Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Mississippi Comprehensive Program Integrity Review

Final Report

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TABLE OF CONTENTS

Introduction 1

The Review 1
- Objectives of the Review 1
- Overview of Mississippi's Medicaid Program 1
- Program Integrity Section 1
- Methodology of the Review 2
- Scope and Limitations of the Review 2

Results of the Review 2
- Effective Practices 2
- Regulatory Compliance Issues 3
- Vulnerabilities 5

Conclusion 7

INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Mississippi Medicaid Program. The MIG review team conducted the onsite portion of the review at the Mississippi Division of Medicaid (DOM) offices. The MIG team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Bureau of Program Integrity (BPI) within the DOM. The BPI is responsible for Medicaid program integrity activities. This report describes three effective practices, three regulatory compliance issues, and four vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Mississippi improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Mississippi's Medicaid Program

The DOM is housed in the Office of the Governor and administers the Mississippi Medicaid program. The delivery network is fee-for-service (FFS). Mississippi Medicaid has no MCOs contracted to provide Medicaid services in the State. In State fiscal year (SFY) 2008, the program served 588,985 recipients. Mississippi operates home and community based waiver programs which serve seniors and people with disabilities. The State also operates a waiver program that allows the use of a transportation broker to arrange non-emergency medical transportation (NEMT) through the most appropriate and cost effective means of transportation available.

At the time of the review, DOM had approximately 20,000 participating Medicaid providers. Medicaid expenditures in Mississippi for the SFY ending September 30, 2008, totaled $3,136,033,726. The Federal medical assistance percentage (FMAP) rate for Mississippi for Federal fiscal year 2008 was 76.29 percent, the highest FMAP rate in the nation.

Program Integrity Section

The BPI, within the Administrative Services section of the DOM, is the organizational component dedicated to fraud and abuse detection activities. At the time of our review, BPI had approximately 28 full-time equivalent employees focusing on Medicaid program integrity. During SFY 2005 through SFY 2008, BPI staff conducted an annual average of 241 preliminary investigations and 106 full investigations. The table below presents the total number of

investigations and overpayment amounts identified and collected for the last four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Recovered By Administrative Actions
2005	406	163	$5,757,407	$1,559,265
2006	180	47	$1,240,573	$1,865,200
2007	174	149	$3,635,995	$2,156,022
2008	204	63	$2,481,058	$2,976,012

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.

Methodology of the Review

In advance of the onsite visit, the review team requested that Mississippi complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, and the MFCU. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of June 1, 2009, the MIG review team visited the DOM and MFCU offices. The team conducted interviews with numerous DOM officials, as well as with staff from the State's provider enrollment contractor, the NEMT contractor, and the MFCU. The team also conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of BPI as they relate to program integrity. In Mississippi, the Children's Health Insurance Program operates under Title XXI of the Social Security Act and was, therefore, not included in this review.

Unless otherwise noted, Mississippi provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that the State provided.

RESULTS OF THE REVIEW

Effective Practices

The State of Mississippi has highlighted several practices that demonstrate its commitment to program integrity. These practices consist of the use of a statistician and an independent auditor, and an organizational review to enhance efficiency.

Use of a statistician to determine an accurate dollar loss value
The BPI uses a consulting statistician on all cases that are deemed of investigative merit. This allows the Division to determine an accurate dollar loss value to the Medicaid program. In addition, the efforts of the MFCU during prosecution are enhanced by the State's provision of an expert who can show how the loss was determined and also provide a detailed analysis of the actual loss of dollars versus theoretical losses.

Use of an independent auditor to enhance audit services
The DOM contracted with an independent audit vendor to enhance the audit services of the BPI by adjusting facility rates for providers to the most accurate amount. This includes audit services for Disproportionate Share Hospitals (DSH), Medicare cost reports, and claims reviews of facilities.

The auditor assists the State in complying with 42 CFR § 455 Subpart A - Medicaid Agency Fraud Detection and Investigation Program and 42 CFR § 455 Subpart D - Independent Certified Audit of State DSH Payment Adjustments. The contractor was engaged because of limited State staff and the number of providers to be audited.

Use of an organizational review to enhance efficiency of operations
The DOM conducted an independent evaluation of BPI to assess functionality, structure, and effectiveness. Specifically, the State reviewed processes and procedures and the organizational structure of the Bureau to ensure that staff and other resources were in place to conduct claims audits and reviews.

Regulatory Compliance Issues
The State is not in compliance with Federal regulations regarding disclosure of information requirements.

The State does not capture all required ownership, control, and relationship information from FFS providers and from the fiscal agent.
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more.

Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or

controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

Although Section B, Sub-Section 8 of the Mississippi Medicaid Enrollment Application requests disclosure of the name of owners with a 5 percent or more interest in the group provider, there is no space to enter the address as is required. In addition, the application does not request disclosure of familial relationships and disclosure of ownership information of any other disclosing entities by persons with ownership or control of the group provider that is submitting the application.

The signed contract between the State and its fiscal agent indicates that the contractor is to meet all requirements as described in the request for proposal (RFP). Mississippi's RFP for its fiscal agent requires the contractor to meet the Federal regulations 42 CFR § 455.100 through 42 CFR § 455.106. Mississippi's provider enrollment unit did not provide evidence that the fiscal agent had disclosed the required ownership or control information.

Recommendations: Modify all provider enrollment applications and contracts to capture the required ownership, control, and relationship information. Obtain necessary disclosures from all providers and from the fiscal agent.

Mississippi's provider enrollment agreement does not require providers to disclose certain business transactions.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or the U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors. Providers must submit business information within 35 days of the date of a request by the Secretary or the Medicaid agency.

Mississippi's provider enrollment agreement does not require individual providers to disclose, upon request, the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 or any significant business transactions between the provider and any wholly owned supplier or any subcontractor. In addition, the provider enrollment agreement does not include a statement that the provider agrees to furnish business transaction disclosures within 35 days of a request by DOM or HHS.

Recommendation: Modify the provider enrollment agreement to require disclosure upon request of the information identified in 42 CFR § 455.105(b).

Mississippi's provider enrollment applications do not capture required criminal conviction information.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they

apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the HHS Office of the Inspector General (HHS-OIG) whenever such disclosures are made. Pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The Mississippi Medicaid Enrollment Application, Section B, Sub-Section 7 - Type of Ownership, requests criminal conviction disclosures from an individual provider but not for its managing employees or agents, or any person with an ownership or control interest, if applicable. As a result, the State is unable to notify HHS-OIG within 20 days of any disclosures made under this section as required.

Recommendations: Modify the provider enrollment process to meet the full criminal conviction disclosure requirements of the regulation. Develop and implement a procedure to report criminal conviction information to HHS-OIG within 20 working days.

Vulnerabilities

The review team identified four areas of vulnerability in Mississippi's practices regarding not conducting monthly exclusion searches, not capturing managing employee information, lack of effective communication between the State agency and the MFCU, and not including a valid case closure justification in all full investigation files.

Not conducting monthly exclusion searches.
In February 2009, Mississippi's provider enrollment unit initiated exclusion searches on the names noted within the application as owners, managing directors and authorized representatives for group applicants during the initial enrollment process. Mississippi only checks the List of Excluded Individuals/Entities (LEIE) when a provider applies for FFS Medicaid and not thereafter on a monthly basis. Neither the Medicaid agency nor its fiscal agent conducts any monthly comparisons of provider files against the Medicare Exclusion Database (MED) or the LEIE. This practice does not follow the directives on exclusion checking issued in State Medicaid Director Letters of June 12, 2008 (#08-003) and January 16, 2009 (#09-001). These letters directed States to conduct monthly exclusion checks on providers, owners and managing employees within the Medicaid program.

Recommendation: Develop and implement policies and procedures to perform monthly checks of the MED or LEIE in the Medicaid program.

Not capturing managing employee information on enrollment application forms.
Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." The BPI does not solicit managing employee information for individual providers on its application form.

Recommendation: Modify the provider enrollment application forms to capture the information identified in 42 CFR §455.101.

Lack of effective coordination and communication between the State agency and the MFCU.
There is little coordination and communication between BPI and the MFCU. There are no regularly scheduled meetings and no standards for determining whether a case should be referred to the MFCU. The results from a sampling of full investigations indicated information on investigations was not always shared between the BPI unit and the MFCU. The *Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units* (September 2008) document outlines opportunities for interactions between each State's Program Integrity Unit and the MFCU. It also contains specific examples of actions taken by States that have created well-functioning and committed partnerships between the two entities.

Recommendation: Utilize MIG's *Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units* document and improve ongoing communication and collaboration, including the quality of referrals.

Not including a valid case closure justification in full investigation files.
Federal regulation stipulates that a full investigation must continue until appropriate legal action is initiated, the case is closed or dropped due to insufficient evidence, or the case is resolved.

During the review, the review team sampled full investigations, of which two were dental cases. Both cases alleged that the providers were potentially misusing billing code D2930: *Prefabricated stainless steel crown-primary tooth* on juvenile patients. Both dental cases were referred to the BPI in January 2008 and closed in April 2008. The review team noted that the cases were closed and the files did not contain a valid case closure justification.

During a review of the two case files, the MIG review team noticed that in both instances the providers' records and radiographs were returned before the State's Quality Improvement Organization was able to review them for an opinion as to accuracy, validity and medical necessity. In one of the sampled case files, the provider was unable to provide the files on over 50 percent of the files reviewed by the BPI. There was no documentation in the file that the BPI made any recoupment efforts with this provider. The file disposition indicated that the case was being closed since the x-rays were returned to this provider prior to the consultant review. When the review team expressed its concerns about the absence of any case closure justification, the program integrity director was only able to advise the team that the decision to close the cases were made above the Program Integrity Director level. The cases were never referred to the MFCU and no policy was provided by the BPI in regards to the specifics on why these dental cases were closed.

Recommendation: Ensure files include valid closure justification for every case that warrants a full investigation. Review these cases to determine if recoupment or referral to MFCU is warranted.

CONCLUSION

The State of Mississippi applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- use of a statistician to determine an accurate dollar loss value to the program,
- use of an independent auditor to enhance fraud effort, and
- conducting an organizational review to enhance efficiency of operations

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of three areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, four areas of vulnerability were identified. The CMS encourages BPI to closely examine each area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require BPI to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Mississippi will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Mississippi has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Mississippi on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.