule-cms-2452-p>

State Directed Payments

WFTC legislation included limitations on state directed payments. While the limitations imposed on expansion states are more severe, the legislation does limit the total rate of payment that can be used for state directed payments to 110% of Medicare for non-expansion states. As required in the legislation, the reduction of those payment rates will begin in state fiscal year 2029 and will step down gradually over several years. This is expected to impact hospital, emergency ambulance and physician directed payment programs.

HCBS Waiver Rate Increase

During Fiscal Year 2025, DOM performed a rate study for all waiver services. This study involved a workgroup comprised of DOM staff and a variety of providers of both agency-directed and beneficiary-directed HCBS services across the state. A rate increase was implemented in January 2026 at the request of Legislative leadership. Due to current budget constraints, a waiver rate increase is not included in the 2028 budget request, although a rate increase was calculated by the actuaries to keep track with economic factors. The expected increase would have been an additional 2.7% in total expenditures for HCBS annually. This amount will be further refined in the December update of total projected expenditures, but it is currently expected to cost an additional \$29 million. The state share of that increase would be \$6.5 million and would be allocated across the three agencies that pay the state share for waiver expenditures – DOM, MS Department of Rehabilitation Services and the MS Department of Mental Health (MDMH). Additionally, DOM received a recommendation from the Long-Term Care Ombudsman at the MS Department of Human Services to increase the Personal Needs Allowance. The rate was last increased in 1998 – over 25 years ago. This change would increase Medicaid's total cost by \$2.3 million annually, \$.5 million in state share funding. These two changes are **not** included in the FY2028 request due to the expected budget shortfall in FY2027. DOM hopes to discuss these funding needs with Legislative leadership during the 2027 session.

This budget request **does** include an increase of \$4.4 million for an increase of 200 funded slots for the ID/DD waiver for FY2028. The state share of that spending is \$1 million, and it will be funded by MDMH.

Quality Strategy

In accordance with 42 C.F.R. § 438.340, DOM must revise its Comprehensive Quality Strategy every three years. The latest update was issued for 2026-2029:

https://medicaid.ms.gov/wp-content/uploads/2026/06/2026-MS-Managed-Care-Quality-Strategy-v10_FINAL.pdf. The Comprehensive Quality Strategy (CQS) reflects many ongoing and planned quality improvement efforts within the managed care and fee-for-delivery systems. See this page for all quality initiatives: <https://medicaid.ms.gov/value-based-incentives/>. The COVID-19 pandemic and sweeping federal changes have caused a dramatic upheaval over the past several years, but it has not diminished the importance of fidelity to high-quality care practices. As Mississippi's largest payer of health care services, DOM recognizes that it is uniquely positioned to drive positive change in the healthcare market. The CQS creates one overarching quality improvement strategy and provides an opportunity to connect the numerous quality improvement efforts occurring throughout DOM and move toward coordination of all initiatives under a more unified approach. The CQS also presents an overview of the different methods DOM uses to assess the performance of Mississippi's Medicaid programs, including program improvement activities, performance results, successes, and opportunities for advancement.

High-Cost Drug Risk Corridor

With CMS approval, DOM can implement an annual risk corridor to address the uncertainty of certain medical costs. The Managed Care Organization (MCO) capitation rates reflect a target medical loss ratio (MLR), which measures the projected medical service costs as a percentage of the total MCO capitation rates. Beginning in FY2024, DOM requested to add a high-cost drug risk corridor to its managed care contract rates. This will be a two-sided risk corridor protecting both DOM and the MCOs from large losses or gains due to the cost of new pharmaceuticals that can total over \$2 million per dose. In FY2027 and 2028, DOM expects to retain the high-cost risk corridor.

Pharmacy Benefit Administrator

The vendor operating as DOM's fiscal agent took over as the single Pharmacy Benefit Administrator (PBA) for DOM on July 1, 2024. DOM expects a single PBA, rather than one for each of the managed care organizations, to consolidate Medicaid pharmacy claim processing for efficient, consistent, and transparent operations at a lower cost to the state. Prior to this change, each of the three managed care organizations had their own Pharmacy Benefit Management (PBM) contracts. Having multiple PBMs increased costs for DOM and required pharmacies to submit claims to multiple organizations for Medicaid beneficiaries. This change has streamlined the submission of claims for pharmacies. DOM continues to monitor utilization and costs in relation to the change in pharmacy administration.

Data Storage and Systems

The Division of Medicaid is undertaking a comprehensive enterprise transformation that modernizes how Medicaid services are delivered to beneficiaries, providers, and agency staff. These initiatives include modernizing core eligibility and Medicaid Management Information System capabilities, implementing an enterprise operational data store and interoperability platform, expanding secure digital identity management, strengthening cybersecurity and system observability, and deploying standards-based Application Programming Interfaces (API) that improve data sharing across the healthcare and state government ecosystem. Several of these initiatives are driven by federal requirements, including the CMS Interoperability and Prior Authorization Final Rules (CMS_9115-F, CMS-0057-F, CMS-0062-P, CMS-0053-F), WFTC legislation, 2023 Consolidated Appropriation Act, etc. which requires implementation of Patient Access, Provider Access, Payer-to-Payer, Provider Directory, and Prior Authorization APIs using HL7® FHIR® standards. Additional modernization efforts support compliance with HIPAA transaction standards, CMS Medicaid Enterprise System (MES) guidance, MARS-E/ARC-AMPE security requirements, and evolving CMS expectations for modular, interoperable, cloud-based Medicaid systems.

Collectively, these transformation efforts will create a more connected, secure, and data-driven Medicaid enterprise that improves the experience of both beneficiaries and providers. Beneficiaries will benefit from faster access to healthcare information, more streamlined enrollment and identity verification processes, improved care coordination, greater transparency into prior authorization decisions, and more timely delivery of services. Providers will experience simplified interactions with the agency through modern digital portals, reduced administrative burden, faster access to eligibility and claims information, improved interoperability with electronic health records, and more efficient prior authorization workflows. At the same time, the agency will gain enhanced analytics, stronger program integrity capabilities, real-time performance monitoring, improved cybersecurity, and the flexibility to adapt more rapidly to future federal requirements and changing healthcare needs, ultimately resulting in a more efficient, responsive, and sustainable Medicaid program for the citizens of Mississippi.

Medicaid Modernized Eligibility Determination System (MEDS)

Medicaid's legacy Eligibility Determination System (MEDS) has undergone an extensive modernization effort that began many years ago. This multi-year effort allowed DOM to accommodate changes to eligible populations as those were required, to meet the many changing eligibility requirements during the COVID-19 pandemic and public health emergency, and to update the technology and security structure supporting the system. The modernized system integrates all Medicaid-eligible populations for processing through one system, provides an online, streamlined application via a common web portal (CWP)

that will allow Mississippians to apply for Medicaid, CHIP, SNAP, TANF and other social services programs in one place, and a common fraud and abuse platform that will perform enhanced verifications for eligibility, identity and assets and identity authentication. Upgrades to the current infrastructure and security posture began in FY2025 and will continue into FY2027. Enhancements to workflow and internal processes will also carry on into the coming fiscal years. DOM expects to continue to see changes to eligibility requirements from the federal level in the coming years and will keep working toward efficiencies in the eligibility determination process. This budget request includes costs in FY2028 to move the system to a cloud-based infrastructure.

MississippiCAN and CHIP Contracts

On July 1, 2025, the new managed care and CHIP contracts became operational. This is the first time DOM will have vendors administering both MississippiCAN and CHIP services jointly, with the aim of easing administrative burden for both providers and members. Magnolia Health, Molina and TrueCare were the winning offerors, and they will be responsible for both programs, including any differences in the regulations and requirements governing each. Management of the managed care and CHIP contract requirements, continued contractor performance monitoring, and financial oversight remains a focus area for the agency. There are multiple oversight tasks performed by DOM staff and contractors - quarterly management meetings, monthly executive meetings, External Quality Review Organization reporting, Medical Loss Ratio (MLR) reporting, MLR audit, administrative cost audit, encounter data completion reviews, and many other contract requirement monitoring checkpoints.

The managed care organizations are reimbursed on a per member per month amount, or capitation rate, for each Medicaid or CHIP member in their plan. Section 1903(m) of the Social Security Act and 42 CFR §438.4 require that these capitation rates be actuarially sound, meaning that the capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the annual contract period and the population covered under the terms of the contract. A contracted actuary sets capitation rates annually.

Managed care capitation payments make up approximately 50% of the yearly Medicaid medical expenditures and about 70% of the population. The majority of these payments must be used to reimburse providers for medical services provided to Medicaid members.

Graduate Medical Education/Indirect Medical Education (GME/IME)

GME is expected to increase by \$5.9 million in total. The increase in direct state support is \$673,631.

Transforming Maternal Health (TMaH) Grant

The Mississippi Division of Medicaid was awarded funding under the CMS TMaH (Transforming Maternal Health) Model beginning January 2025. The grant is \$17 million and will run for 10 years (2025-2034). DOM is coordinating with the MS Department of Health, the managed care organizations, and various provider groups in the state.

The TMaH model supports participating state Medicaid agencies in the development of a whole-person approach to pregnancy, childbirth, and postpartum care. By addressing the physical, mental health, and social needs experienced during pregnancy, the model aims to improve outcomes and experiences for mothers and babies while also reducing overall expenditures. TMaH funds will be used for maternal health initiatives such as remote patient monitoring for high-risk pregnancies, data infrastructure for reporting performance, and provider incentives for participation in the payment model.

Cell and Gene Therapy (CGT) Access Model

The Cell and Gene Therapy (CGT) Access Model is a multi-year model for states and manufacturers to test whether a CMS-led approach to developing and administering outcomes-based agreements for CGTs increases Medicaid members' access to innovative treatments, improves their health outcomes, and reduces health care costs and burden to state Medicaid programs.

The initial focus of the model is on CGTs for sickle cell disease. DOM began participating in the CGT Access Model on January 1, 2026. In addition to participation in the CMS negotiated agreements, DOM was also awarded CGT Access Model Cooperative Agreement funding for calendar years 2026-2030 to:

- Create dedicated patient support roles to guide and support members throughout their gene therapy treatment journey; and
- Partner with a community-based organization to:
 - Expand, and not duplicate or replace, transportation and travel-related support, including lodging and meals, for members and their caregivers;
 - Connect patients and caregivers in the Model to subsidized childcare from licensed providers; and
 - Develop and launch educational and awareness efforts for members, providers, and local communities about sickle cell disease, cell and gene therapies, and supportive services available.

HB 565 Jill's Law – Biomarker Coverage

House Bill 565 of the 2026 Regular Session required DOM to offer coverage for biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition when use of the test is supported by medical and scientific evidence. A cost increase of \$15.7 million (\$3.6 million in state funds)

was included in the FY2027 and FY2028 projections. However, future utilization, pricing for codes, and development of new tests is highly unpredictable. DOM looks at these estimates with a degree of caution and will monitor costs resulting from this bill.

Cost Saving Strategies

DOM has launched several new initiatives aimed at decreasing agency costs and ensuring the highest level of payment integrity:

- DOM has expanded Long Term Care facility audits from 10% of facilities to 50% through two audit contracts.
- A fraud, waste and abuse analytics system has been procured and will be fully implemented by the end of FY2027.
- A 5-year contract for an annual comprehensive audit of DOM's Pharmacy Benefit Administrator has been executed.
- A 5-year contract for an annual audit of claims paid by DOM's fiscal agent will be procured in the next several months.
- DOM performs annual audits on MCO reported administrative costs to ensure proper capitation rate setting.
- DOM reduced the margin percentage in MCO capitation payments from 1.8% to 1.5% for FY2027.
- DOM has undertaken a comprehensive review of prior authorizations, claims edits, and claims audits to ensure that state plan and administrative code requirements are included in claims adjudication.

Budget Category Request Totals by Program

The Medicaid budget request is organized by four program areas, Administrative Services, Medical Services, CHIP and Home and Community Based Services. Narratives explaining key areas and changes in funding needs for FY2028 are addressed for each program within this budget request submission. A summary of program-area narratives and decision units contributing to the total funding changes are below.

Table 1 Source: MBR-1 Funding Data

BUDGET TO BE FUNDED	ACTUAL 2026	ESTIMATE 2027	REQUEST 2028	OVER/(UNDER)	NOTE
CASH BAL	228,649,997	27,790,101	0	(27,790,101)	(1), (2)
GEN FUND	906,639,774	1,026,866,812	1,285,554,456	258,687,644	(2)
STATE SUPP	98,230,003	143,230,003	63,230,003	(80,000,000)	(2)
FED	6,303,320,797	6,832,216,292	7,269,762,049	437,545,757	(3)
ST AGENCY	130,434,348	127,012,498	127,951,312	938,814	
PROV TAXES	627,486,429	652,890,780	664,639,232	11,748,452	(4)
CASH	(27,790,101)				
TOTAL FUNDS	8,266,971,247	8,810,006,486	9,411,137,052	601,130,566	

NOTES:

- (1) The cash balance brought forward from FY2026 into 2027 will be spent during FY2027. This creates the difference of (\$27.8) million between FY2027 and FY2028. It also creates the need in 2028 for an increased need for general funds to continue to pay providers at level rates.
- (2) There is an expected increase in total spending of \$601.1 million, or 6.8%. However, because of the spend down of cash balance and because FY2027 is underfunded by the state by an expected \$34.2 million, the increase in the state support need is 15.3% or \$178.7 million. The increase in state expenditures is made up of \$7.8M in Administration, \$516.9M in Medical Services, \$52.9 million in HCBS, and \$7.8 in CHIP.
- (3) The federal spending increase is 6.4% or \$437.5 million and is made up of an increase in Administrative Services of \$15.7 million, \$373.7 million for Medical Services, \$6.7 million for CHIP, and \$41.4 million for HCBS.
- (4) Provider taxes are dependent on the supplemental and directed payments paid to the providers as well as the FMAP in place for the period of the payment. This increase in funding would be used to directly fund the state share of payments to hospitals or emergency ambulance providers.

Administrative Services

Salaries

DOM is requesting an increase of \$9,309,711 in total costs for salaries in FY2028. The request for state funding for salaries increase is \$3,723,885. \$1,071,339 of the increase is for salary progression, \$82,829 is for new positions and \$2,569,716 is for vacancy funding.

Headcount: There are 3 new positions requested for a state funding increase of \$185,418: two Auditor IIs and one Auditor III to assist DOM with compliance in federal and state regulations. These positions will become more important as CMS regulations become effective over the next several years. The state share of this cost is \$82,829. Details of this request are included on the SPB BR form and have also been submitted to SPB.

Salary Progression: Salary progression changes are requested for most employees for a total state funding increase of \$1,071,340. Salary progression helps with retention of trained staff and is representative of the ability of knowledgeable staff to perform at a higher level than new staff. The agency is implementing a merit pay system and requests this funding to support that system. Details of this request are included on the SPB BR form and have also been submitted to SPB.

Vacancy Funding: Additional funding is requested for the vacancies expected during FY2028. This request represents full funding of vacant positions at an average salary of approximately \$51,000. An increase of state funding of \$2,569,716 is requested in vacancy funding to ensure funding for additional employees is available. This is for 99 vacancies. Details of this request are included on the SPB BR form and have also been submitted to SPB.

Travel

DOM is requesting an increase of \$4,600 in total costs for travel in FY2028. The total travel budget request of \$495,504 is a very small part of the administrative budget request, less than 0.1%. The Travel category represents \$198,202 in state support spending. Travel funding is needed and used for a wide range of oversight, training and compliance responsibilities, many of which are mandated by CMS, such as auditing facilities and providers, providing service support to our regional offices, reviewing facilities for compliance and rate setting purposes (performed by specialized staff such as nurses and social workers), conducting unannounced provider site visits, and training for staff to meet

the administrative and regulatory requirements of the ever-changing Medicaid environment.

Contractual Services

DOM is requesting an increase of \$14,520,173 in total costs for contractual services in FY2028. Contractual services is the largest administrative expense category for DOM. All services are eligible for federal match of at least 50%. DOM maximizes the federal match funding to the full extent of the law and overall expects federal funding to cover approximately 71% of our contractual spending. Federal funding is contingent on availability of the state match. DOM requests \$61,784,537 in state funding for 2028 contractual spending to be matched with \$151,265,593 in federal funding. DOM's contractual services spending ensures fiscal agent services for paying claims, our reporting system, our workforce, location leases for our regional offices and various contractors to help with administration and oversight of the program. Additionally, we have included in our request the funding needs for the continued procurement and establishment of new systems to comply with CMS requirements which are necessary to receive continued federal funding.

Commodities

DOM is requesting an increase of \$4,200 in total costs for commodities in 2028. The commodities budget is \$521,250 of our total 2028 request, with the state share request of \$260,625 making up half.

Equipment

DOM is requesting a decrease of \$350,000 in total costs for equipment in 2028. This represents \$175,000 less in state funds than the agency is expecting to spend in 2027.

Vehicles

DOM is requesting the same amount for vehicle costs in FY2028 as in 2028 to replace 1 vehicle each year. During FY2026 and 2027, DOM decommissioned a total of 4 vehicles and only expects to need replacement of 2 vehicles during 2027 and 2028. Fleet purchases, service, and maintenance costs are more efficient when compared to the cost of mileage reimbursement for employees using their personal vehicles for work-related travel. DOM maintains all vehicles in strict accordance with DFA's rules and best practices. Though not strictly required to retire vehicles at 120,000 miles, DOM evaluates the working condition of all vehicles upon reaching 120,000 miles and usually keeps the vehicles in working order much longer.

Wireless Communication Devices

DOM is not requesting any funding for wireless communication devices in 2028.

Program Management: There is a net decrease in administrative costs for travel, commodities, and equipment related to general program management. The total state share decrease is (\$178,989).

LTC Facility Audit Contract: DOM has planned an expansion of the number of audits performed on long term care facility cost reports.

EQRO Contract Requirements: DOM must meet new CMS requirements for reviews of Managed Care contractors by External Quality Review Organization.

UMQIO Contract: DOM's contract for a Utilization Management/Quality Initiative Organization includes annual increases in costs.

Cloud Services - Eligibility: DOM estimates an increase in costs as the Eligibility and Enrollment system is migrated to the cloud.

Cloud Services – Infrastructure: DOM estimates an increase in costs as various infrastructure systems are migrated to the cloud.

MCO Oversight: DOM anticipates an increase in costs for actuarial and accounting contract costs due to new CMS requirements for managed care oversight and changes in managed care directed payment structures.

MMIS Contract: DOM anticipates an annual increase in contractual costs for the Fiscal Agent contract for system updates and enhancements.

LTSS Contract: DOM anticipates an annual increase in contractual costs for the Long Term Services and Supports system which includes updates and enhancements.

Medical Services

Subsidies, Loans & Grants

DOM is requesting an increase of \$516,864,156 in total costs in FY2028 which is an increase in direct state support of \$159,232,152, an increase in federal funds of \$373,737,156 and a decrease in special funds of \$16,105,155. These funding changes are explained below:

FMAP Increase: The blended FMAP is projected to increase from .7722 in fiscal year 2027 to .7727 in fiscal year 2028. With the increase in federal funding, there is a decrease in the state general fund support needed.

Enrollment Mix Trend: Changes in Medicaid enrollment levels and population mix over time account for changes in total enrollment as well as differing service utilization patterns. There is an expected increase of 1.4% from FY27 to FY28 due to enrollment.

Utilization Trend: Utilization trends are calculated using the number and intensity of services the average person eligible for Medicaid tends to use over time. The utilization trend expected for Medical Services from FY27 to FY28 is an increase of 1.7%.

Cost Trend: Cost trends are calculated using the annualized provider reimbursement trends for each category of service and expected impacts on capitation services. The cost trend from 2027 to 2028 is an increase of 1.6%.

Program Changes: Program changes are changes to payment policy and/or rates. The \$6 million increase from FY2027 to FY2028 is for an annual increase in payments for out of state Psychiatric Residential Treatment Facility services. These services are largely needed for youths under the care of the MS Department of Child Protection Services.

One-Time Payments: One-time payments are payments that only happen in 2027 or 2028 and create an increase or decrease in overall expenditures in the following year. The following adjustments are projected to impact 2028 expenditures: Capitation Rate adjustment for prior period (22.7) million, MHAP payments for FY2027 held for reconciliation purposes to FY2028 134.4 million, Quality Withhold payments 1.4 million, Managed Care Pharmacy Premium Tax 1.5 million, retroactive membership changes to capitation payments 9.8 million, MCO VBP payments (3.9) million, MOMS Directed Payment (3.8) million, managed care APC Opt-out payment .3 million, high cost pharmacy risk corridor payments 9.8 million, program wide risk corridor payments (1.8) million, and state-owned facility cost settlements 13.7 million. The total impact on SFY2028 projection is an increase of 138.7 million.

Graduate Medical Education: Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) payments made to support teaching hospitals. The state share of GME payments is paid by General Fund appropriation. IME is only paid to governmental teaching hospitals, and the state share is provided by those facilities.

Medicare Premiums (Parts A, B and D): These expenditures are driven by the number of dually eligible participants and the premium rates charged by CMS. DOM pays premiums and providers bill Medicare as the primary payer for eligible services; this reimbursement is known as Part A and Part B. States are required to reimburse the federal government a

percentage of the savings realized by the state for dual eligibles that participate in Medicare's Part D prescription drug program; this reimbursement is referred to as Clawback or Part D. Increases in Parts A, B and D result from projected increases in enrollment and premium trends. DOM expects expenditures to increase from FY27 to FY28 by \$31 million. Just over half of the increase is expected to come from Part D which is paid from 100% state funds. The rates for Parts A, B and D are set by CMS.

DSH/UPL Increase: DSH, UPL and other Supplemental payments are expected to increase in 2028 compared to 2027. The increase of \$30.7 million is largely based on a projected increase in expenditures of 5%.

Out of State Pediatric Hospital Payment: In fiscal year 2026, a new payment to an out of state teaching hospital was created by legislative action. The state share of the payment is expected to be provided by a community college.

CHIP

Subsidies, Loans & Grants

DOM is requesting an increase of \$7,834,036 in total costs in FY2028. This will be an increase in state funding of \$1,169,087 and an increase in federal funding of \$6,664,949. The changes in funding are explained below:

FMAP Decrease: The blended FMAP for CHIP is projected to increase from .8405 in fiscal year 2027 to .8409 in fiscal year 2028. With the increase in federal funding, there is a decrease in the state general fund support needed.

Enrollment Mix Trend: Enrollment trends are calculated using the number and intensity of services the average person eligible for Medicaid tends to use over time. The utilization trend expected for CHIP from FY27 to FY28 is an increase of 1.7%.

Utilization Trend: Utilization trends are calculated using the amount of services the average person eligible for CHIP tends to use over time. These trends account for expected change in the quantity of services utilized as well as changes in the average intensity of services reimbursed. The utilization trend for CHIP from FY27 to FY28 is an increase of 1.6%.

Cost Trend: Cost trends are calculated using the annualized provider reimbursement trends for each category of service and expected impacts on capitation services. The unit cost trends were updated based on pharmacy services, physician, and other medical services. The cost trend for CHIP from FY27 to FY28 is an increase of 0.1%.

One-Time Payments: Risk corridor recoupments and rate change adjustments are expected to cause a reduction in CHIP spending in FY28.

HCBS

Subsidies, Loans & Grants

DOM is requesting an increase of \$52,943,693 in total costs in FY2028 which is an increase in general funds of \$10,522,730, an increase in federal funding of \$41,418,643, and an increase in funding from other state agencies of \$1,002,320. The changes in funding are explained below:

FMAP Decrease: The blended FMAP is projected to increase from .7722 in fiscal year 2027 to .7727 in fiscal year 2028. With the increase in federal funding, there is a decrease in the state general fund support needed.

Enrollment Mix Trend: Changes in Medicaid enrollment levels and population mix over time account for changes in total enrollment as well as differing service utilization patterns. There is an expected increase of 1.7% in enrollment from FY27 to FY28.

Utilization Trend: Utilization trends are calculated using the number of services the average person eligible for Medicaid tends to use over time. The trend expected for HCBS from FY27 to FY28 is an increase of 1.6% in utilization of services.

Program Change: There is an expected request for an increase of 200 in funded slots for the ID/DD waiver operated by the MS Department of Mental Health.

Federal Funding Rates

Expenditures are eligible for federal matching funds at varying levels. All expenditures and match rates are approved by CMS through varying types of requests – Cost Allocation Plan, Medicaid State Plan, Waivers, Advanced Planning Documents, Managed Care contracts, and State Directed Payment requests. See federal match rates in the table below:

General Expenditure Category	Federal Matching Rate
General Administrative Expenditures	50%
Eligibility Workers	75%
Skilled Professional Medical Personnel	75%
Certain information technology administration	75%
Certain information technology administration	90%
Pre-Admission screening administration	75%
Quality Improvement Organization administration	75%
General Medical Services	FMAP
Certain Waiver Expenditures	90%
CHIP medical services and administration	Enhanced FMAP
Indian Health Services	100%
Breast and Cervical Cancer Medical Services	Enhanced FMAP
State-Only Programs	0%

The Federal Medical Assistance Percentage (FMAP) and enhanced FMAP rates applicable to this budget request are as follows:

	Federal Fiscal Year 2025	Federal Fiscal Year 2026	Federal Fiscal Year 2027	Federal Fiscal Year 2028 (Preliminary)
FMAP	76.90%	76.90%	77.32%	77.25%
Enhanced FMAP (CHIP)	83.83%	83.83%	84.12%	84.08%
State Fiscal Year Blended FMAPs				
	2026	2027	2028	
Blended FMAP used in Budget Calculations	76.90%	77.22%	77.27%	

The FMAP rates are blended for budget purposes by reflecting the rate applicable to each quarter. For example: DOM uses 25% of the FMAP that ends September 30 and 75% of the FMAP that starts October 1 of each year to create a blended rate for the state fiscal year.



MISSISSIPPI DIVISION OF
MEDICAID

Legislative Budget Office (LBO) Report

June 2026



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The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians.

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MONTHLY EXPENDITURE OVERVIEW

Expenditure amounts are presented on a cash basis. Medical service and administrative expenditures reflect the date of payment rather than the date goods or services are received.

See **Appendices A-D** for more detail on expenditures.

YTD Medicaid Expenditures

FY26: \$5,997,308,558

FY25: \$5,744,241,047

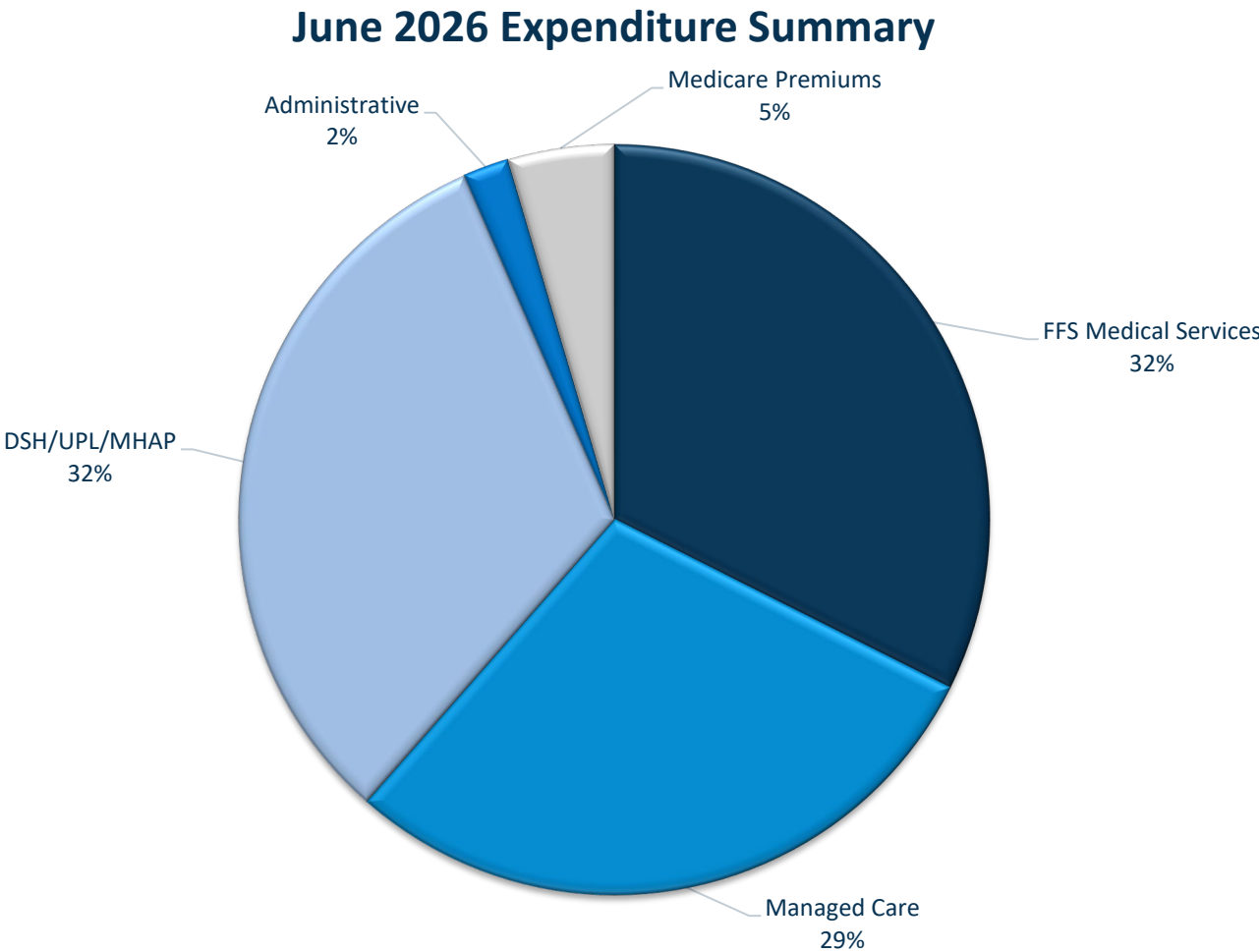
\$253,067,512

Medicaid Beneficiaries

June 2026: 641,565

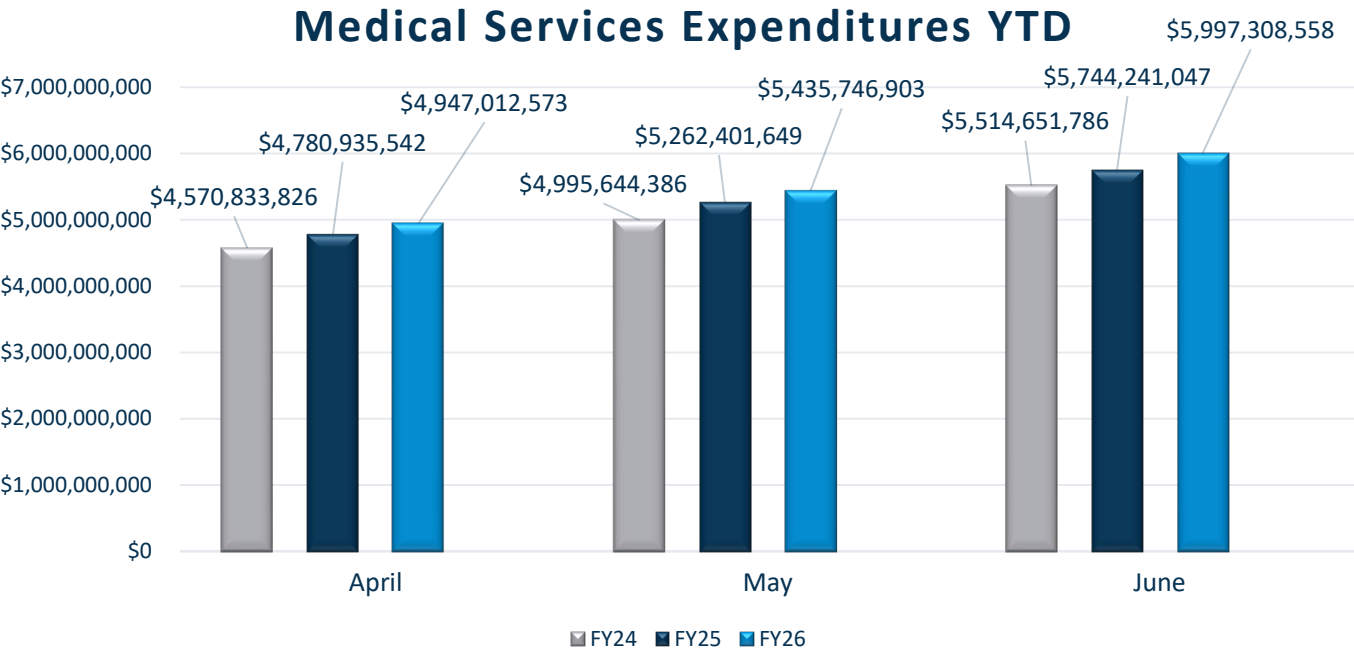
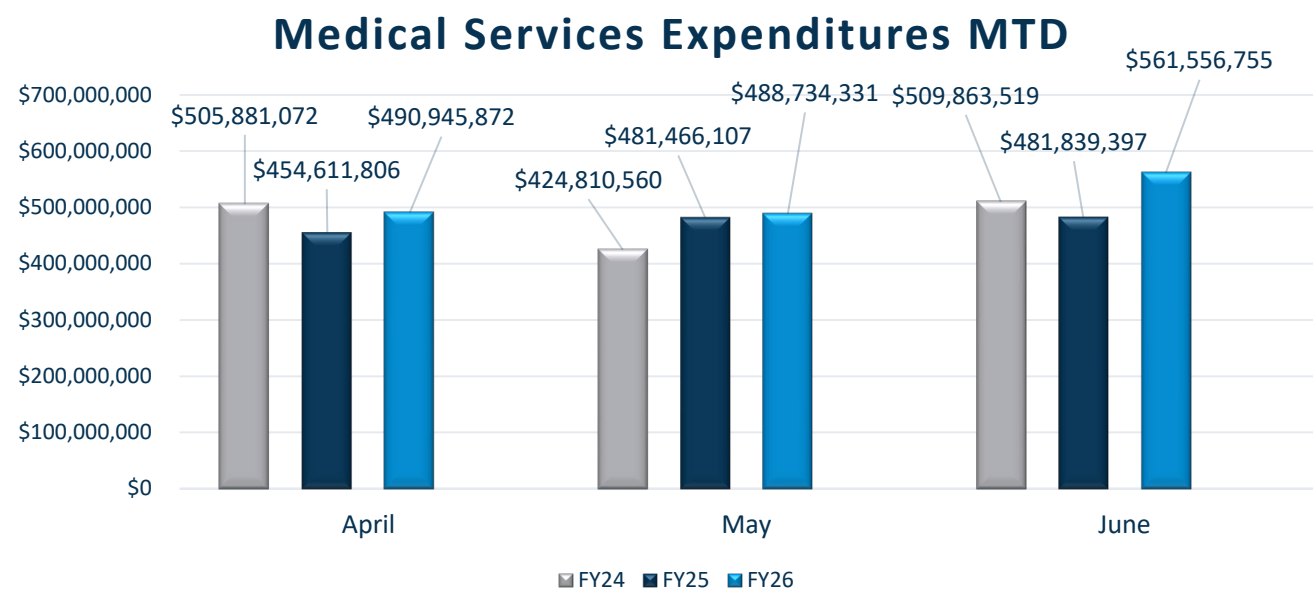
June 2025: 649,345

-7,780



MEDICAL SERVICE EXPENDITURES

The bar graphs below compare just the medical service expenditures compared to the previous three fiscal years, and in relation to the two preceding months, by month to date (MTD) and year to date (YTD).



Weekly medical claims cycles are reported each Monday. Months that include five Mondays include an extra claims cycle which will inflate medical service expenditures for these months.

MONTHLY MEDICAID ENROLLMENT

The line graph below highlights the monthly enrollment of Medicaid beneficiaries (excluding CHIP) over the past 12-month period from July 2025 to June 2026. See **Appendix E** for more details.

Medicaid Beneficiaries

June 2026: 641,565

June 2025: 649,345

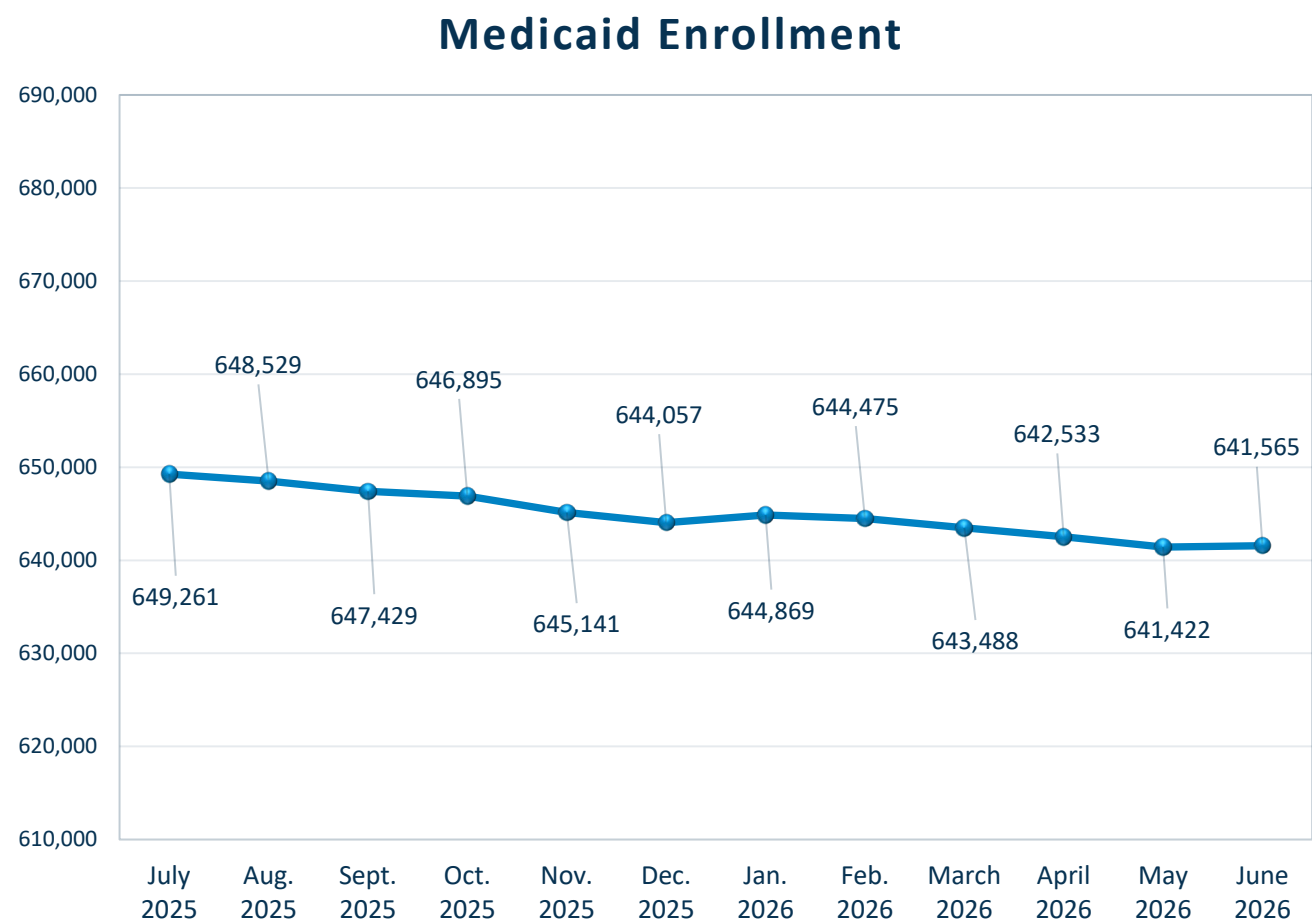
-7,780

Medicaid & CHIP Beneficiaries

June 2026: 694,432

June 2025: 702,143

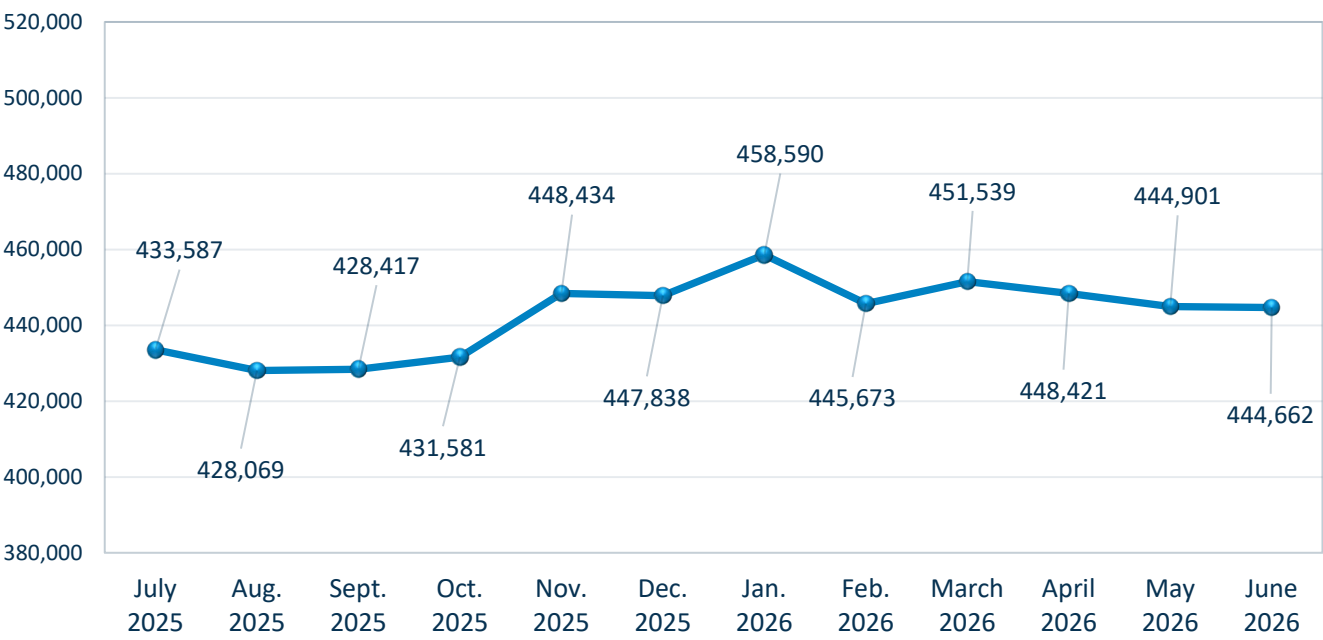
-7,711



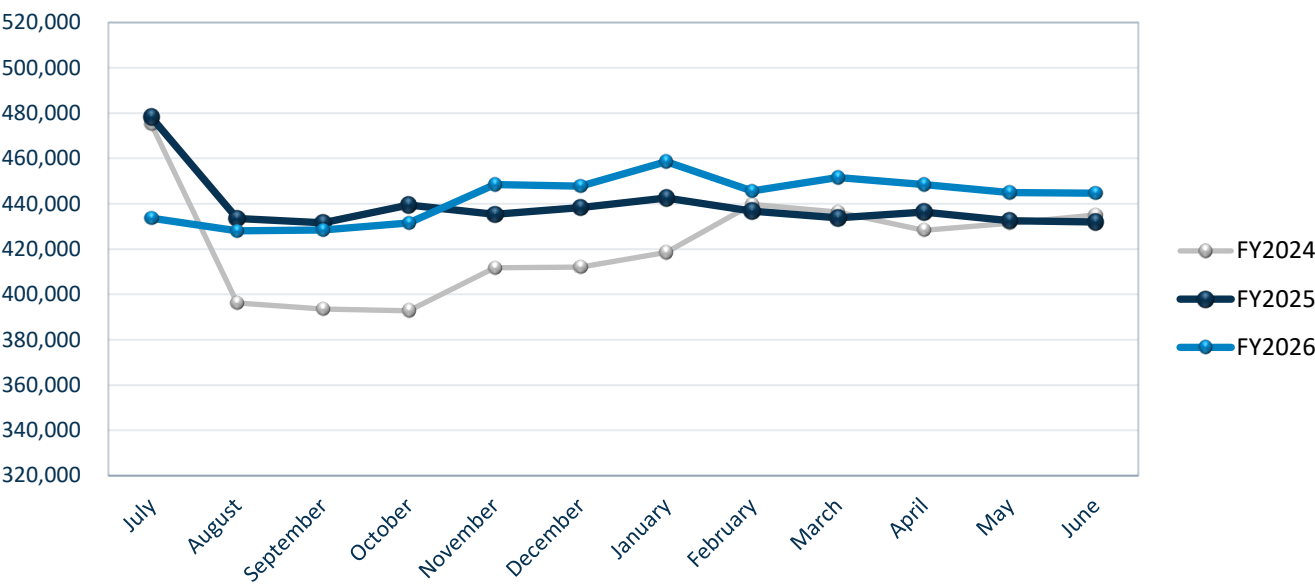
MISSISSIPPICAN OVERVIEW

The line graph below highlights the monthly enrollment of MSCAN beneficiaries over the past 12-month period. See **Appendix G** for data on capitation payments and provider expenditures.

MississippiCAN Population



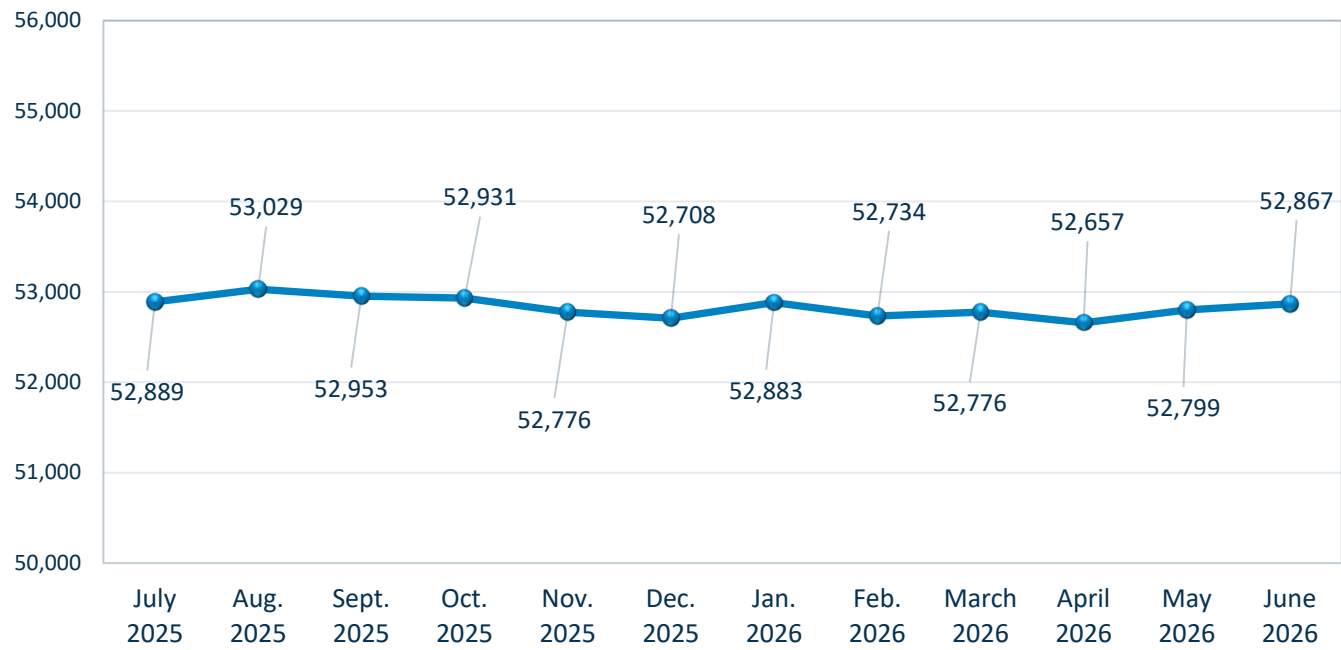
MississippiCAN Population by Fiscal Year



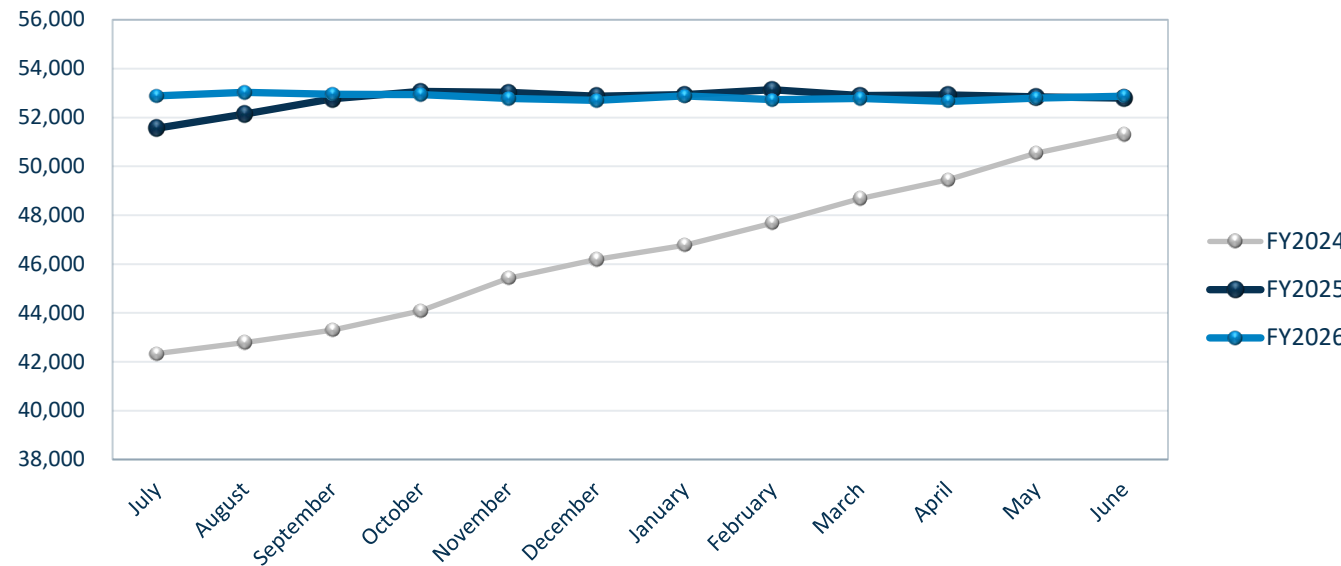
CHIP OVERVIEW

The line graph below highlights the monthly enrollment of CHIP beneficiaries over the past 12-month period. See **Appendix H** for data on capitation payments and provider expenditures.

Mississippi CHIP Population



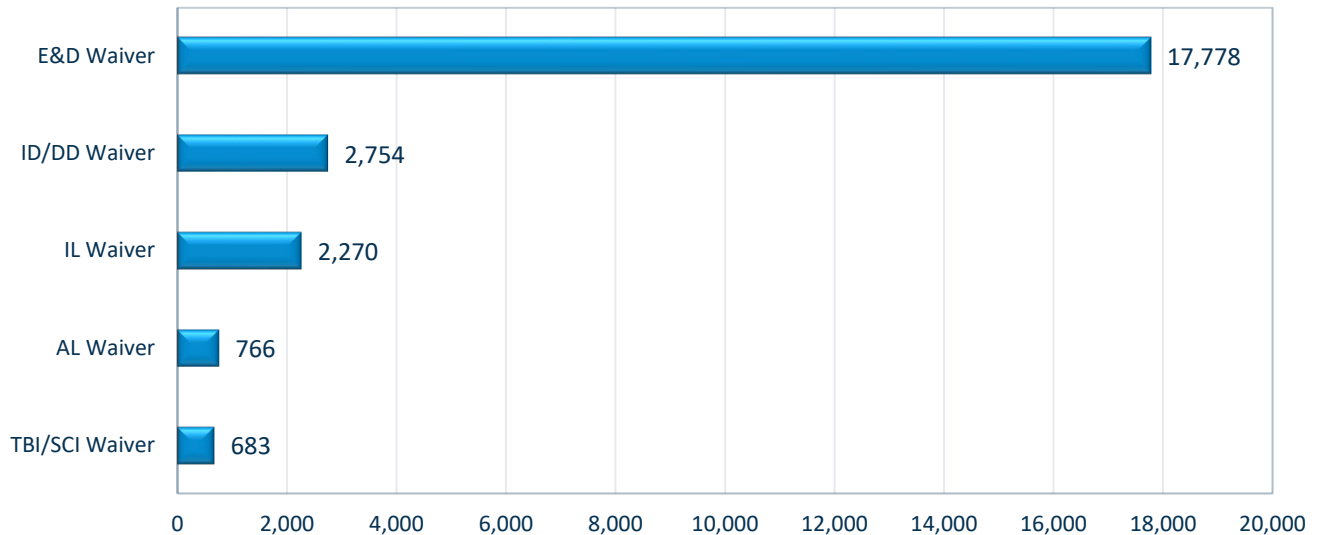
Mississippi CHIP Population by Fiscal Year



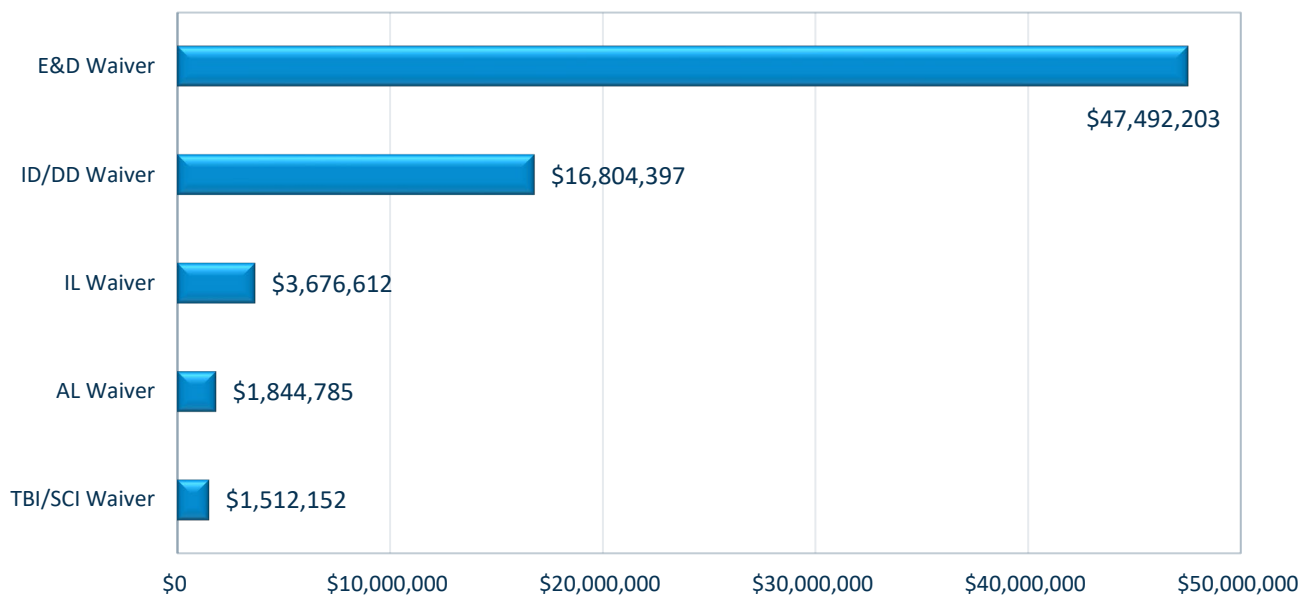
HOME AND COMMUNITY BASED SERVICES OVERVIEW

The bar graphs below show May expenditures for Home and Community Based Services (HCBS) and the number of waiver participants for the month. Because there is a one-month delay in reporting data for waivers, June figures will appear in the July report. See **Appendix I** for more details.

Home and Community Based Participants



Home and Community Based Expenditures



APPENDIX: MONTHLY EXPENDITURE DATA

- **Appendix A:** Monthly Legislative Report Notes
- **Appendix B:** Medicaid Expenditure Summary
- **Appendix C:** Monthly Medical Services Comparison
- **Appendix D:** Medical Services Comparison Fiscal Year to Date
- **Appendix E:** Participant Counts
- **Appendix F:** Other Medical Services Comparison Fiscal Year to Date
- **Appendix G:** MississippiCAN Managed Care Summary
- **Appendix H:** Mississippi CHIP Managed Care Summary
- **Appendix I:** Home and Community Based Services Expenditures
- **Appendix J:** Administrative Expenditures Detail and Cash Flow Summary
- **Appendix K:** Supplemental/Directed Payments

Office of the Governor - Division of Medicaid
Monthly Legislative Report Notes
Month Ended June 30, 2026

Appendix A

The expenditure amounts included in this report are presented on a cash basis. Medical service and administrative expenditures reflect the date of payment rather than the date of service or the date goods or services are received. The report reflects all payments made during the reporting period, and will include funds spent from both SFY-25 and SFY-26 budgets.

(Note 1) *Administrative expenditures include agency salaries, fringe, travel, commodities, and equipment. They also include contractual services, which account for approximately 68% of total administrative expenditures. The majority of these contracts are related to the administration and monitoring of the agency's medical service claims payments. Specific planning and implementation administrative expenditures are paid with 90% federal funds. Administrative expenditures related to claims processing, survey and certification activities of long term care facilities, quality improvement organizations, skilled professional medical personnel, eligibility determination personnel, and MMIS personnel are paid with 75% federal funds. The remainder of DOM administrative expenditures are paid with 50% federal funds. Also, the YTD amounts reflected were paid from either the SFY25 or SFY26 budget depending upon when goods and services were received.*

(Note 2) *The public health emergency (PHE) ended on May 11, 2023. The 2023 Consolidated Appropriation Act (CAA) provided an enhanced FMAP step down during calendar year 2023. Specifically, the FMAP increase is scheduled to decline to 5 percentage points for April-June 2023, decline to 2.5 percentage points for July-September 2023 and then fall to 1.5 percentage points for October-December 2023. The CAA also removed the continuous coverage requirement required during the PHE. Disenrollments due to eligibility redeterminations are being processed monthly. The disenrolled members have an additional 90 days to send in their eligibility paperwork and their membership may be retroactively reinstated. After that time, they must reapply for benefits. The Division completed redeterminations for all members in June 2024.*

(Note 3) *The MTD Medical Services expenditures are higher in FY2026 due to processing of SFY2023 and SFY2024 Risk Corridor Recoupments during June of 2025.*

(Note 4) *The MTD and YTD expenditures for DSH/MHAP/UPL/ GME/TREAT increased due to processing of MAPS SFY 2026 Q1-Q3 payments, SFY2025 MAPS reconciliation payments and SFY2024 Risk Corridor payments.*

(Note 5) *Administrative monthly expenditures increased as a result of contractual payments.*

Office of the Governor - Division of Medicaid
Monthly Legislative Report - Medicaid Expenditure Summary
Month Ended June 30, 2026

<u>Medical Service Expenditures</u>	<u>SFY-26</u>	<u>SFY-25</u>	<u>\$ Change</u>	<u>% Change</u>
	<i>Jun-26</i>	<i>Jun-25</i>		
Totals - MTD	\$561,556,755	\$481,839,397	\$79,717,358	16.5% (Note 3)
	<i>July - June 2026</i>	<i>July - June 2025</i>		
Totals - YTD	\$5,997,308,558	\$5,744,241,047	\$253,067,512	4.4%
 <u>Other Medical Service Type Expenditures</u>	 <u>SFY-26</u>	 <u>SFY-25</u>	 <u>\$ Change</u>	 <u>% Change</u>
	<i>Jun-26</i>	<i>Jun-25</i>		
Totals - MTD	\$59,841,736	\$56,246,872	\$3,594,864	6.4%
	<i>July - June 2026</i>	<i>July - June 2025</i>		
Totals - YTD	\$687,962,887	\$644,160,819	\$43,802,067	6.8%
 <u>DSH/MHAP/UPL/GME/TREAT Expenditures</u>	 <u>SFY-26</u>	 <u>SFY-25</u>	 <u>\$ Change</u>	 <u>% Change</u>
	<i>Jun-26</i>	<i>Jun-25</i>		
Totals - MTD	\$300,674,781	\$223,625,177	\$77,049,604	34.5% (Note 4)
	<i>July - June 2026</i>	<i>July - June 2025</i>		
Totals - YTD	\$1,750,051,177	\$1,854,151,944	(\$104,100,768)	-5.6%
 <u>Administrative Expenditures</u>	 <u>SFY-26</u>	 <u>SFY-25</u>	 <u>\$ Change</u>	 <u>% Change</u>
	<i>Jun-26</i>	<i>Jun-25</i>		
Totals - MTD	\$18,714,119	\$15,727,203	\$2,986,915	19.0% (Note 5)
	<i>July - June 2026</i>	<i>July - June 2025</i>		
Totals - YTD	\$198,712,603	\$192,648,363	\$6,064,240	3.1%

***See Monthly Legislative Report Notes on following page.**

DSH - Disproportionate Share Hospital

MHAP - Mississippi Hospital Access Payment

UPL - Upper Payment Limit

GME - Graduate Medical Education

TREAT - Transforming Reimbursement for Emergency Ambulance Transportation

Office of the Governor - Division of Medicaid
Monthly Medical Services Comparison
June 2026 vs June 2025

Appendix C

Service	Jun-26	Jun-25	\$ Change	% Change
Total Expenditures	\$561,556,755	\$481,839,397	\$79,717,358	16.5%
Total Managed Care	256,897,948	161,667,051	95,230,897	58.9%
Total Fee for Service	\$304,658,807	\$320,172,347	(\$15,513,539)	-4.8%
Fee for Service Totals by Service Type				
Inpatient Hospital	\$6,997,155	\$8,077,391	(\$1,080,236)	-13.4%
Outpatient Hospital	\$9,093,267	\$8,835,060	\$258,206	2.9%
Lab and X-Ray	\$264,401	\$502,137	(\$237,736)	-47.3%
Nursing Facility	\$92,654,056	\$92,532,933	\$121,123	0.1%
Physician	\$3,705,224	\$3,685,486	\$19,738	0.5%
Home and Comm. Based	\$95,578,346	\$98,279,325	(\$2,700,979)	-2.7%
Home Health Services	\$117,059	\$121,391	(\$4,332)	-3.6%
Swing Bed Skilled	\$21,597	\$16,539	\$5,058	30.6%
Mental Health Clinic	\$3,131,935	\$3,942,415	(\$810,480)	-20.6%
EPSDT Screening	\$262,386	\$306,904	(\$44,518)	-14.5%
Transportation	\$493,805	\$493,564	\$240	0.0%
Non-Emergency Transport	\$1,698,643	\$3,733,593	(\$2,034,949)	-54.5%
Dental Services	\$176,339	\$323,258	(\$146,919)	-45.4%
Eyeglass Services	\$97,775	\$127,229	(\$29,454)	-23.2%
Pharmacy	\$12,549,805	\$12,261,446	\$288,359	2.4%
Dental Screening	\$140,200	\$338,025	(\$197,825)	-58.5%
Eyeglass Screening	\$29,139	\$76,979	(\$47,840)	-62.1%
Hearing Screening	\$7,988	\$7,120	\$868	12.2%
ICF IID Facility	\$27,101,245	\$27,813,145	(\$711,900)	-2.6%
Swing Bed Intermediate	\$6,509	\$21,595	(\$15,086)	-69.9%
Rural Health Clinic	\$700,729	\$886,726	(\$185,996)	-21.0%
Federally Qualified Hlth Ctr	\$135,770	\$240,025	(\$104,255)	-43.4%
Medical Supply (DME)	\$5,911,140	\$4,580,067	\$1,331,072	29.1%
Therapy Services	\$1,008,125	\$782,649	\$225,477	28.8%
Inpt. Residential Psych.	\$209,367	\$224,507	(\$15,140)	-6.7%
Inpt. Free Standing Psych.	\$52,157	\$255,301	(\$203,144)	-79.6%
Nurse Services	\$3,766,704	\$3,899,729	(\$133,025)	-3.4%
Ambulatory Surg. Center	\$91,847	\$211,332	(\$119,485)	-56.5%
Personal Care Services	\$0	\$0	\$0	N/A
Hospice	\$7,445,607	\$6,538,241	\$907,365	13.9%
Outpat. Free Stand. Psych	\$6,832	\$13,131	(\$6,299)	-48.0%
Mental Health Priv. Serv.	\$300,793	\$236,859	\$63,934	27.0%
Fam. Planning Drugs	\$71,353	\$78,868	(\$7,515)	-9.5%
Free Standing Dialysis	\$370,351	\$383,627	(\$13,276)	-3.5%
Crossover Part A	\$6,292,580	\$6,009,667	\$282,913	4.7%
Crossover Part B	\$21,616,375	\$32,403,993	(\$10,787,619)	-33.3%
NET Accommodation Prov	\$0	\$0	\$0	N/A
MYPAC	\$0	\$0	\$0	N/A
Inpatient Pediatric LTC Hosp.	\$0	\$0	\$0	N/A
Outpatient Pediatric LTC Hosp.	\$0	\$0	\$0	N/A
Crossover Part A-Pediatric LTC Hosp.	\$29,305	\$0	\$29,305	N/A
Prescribed Ped. Ext. Care Center	\$2,431,679	\$2,007,507	\$424,172	21.1%
Other	\$91,220	(\$75,416)	\$166,637	-221.0%

The expenditure amounts included in this report are presented on a cash basis and reflect the date of payment rather than the date of service or the date goods or services are received. The report reflects all payments made during the reporting period, and will include funds spent from both SFY-23 and SFY-24 budgets.

Office of the Governor - Division of Medicaid
Medical Services Comparison Fiscal Year to Date (FYTD)
FYTD 2026 vs 2025

Appendix D

Service	FYTD 2026	FYTD 2025	\$ Change	% Change
Total Expenditures	\$5,997,308,558	\$5,744,241,047	\$253,067,512	4.4%
Total Managed Care	\$2,747,690,838	\$2,519,042,938	\$228,647,899	9.1%
Total Fee for Service	\$3,249,617,721	\$3,225,198,108	\$24,419,612	0.8%
Fee for Service Totals by Service Type				
Inpatient Hospital	\$82,154,814	\$98,559,845	(\$16,405,031)	-16.6%
Outpatient Hospital	\$78,961,695	\$82,795,164	(\$3,833,469)	-4.6%
Lab and X-Ray	\$3,721,979	\$5,427,946	(\$1,705,967)	-31.4%
Nursing Facility	\$1,034,985,724	\$1,074,444,293	(\$39,458,569)	-3.7%
Physician	\$35,904,286	\$43,847,610	(\$7,943,324)	-18.1%
Home and Comm. Based	\$937,546,657	\$864,050,799	\$73,495,858	8.5%
Home Health Services	\$1,030,222	\$1,606,859	(\$576,637)	-35.9%
Swing Bed Skilled	\$173,727	\$116,406	\$57,321	49.2%
Mental Health Clinic	\$37,632,859	\$39,870,396	(\$2,237,537)	-5.6%
EPSDT Screening	\$4,029,583	\$4,712,860	(\$683,276)	-14.5%
Transportation	\$5,421,464	\$6,019,415	(\$597,951)	-9.9%
Non-Emergency Transport	\$22,986,219	\$19,710,622	\$3,275,597	16.6%
Dental Services	\$2,551,721	\$3,872,698	(\$1,320,977)	-34.1%
Eyeglass Services	\$1,238,094	\$1,592,180	(\$354,087)	-22.2%
Pharmacy	\$130,345,040	\$118,198,521	\$12,146,520	10.3%
Dental Screening	\$2,443,658	\$4,653,194	(\$2,209,536)	-47.5%
Eyeglass Screening	\$603,722	\$1,104,430	(\$500,708)	-45.3%
Hearing Screening	\$85,093	\$76,307	\$8,786	11.5%
ICF IID Facility	\$342,331,279	\$340,310,457	\$2,020,821	0.6%
Swing Bed Intermediate	\$110,473	\$107,487	\$2,986	2.8%
Rural Health Clinic	\$9,132,038	\$10,691,288	(\$1,559,250)	-14.6%
Federally Qualified Hlth Ctr	\$1,864,369	\$2,804,648	(\$940,279)	-33.5%
Medical Supply (DME)	\$53,552,386	\$47,448,967	\$6,103,420	12.9%
Therapy Services	\$9,441,747	\$8,376,513	\$1,065,234	12.7%
Inpt. Residential Psych.	\$4,107,552	\$6,502,041	(\$2,394,489)	-36.8%
Inpt. Free Standing Psych.	\$1,641,303	\$2,293,322	(\$652,018)	-28.4%
Nurse Services	\$41,482,009	\$41,788,072	(\$306,064)	-0.7%
Ambulatory Surg. Center	\$1,665,894	\$2,002,904	(\$337,010)	-16.8%
Personal Care Services	\$0	\$0	\$0	N/A
Hospice	\$82,375,798	\$77,132,599	\$5,243,199	6.8%
Outpat. Free Stand. Psych	\$53,855	\$54,089	(\$234)	-0.4%
Mental Health Priv. Serv.	\$2,943,204	\$2,144,584	\$798,619	37.2%
Fam. Planning Drugs	\$785,488	\$956,491	(\$171,002)	-17.9%
Free Standing Dialysis	\$3,462,126	\$3,833,645	(\$371,519)	-9.7%
Crossover Part A	\$60,492,221	\$56,808,750	\$3,683,471	6.5%
Crossover Part B	\$226,949,576	\$233,817,335	(\$6,867,759)	-2.9%
NET Accomodation Prov	\$0	\$0	\$0	N/A
MYPAC	\$0	\$0	\$0	N/A
Inpatient Pediatric LTC Hosp.	\$0	\$0	\$0	N/A
Outpatient Pediatric LTC Hosp.	\$0	\$0	\$0	N/A
Crossover Part A-Pediatric LTC Hosp.	\$1,058,575	\$0	\$1,058,575	N/A
Prescribed Ped. Ext. Care Center	\$24,272,017	\$17,745,205	\$6,526,812	36.8%
Other	\$79,253	(\$279,833)	\$359,086	-128.3%

The expenditure amounts included in this report are presented on a cash basis and reflect the date of payment rather than the date of service or the date goods or services are received. The report reflects all payments made during the reporting period, and will include funds spent from both SFY-23 and SFY-24 budgets.

**Office of the Governor - Division of Medicaid
Monthly Legislative Report - Participant Counts
Month Ended June 30, 2026**

Appendix E

<u>MS Medicaid Beneficiaries</u>	SFY-26	SFY-25	Change	% Change
	<i>Jun-26</i>	<i>Jun-25</i>		
As of Last Day of the Month	641,565	649,345	(7,780)	-1.2% <i>(Note 2)</i>
	<i>July - June 2026</i>	<i>July - June 2025</i>		
Average for the Period	644,972	654,906	(9,934)	-1.5%
<u>CHIP Beneficiaries</u>	SFY-26	SFY-25	Change	% Change
	<i>Jun-26</i>	<i>Jun-25</i>		
Capitation Payment Population	52,867	52,798	69	0.1%
<u>Dialysis Transport</u>	SFY-26	SFY-25	Change	% Change
	<i>Jun-26</i>	<i>Jun-25</i>		
Participants Covered by Monthly Payment	1	1	0	0.0%

* Home and Community Based Waiver Participants are included in the MS Medicaid Beneficiaries total.

OFFICE OF THE GOVERNOR - DIVISION OF MEDICAID
Other Medical Services Comparison Fiscal Year to Date (FYTD)
FYTD 2026 vs 2025

Appendix F

Service	MTD 6/1/2026	MTD 6/1/2025	FYTD 2026	FYTD 2025	\$ Change	% Change
TOTAL Expenditures	\$59,841,736	\$56,246,872	\$687,962,887	\$644,160,819	\$43,802,067	6.8%
CHIP ¹	\$16,820,380	\$17,248,890	\$196,199,594	\$189,248,740	\$6,950,854	3.7%
Part A & B Premiums ²	\$36,569,693	\$32,835,103	\$416,963,538	\$385,328,460	\$31,635,078	8.2%
Clawback	\$6,451,452	\$6,162,609	\$74,789,074	\$69,579,868	\$5,209,205	7.5%
Dialysis Transport	\$210	\$270	\$10,680	\$3,750	\$6,930	184.8%
State Funded Subsidies ³	\$0	\$0	\$0	\$0	\$0	N/A

¹ The SFY26 CHIP capitation rate increased to \$237.50 per member per month from the SFY25 rate of \$227.64.

² Part A & B Premiums

Effective Date - Calendar Year	Premium Amount	
	Part A	Part B
Year 2026	\$565	\$202.90
Year 2025	\$518	\$185.00
Year 2024	\$505	\$174.70
Year 2023	\$506	\$164.90
Year 2022	\$499	\$170.10
Year 2021	\$471	\$148.50
Year 2020	\$458	\$144.60
Year 2019	\$437	\$135.50
Year 2018	\$422	\$134.00
Year 2017	\$413	\$134.00
Year 2016	\$411	\$121.80
Year 2015	\$407	\$104.90

³ No State-Funded Subsidies were appropriated in SFY2023, SFY2024, SFY2025 and SFY2026.

Office of the Governor - Division of Medicaid
MSCAN Managed Care Summary
Month Ended May 31, 2026*

Appendix G

MSCAN Population	SFY 2026 <i>Month of May</i>	SFY 2025 <i>Month of May</i>	Change	% Change
Magnolia	215,522	176,733	38,789	21.9%
Molina	139,034	104,588	34,446	32.9%
TrueCare	90,345	-	90,345	#DIV/0!
United Healthcare	(7)	151,257	(151,264)	-100.0%
Total	444,894	432,578	12,316	2.8%
Percent of Total Medicaid Beneficiaries	69.36%	66.52%	2.84%	4.27%
Narrative/Notes: TrueCare is a new Managed Care Provider effective July 1, 2025. UnitedHealthcare is no longer a Managed Care Provider for DOM effective June 30, 2025.				

MSCAN Capitation Payments	May 2026	Year To Date SFY 26	Per Member Per Month (PMPM)
Magnolia	\$ 77,781,629	\$ 934,649,399	410.41
Molina	\$ 44,965,340	\$ 575,988,374	362.36
TrueCare	\$ 34,385,005	\$ 372,185,342	372.12
United Healthcare	\$ 39,903	\$ 7,525,323	(9,501.67)
Total	\$ 157,171,878	\$ 1,890,348,438	388.46
Retroactive transactions prior to SFY2026 caused negative Per Member Per Month (PMPM) MSCAN enrollment for United Healthcare.			
Narrative: The Capitation Payments are paid to the MCOs on a monthly basis at a state-wide rate to cover the following components of each beneficiaries medical care based on rates as determined by DOM's actuaries: - Targeted Medical Loss Ratio 86.33% - Administrative Expenses 8.87% - State of Mississippi Premium Tax 3.00% - Targeted MCO Margin 1.80% Total 100.00%			
The Per Member Per Month (PMPM) rate is calculated based on the Year To Date SFY 26 Total Capitation divided by the total Member Months for each MCO during that YTD period.			
The above Capitation Payments do not include state directed payment expenditures which include the Mississippi Hospital Access Program (MHAP), Mississippi Medicaid Access to Physician Services (MAPS), Transforming Reimbursement for Emergency Ambulance Transportation (TREAT), Mississippi Outcomes for Maternal Safety (MOMS) Program and the Rural Hospital APC Opt-Out Program. These programs are paid to hospitals and other providers through the MCOs.			
In addition to the basic PMPM capitation payment, the capitation payment amounts above may include necessary adjustments, including: retro-rate adjustments, and liquidated damages assessed against the MCOs.			

MSCAN Provider Expenditures	May 2026	Year To Date SFY 26
CCO Fee-for-Service (Non-Vendor)**	\$ 120,728,628	\$ 1,258,506,256
Behavioral Health Services	\$ 12,476,271	\$ 143,974,649
Dental Services	\$ 9,530,271	\$ 113,156,068
Vision Services	\$ 1,627,799	\$ 21,917,559
Non-Emergency Transportation Services	\$ 1,459,019	\$ 13,556,924
Pharmacy Benefit Services	\$ (6,376)	\$ (19,565)
Total	\$ 145,815,613	\$ 1,551,091,891
Narrative: DOM utilizes the MCO monthly Cash Disbursements Journal (CDJ) to track the different types of medical services paid by the MCO's on a cash basis. The MCO's have subcontractors that pay for Behavioral Health Services, Dental Services, and Vision Services. The remainder of their medical payments are included in the MCO Fee-for-Service amounts above. Beginning with SFY 25, the Pharmacy expenditures were transferred to the DOM PBA.		
The MCOs are contractually required to pay out not less than 91.3% of capitation rates in medical expenditures. This was revised up from 87.5% due to the inclusion of MHAP, MAPS and TREAT directed payments into the MLR report as required by CMS.		
DOM monitors these payments to providers both monthly in the CDJ amounts shown above and in the Medical Loss Ratio (MLR) Reports that are provided by each MCO on a quarterly and annual basis.		
For the most recent period ended June 30, 2025, the MSCAN MLR rates, per the MCO submitted reports, were: Magnolia Health 95.5% United Healthcare 95.7% Molina Healthcare 91.7% Total 94.2%		
Note: These are Reporting MLR Rates per the MSCAN Contract which include HCQI, HIT eligible expenses. (HCQI - Health Care Quality Improvements; HIT - Health Information Technology)		

*There is a one month delay in reporting data for managed care. The vendors send data after their end of month processing, usually by the 15th of the following month.

**Office of the Governor - Division of Medicaid
MSCHIP Managed Care Summary
Month Ended May 31, 2026***

Appendix H

MSCHIP Population	SFY 2026	SFY 2025	Change	% Change
	<i>Month of May</i>	<i>Month of May</i>		
Magnolia	15,744	-	15,744	#DIV/0!
Molina	25,875	25,126	749	3.0%
TrueCare	11,186	-	11,186	#DIV/0!
United Healthcare	4	28,191	(28,187)	-100.0%
Total	52,809	53,317	(508)	-1.0%

Narrative/Notes:
TrueCare and Magnolia Health Plan are the new Managed Care Providers effective July 1, 2025.
UnitedHealthcare is no longer a Managed Care Provider for DOM effective June 30, 2025.

MSCHIP Capitation Payments	May 2026	Year To Date SFY 26	Per Member Per Month (PMPM)
Magnolia	3,960,935	37,383,306	\$ 241.99
Molina	6,002,789	71,296,642	\$ 233.62
TrueCare	2,685,502	29,753,107	\$ 239.54
United Healthcare	916	144,246	\$ (542.28)
Total	12,650,141	138,577,301	\$ 237.45

Retroactive transactions prior to SFY2026 caused negative Per Member Per Month (PMPM) CHIP enrollment for United Healthcare.

Narrative:
The Capitation Payments are paid to the CCOs on a monthly basis at a state-wide rate to cover the following components of each beneficiaries medical care based on rates as determined by DOM's actuaries:

- Targeted Medical Loss Ratio	85.25%
- Administrative Expenses	9.95%
- State of Mississippi Premium Tax	3.00%
- Targeted CCO Margin	1.80%
Total	100.00%

The Per Member Per Month (PMPM) rate is calculated based on the Year To Date SFY 26 Total Capitation divided by the total Member Months for each CCO during that YTD period.

In addition to the basic PMPM capitation payment, the capitation payment amounts above may include necessary adjustments. These capitation payments also include the DOM PBA payments.
The only CHIP program expenses that do not flow through the CCOs are CHIP vaccine program payments made by DOM to the MS State Department of Health. These vaccine payments average \$2.7 million annually. The current CHIP rate for SFY2026 is \$237.50.

MSCHIP Provider Expenditures	May 2026	Year To Date SFY 26
CCO Fee-for-Service (Non-Vendor)**	\$ 9,558,881	\$ 84,778,834
Behavioral Health Services	\$ 354,430	\$ 3,827,245
Dental Services	\$ 1,486,239	\$ 19,033,599
Vision Services	\$ 185,972	\$ 2,670,188
Non-Emergency Transportation Services	\$ 8,910	\$ 65,170
Pharmacy Benefit Services	\$ -	\$ (2,513)
Total	\$ 11,594,432	\$ 110,372,523

Narrative:
DOM utilizes the MCO monthly Cash Disbursements Journal (CDJ) to track the different types of medical services paid by the MCO's on

The MCOs are contractually required to pay out not less than 85% of all capitation payments received in medical payments to healthcare providers. The capitation rates include 85.31% on average for expected medical payments.

DOM monitors these payments to providers both monthly in the CDJ amounts shown above and in the Medical Loss Ratio (MLR) Reports that are provided by each MCO on a quarterly and annual basis.

For the most recent period ended June 30, 2025, the MSCHIP MLR rates, per the MCO submitted reports, were:

Molina	92.3%
UnitedHealthcare	92.9%
Total	92.5%

Note: These are Reporting MLR Rates per the MSCHIP Contract which include HCQI, HIT eligible expenses.
(HCQI - Health Care Quality Initiatives; HIT - Health Information Technology)

**Office of the Governor - Division of Medicaid
Home and Community Based Expenditures
Month Ended May 31, 2026**

Appendix I

	Waiver Services	State Plan Services	Total ¹	Participants ^{2, 3}
Assisted Living Waiver for Elderly and Disabled Adults	\$1,194,798	\$649,987	\$1,844,785	766
Waiver for Elderly and Disabled Individuals	\$41,002,800	\$6,489,402	\$47,492,203	17,778
Independent Living Waiver	\$2,608,907	\$1,067,705	\$3,676,612	2,270
Waiver for Intellectual Disabilities / Developmentally Disabled	\$15,061,641	\$1,742,757	\$16,804,397	2,754
Waiver for Individuals with a Traumatic Brain or Spinal Cord	\$969,947	\$542,205	\$1,512,152	683

¹ Home and Community Based Waiver expenditures are also included in Medical Service Expenditure totals cited in this report.

² The expenditure totals above reflect claims payments made during the report month. Claims payments could be related to dates of service to 2 years prior to the claims payment date. Therefore, any comparison of expenditures and participants noted above will not provide accurate number enrolled and the amount of paid claims must be viewed independent of one another.

³ Participant count does not include pending applications during the month.

*There is a one month delay in reporting data for waivers. Agencies send data after their end of month processing, usually by the 15th of the following month.

**Office of the Governor - Division of Medicaid
Administrative Expenditures Detail
Month Ended June 30, 2026**

Appendix J

	<u>MTD</u> <u>June-26</u>	<u>YTD</u> <u>July '25 - June '26</u>	
1. PERSONAL SERVICES - SALARIES	\$ 4,919,029	\$ 57,779,079	
2. PERSONAL SERVICES - TRAVEL	\$ 54,868	\$ 551,436	\$ 45,952.96
3. CONTRACTUAL SERVICES	\$ 13,623,241	\$ 138,055,337	
4. COMMODITIES	\$ 77,993	\$ 861,994	
5. CAPITAL OUTLAY - EQUIP	\$ 38,987	\$ 1,442,849	
6. CAPITAL OUTLAY - VEHICLES	\$ -	\$ 21,909	
TOTAL ADMINISTRATIVE EXPENSE	\$ 18,714,119	\$ 198,712,603	

The expenditure amounts included in this report are presented on a cash basis and reflect the date of payment rather than the date of service or the date goods or services are received. The report reflects all payments made during the reporting period, and will include funds spent from both SFY-21 and SFY-22 budgets.

**CASHFLOW PROJECTION
Month Ended June 30, 2026
FY 26**

The Division of Medicaid's Cashflow Projections represent the agency's best predictor of future cash requirements based on current and estimated future expenditure trends. Expenditures for medical services are highly volatile in nature and control by our agency is limited. These expenditures are components of rates and utilization of services that are dictated by state and federal legislation, as well as economic changes. Predicting cashflow outcomes into the future is not possible with 100% accuracy, and these projections will change on a monthly basis.

Cash and Additional Sources

Funding Sources Available	\$ 4,102,891
Tobacco Funds Due to DOM	\$ -
State Agency Matching Funds	\$ 42,591,927
Deficit Appropriation	\$ -
Provider Taxes	\$ 8,643,440

Total Funding Sources Available	\$ 55,338,258
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Funding Uses Projected

Medical Service Claims	\$ -
Other Medical Service Expenditures	\$ -
Administrative Expenditures	\$ (33,070,967)

Total Funding Uses Projected	(33,070,967)
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Projected Cash Balance (Shortfall) FY-26	\$ 22,267,291
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The Cashflow Projection will be issued with the September, December and January - June reports.

OFFICE OF THE GOVERNOR - DIVISION OF MEDICAID
Supplemental/Directed Payment Detail
FYTD 2026 vs 2025

Appendix K

Service	MTD 6/1/2026	MTD 6/1/2025	FYTD 2026	FYTD 2025	\$ Change	% Change
TOTAL Expenditures	\$300,674,781	\$223,625,177	\$1,750,051,177	\$1,854,151,944	(\$104,100,768)	-5.6%
DSH*	\$6,692,747	\$4,831,657	\$19,071,762	\$53,933,612	(\$34,861,850)	-64.6%
MHAP	\$237,679,519	\$181,325,785	\$1,467,208,859	\$1,497,019,353	(\$29,810,494)	-2.0%
MSCAN Withhold Incentive	\$0	\$0	\$24,592	\$0	\$24,592	N/A
MSCAN VBP Incentive	\$108,505	\$0	\$9,170,369	\$0	\$9,170,369	N/A
Nursing UPL	\$0	\$0	\$0	\$2,002,949	(\$2,002,949)	-100.0%
Physician UPL	\$0	\$0	\$6,126,616	\$7,473,711	(\$1,347,095)	-18.0%
Hospital UPL	\$10,813,943	\$13,430,493	\$139,871,216	\$158,956,138	(\$19,084,923)	-12.0%
Ambulance (TREAT)	\$3,790,257	\$9,477,079	\$15,161,027	\$37,946,808	(\$22,785,781)	-60.0%
GME	\$15,450,013	\$14,560,163	\$61,950,050	\$58,240,650	\$3,709,400	6.4%
MAPS	\$26,139,798	\$0	\$31,466,686	\$38,578,722	(\$7,112,036)	-18.4%

* This can be negative due to DSH recoupments for prior years. In accordance with the State Plan, the recouped funds will be paid to other hospitals which had remaining uncompensated care balances.