



**State of Mississippi**  
OFFICE OF THE STATE AUDITOR  
PHIL BRYANT  
Auditor

December 3, 2004

**Financial Audit Management Report**

Warren A. Jones, M.D., FAAFP, Executive Director  
Office of the Governor – Division of Medicaid  
Suite 801, Robert E. Lee Building  
239 North Lamar Street  
Jackson, MS 39201

Dear Dr. Jones:

Enclosed for your review are the financial audit findings for the Office of the Governor – Division of Medicaid for the Fiscal Year 2004. In these findings, the Auditor's Office recommends the Office of the Governor – Division of Medicaid:

1. Strengthen controls over bank reconciliations;
2. Strengthen controls over the issuance of manual checks by the fiscal agent;
3. Strengthen controls over reports;
4. Strengthen controls over the disbursement account; and
5. Strengthen controls over checks voided by the fiscal agent.

Please review the recommendations and submit a plan to implement them by December 28, 2004. The enclosed findings contain more information about our recommendations.

During future engagements, we may review the findings in this management report to ensure procedures have been initiated to address these findings.

This report is intended solely for the information and use of management, Members of the Legislature and federal awarding agencies and is not intended to be and should not be used by anyone other than these specified parties. However, this report is a matter of public record and its distribution is not limited.

I hope you find our recommendations enable the Office of the Governor – Division of Medicaid to carry out its mission more efficiently. I appreciate the cooperation and courtesy extended by the officials and employees of the Office of the Governor – Division of Medicaid throughout the audit. If you have any questions or need more information, please contact me.

Sincerely,

Phil Bryant  
State Auditor

Enclosures

The Office of the State Auditor has completed its audit of selected accounts included on the financial statements of the Office of the Governor – Division of Medicaid for the year ended June 30, 2004. These financial statements are consolidated into the State of Mississippi's Comprehensive Annual Financial Report. The Office of the State Auditor's staff members participating in this engagement included Karlanne Coates, CPA, Amy Buller, CPA, Daphonie Moulder, Sheila Sykes, and Oliver Strange.

The fieldwork for audit procedures and tests was completed on October 8, 2004. These procedures and tests cannot and do not provide absolute assurance that all state legal requirements have been met. In accordance with Section 7-7-211, Miss. Code Ann. (1972), the Office of the State Auditor, when deemed necessary, may conduct additional procedures and tests of transactions for this or other fiscal years to ensure compliance with legal requirements.

### **Internal Control over Financial Reporting**

In planning and performing our audit of selected accounts included on the financial statements, we considered the Office of the Governor – Division of Medicaid's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on these accounts and not to provide assurance on the internal control over financial reporting.

However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgement, could adversely affect the department's ability to record, process, summarize and report financial data consistent with assertions of management in the financial statements. These matters are noted under the heading **REPORTABLE CONDITIONS**.

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are considered to be material weaknesses. However, we believe none of the reportable conditions described in this letter is a material weakness.

In addition, we noted other matters involving the internal control over financial reporting that require the attention of management. These matters are noted under the heading **IMMATERIAL WEAKNESSES IN INTERNAL CONTROL**.

### **Compliance**

As part of obtaining reasonable assurance about whether selected accounts included on the financial statements of the Office of the Governor – Division of Medicaid are free of material misstatement, we performed tests of compliance with certain provisions of laws, regulations, contracts and grants, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. We are pleased to report the results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

## **REPORTABLE CONDITIONS**

### Controls Should Be Strengthened over Bank Reconciliations

*Finding:*

The Office of the Governor – Division of Medicaid’s contract with the fiscal agent requires the fiscal agent to submit bank reconciliations on the disbursement account to the agency on a monthly basis. The reconciliations are due within 30 days after the end of the month. We noted in our review of the independent auditor’s SAS 70 report related to the fiscal agent for the period January 2003 through December 2003 that the bank reconciliations performed by the fiscal agent were determined to be insufficient. The fiscal agent was preparing a recap of information from the bank statement (ex: beginning balance, total amount of deposits, total amount of checks, ending balance, etc.) as their bank reconciliation instead of reconciling the bank statement to the general ledger for the period from July 2003 through December 2003. No bank reconciliations had been prepared for the period from January 2004 through June 2004. Good internal control procedures require the reconciliation of monthly bank statements with accounting records. Failure to prepare proper monthly reconciliations could result in errors or fraud occurring without being detected promptly, or inaccurate information to be used or distributed by the agency.

*Recommendation:*

We recommend the Office of the Governor – Division of Medicaid ensure that internal controls over the preparation of the monthly bank reconciliations be strengthened by the fiscal agent. The agency should ensure accurate bank reconciliations are performed and submitted timely by the fiscal agent.

### Controls Should Be Strengthened over the Issuance of Manual Checks by the Fiscal Agent

*Finding:*

The Office of the Governor – Division of Medicaid’s contract with the fiscal agent requires the fiscal agent to receive and process Medicaid claims through the Medicaid Management Information System (MMIS). In performing our audit procedures at the Division of Medicaid for fiscal year 2004, we selected 45 manual checks issued from July 2003 to June 2004 for testwork at the fiscal agent’s office. In addition, we selected all disproportionate share (DSH) payments made to nine out of 27 eligible providers, and all upper limit (UPL) payments made to 16 out of 176 eligible providers during fiscal year 2004. The following problems were noted:

- Ten manual checks totaling \$3,641,716 related to UPL payments and eight manual checks totaling \$28,809,502 related to DSH payments were not recorded in the MMIS. In addition, three manual checks not related to DSH or UPL totaling \$741,038 were not recorded in the MMIS. It should be noted that six of these checks totaling \$1,837,858 were not included in the fiscal agent’s request for funds to the agency.
- The fiscal agent suspended the recoupment from providers of two cash advances totaling \$1,225,000 under the direction of agency personnel other than the Executive Director. The agency had not provided the fiscal agent a listing of personnel authorized to suspend recoupment of cash advances. The agency subsequently provided a listing of authorized personnel to the fiscal agent upon notification of the deficiency.

We also noted missing documentation on the manual check log and the check stock issue log as follows:

- Forty entries in which check information (provider name, provider number, amount, etc.) was included on the manual check log; however, no check number was assigned to the information;
- Four instances in which manual checks were not recorded on the manual check log; and
- A range of checks, numbers 16308 through 16418, were not recorded on the manual check log or the check stock issue log. Management stated these check numbers had been used by systems personnel for testing purposes.

Good internal controls require all checks be entered in the MMIS to ensure that checks are properly accounted for and reports reflect accurate information. Good internal controls also require that approval be obtained from authorized agency personnel for the suspension of the recoupment from providers of cash advances. Per the fiscal agent's policies and procedures, the Banking Associate is required to complete the manual check database with the following information: manual check number and date, provider name, provider number, amount of advance and the purpose of the check. The failure to have adequate controls in place for the issuance of manual checks could result in errors or fraud occurring without being detected promptly and required additional audit time.

*Recommendation:*

We recommend the Office of the Governor – Division of Medicaid strengthen controls over the issuance of manual checks by the fiscal agent by performing the following:

- Ensure the fiscal agent enters all checks in the MMIS;
- Ensure all transactions involving the suspension of recoupment from providers of cash advances have been approved by authorized agency personnel prior to being processed by the fiscal agent;
- Ensure the fiscal agent maintains support for manual checks issued and accurately documents all check data on the check register, manual check log, and provider correspondence; and
- Ensure the fiscal agent properly accounts for all check numbers on the manual check log and check stock issue log.

Controls Should Be Strengthened over Reports

*Finding:*

The Office of the Governor – Division of Medicaid's contract with the fiscal agent included the design, development, and implementation of a new Medicaid Management Information System (MMIS). This system went "live" in October 2003. The MMIS is used by the fiscal agent to process claims. Part of the programming for the new system includes reports which are used by the agency for budgeting purposes and reports used for audit purposes. During our audit procedures, weaknesses in the reports produced by the MMIS were noted as follows:

- The MR-O-19 report provides the ranking of providers based on payment amounts. We noted the ranking on the report dated June 30, 2004, within the inpatient hospital category of service was not accurate. No provider received a ranking of number one or two, or four through nine. Also, the total year-to-date payment amount per the MR-O-19 report for the inpatient hospital category did not agree to the MR-O-01 report total year-to-date payment amount for the inpatient hospital category by the amount of \$357,964,562. The MR-O-19 report is used to select hospitals for rate setting testwork. The Bureau of Systems Management did generate a separate query to provide the auditors with this data when the error was noted; however, the totals reported on the query did not agree to either the MR-O-19 report or the MR-O-01 report.
- The MR-O-01 report for April 2004 which provides detail of total claims paid by category of service did not add down. The difference in the amount per the MR-O-01 report and the auditor's calculation was \$1,780,262. This report is used to determine the significant claim types for audit. Per discussion with management, this report is also used for budgeting purposes.
- The CP-O-132 report which was previously available to auditors to accumulate totals for the claims payable estimate was not available from the new system. This was a monthly report which documented the total claims paid for the month broken down by month of service. Auditors were referred by the fiscal agent to the MR-O-90 report which shows incurred expense for the month broken down by month of service. We noted the total year-to-date amount did not agree between the MR-O-90 report and the MR-O-01 report at June 30, 2004, by a difference of \$752,998.

Good internal controls require reports generated by the MMIS system to contain accurate data. The failure of the MMIS system to produce accurate reports could cause inaccurate information to be distributed or used by the agency and required significant additional audit time.

*Recommendation:*

We recommend the Office of the Governor – Division of Medicaid strengthen controls over the reports generated by the Medicaid Management Information System (MMIS). Agency personnel should review the reports produced by the MMIS to determine if the programming used in the production of the reports was designed to accurately accumulate and calculate the data presented.

**IMMATERIAL WEAKNESSES IN INTERNAL CONTROL**

Controls Should Be Strengthened over the Disbursement Account

*Finding:*

During our review of internal controls at the Office of the Governor – Division of Medicaid, we noted the names of three former employees of the agency were on the listing of authorized signatures for the disbursement account of the fiscal agent. Good internal controls and prudent business practices require the listing of authorized signatures to be updated promptly in the event an employee included on the listing is terminated. Failure to update the listing of authorized signatures could result in the allowance of unauthorized transactions to the disbursement account.

*Recommendation:*

We recommend the Office of the Governor – Division of Medicaid strengthen controls to ensure the listing of authorized signatures for the disbursement account be updated promptly in the event of a change in employees included on the listing.

Controls Should Be Strengthened over Checks Voided by the Fiscal Agent

*Finding:*

The Office of the Governor – Division of Medicaid contracts with a fiscal agent to process claims payments to providers for Medicaid services. It is necessary at times for the fiscal agent to void previously issued checks. Testwork performed on the fiscal agent's void/stop payment check log for the period of June 2003 through June 30, 2004, revealed the following:

- Twenty-five checks totaling \$752,544 were found in the binder at the fiscal agent which contains all voided checks; however, these checks had not been recorded on the void/stop payment check log.
- Twenty-four checks totaling \$1,801,500 were listed as void per the manual check log but were not listed on the void/stop payment check log. It should be noted that we were able to determine the checks were either properly voided per the bank statement or the physical voided check was on file at the fiscal agent.
- In numerous instances, the void/stop payment check log did not contain the check numbers for the replacement checks. Also, the void/stop payment check log did not always contain descriptions noting the reason for voiding the checks or issuing a stop payment to the bank.

Good internal controls require voided and stop payment checks be properly accounted for and accurate and complete data be maintained on the fiscal agent's void/stop payment check log. Without adequate controls in place to track and support voided checks, errors or fraud could occur and not be detected promptly.

*Recommendation:*

We recommend the Office of the Governor – Division of Medicaid strengthen controls over checks voided by the fiscal agent. The void/stop payment check log should contain accurate and complete information on the voided or stop payment checks in order to support the actions of the fiscal agent.



**State of Mississippi**  
OFFICE OF THE STATE AUDITOR  
PHIL BRYANT  
Auditor

March 4, 2005

**Single Audit Management Report**

Warren A. Jones, M.D., FAAFP, Executive Director  
Office of the Governor - Division of Medicaid  
Suite 801, Robert E. Lee Building  
239 North Lamar Street  
Jackson, Mississippi 39201

Dear Dr. Jones:

Enclosed for your review are the single audit findings and other audit findings for the Office of the Governor - Division of Medicaid for the Fiscal Year 2004. In these findings, the Auditor's Office recommends the Office of the Governor - Division of Medicaid:

Single Audit Findings

1. Strengthen controls over federal cash draws;
2. Strengthen controls over computer edits;
3. Strengthen controls over recipient service limits;
4. Ensure paid hospital claims do not exceed service limits;
5. Ensure physician visit claims in excess of service limits are denied;
6. Ensure pharmacy claims in excess of service limits are denied;

Other Audit Findings

7. Reprocess claims for updated rates and fee schedule changes in a timely manner;
8. Strengthen controls over third party liability audit assessments;
9. Strengthen controls over desk reviews of hospital cost reports;
10. Strengthen controls over federal reporting;
11. Strengthen controls over provider enrollment;
12. Strengthen controls over recipient investigations;
13. Ensure nursing home rates are accurate;
14. Ensure Upper Payment Limit (UPL) Program reimbursements are made in accordance with the State Plan;  
and
15. Ensure outpatient claims are paid in accordance with the State Plan.

Please review the recommendations and submit a plan to implement them by March 18, 2005. The enclosed findings contain more information about our recommendations.

Office of the Governor - Division of Medicaid  
March 4, 2005  
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During future engagements, we may review the findings in this management report to ensure procedures have been initiated to address these findings.

This report is intended solely for the information and use of management, Members of the Legislature and federal awarding agencies and is not intended to be and should not be used by anyone other than these specified parties. However, this report is a matter of public record and its distribution is not limited.

I hope you find our recommendations enable the Office of the Governor - Division of Medicaid to carry out its mission more efficiently. I appreciate the cooperation and courtesy extended by the officials and employees of the Office of the Governor - Division of Medicaid throughout the audit. If you have any questions or need more information, please contact me.

Sincerely,

Phil Bryant  
State Auditor

Enclosures

## **SINGLE AUDIT FINDINGS**

In conjunction with our audit of federal assistance received by the State of Mississippi, the Office of the State Auditor has completed its audit of selected federal programs of the Office of the Governor - Division of Medicaid for the year ended June 30, 2004. This audit was conducted in accordance with auditing standards generally accepted in the United States of America, *Government Auditing Standards*, the Single Audit Act Amendments of 1996, and Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. The Office of the State Auditor's staff members participating in this engagement included Karlanne Coates, CPA, Amy Buller, CPA, Daphonie Moulder, Jessica Short, Oliver Strange, Mike McCollough, Rebecca Wilson, Amy Ellis, CPA, and Cheryl Mize.

The fieldwork for audit procedures and tests was completed on February 10, 2005. These procedures and tests cannot and do not provide absolute assurance that all federal legal requirements have been met. In accordance with Section 7-7-211, Miss. Code Ann. (1972), the Office of the State Auditor, when deemed necessary, may conduct additional procedures and tests of transactions for this or other fiscal years to ensure compliance with legal requirements.

### **Internal Control over Compliance**

The management of the Office of the Governor - Division of Medicaid is responsible for establishing and maintaining effective internal control over compliance with requirements of laws, regulations, contracts and grants applicable to federal programs. In planning and performing our audit, we considered internal control over compliance with requirements that could have a direct and material effect on the major federal programs.

We noted certain matters involving the internal control over compliance and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over compliance that, in our judgment, could adversely affect the department's ability to administer a major federal program in accordance with applicable requirements of laws, regulations, contracts and grants.

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that noncompliance with applicable requirements of laws, regulations, contracts or grants that would be material to a major federal program being audited may occur and not be detected within a timely manner by employees in the normal course of performing their assigned functions. Our consideration of the internal control over compliance would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, we believe none of the reportable conditions described above is a material weakness.

In addition, we noted other matters involving the internal control over compliance that require the attention of management that we have reported on the attached document "Other Audit Findings".

## Compliance

Compliance with the requirements of laws, regulations, contracts, and grants applicable to each of its major federal programs is the responsibility of management. We have audited each of the major federal programs for compliance with the types of compliance requirements described in OMB Circular A-133. Our audit fieldwork included examining, on a test basis, evidence about the department's compliance with those requirements and such other procedures as we considered necessary.

The results of our auditing procedures disclosed instances of noncompliance that are required to be reported in accordance with OMB Circular A-133. We also noted other instances of noncompliance that we have reported on the attached document, "Other Audit Findings."

## REPORTABLE CONDITIONS

### CFDA/Finding Number

### Finding and Recommendation

#### ALLOWABLE COSTS/COST PRINCIPLES

#### *Reportable Condition*

93.778

Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004

04-14

#### Controls Should Be Strengthened over Federal Cash Draws

#### *Finding:*

The Office of the Governor - Division of Medicaid received an enhancement to the federal medical assistance percentage (FMAP) rate, which is the rate used to calculate the federal cash draws, of 2.95 percent effective the last quarter of federal fiscal year 2003 and the first three quarters of federal fiscal year 2004. The grant award noted disproportionate share (DSH) payments were not eligible for the enhanced FMAP percentage. During our review of federal cash draws for the period July 1, 2003, to May 20, 2004, we noted instances in which the agency had incorrectly drawn for DSH payments using the enhanced rate. The net amount overdrawn by the agency due to the use of the enhanced rate for DSH payments and DSH refunds totaled \$4,584,027.

In addition, we noted the agency received a grant award on June 24, 2003, in the amount of \$21,925,000 to support the increase in the federal medical assistance percentage (FMAP) of 2.95 percent for expenditures incurred during the period April 1, 2003, to June 30, 2003. Testwork revealed the agency should have drawn additional federal funds for these expenditures in the amount of \$20,091,536; however, the agency drew the entire grant award amount of \$21,925,000 on August 6, 2003. Therefore, the agency overdraw federal funds in the amount of \$1,833,464.

As a result of the two errors noted above, the agency overdraw federal funds in the amount of \$6,417,491. It should be noted the agency corrected these errors by reducing a subsequent federal cash draw when the auditor brought it to the attention of Division of Medicaid personnel.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid strengthen controls over federal cash draws to ensure they are calculated using the correct federal medical assistance percentage. In addition, all federal cash draws should be supported by actual expenditures incurred. We further recommend the agency contact the federal grantor agency for a determination of any interest owed to the federal government as a result of the amounts overdrawn.

**ALLOWABLE COSTS/COST PRINCIPLES**

***Reportable Condition***

93.778

Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004

04-15

Controls Should Be Strengthened over Computer Edits

*Finding:*

The Office the Governor - Division of Medicaid uses the Medicaid Management Information System (MMIS) to process claims for medical services. Computer edits are designed to prevent errors such as the processing of claims with inaccurate or missing data, duplicate claims and processing of claims in excess of a beneficiary's service limit as defined in the Mississippi Medicaid State Plan (State Plan). The Online Update Activity Report (RG010 report) lists changes which have been made within various areas of the MMIS system. It is possible to search the report under the title "Claims Exception Disposition Table" for the changes which have been made to edits. In addition, the claims exception control screen within the MMIS allows a user to see the current status of an edit.

We identified 115 specific edits which we considered significant for five claim types: inpatient hospital, nursing facility, outpatient hospital, physician and pharmacy. Our testwork on the significant edits revealed inconsistencies between the information shown by the RG010 report and the claims exception control screen in the MMIS on 66 edits. For example, for edit 129 "Beneficiary ID is Missing" for inpatient hospital claims, the RG010 report documents the edit was changed from "deny and report" to "pay" on June 4, 2004; however, the claims exception control screen for the edit showed the last update made to the edit was on May 1, 2003, and the edit was set to "deny and report." It appears the RG010 report was not accurately reflecting the activity occurring within the system. Due to these inconsistencies, we were unable to identify and review all changes made to significant edits throughout the fiscal year.

Good internal controls require documentation of changes to computer edits be accurate. The failure to maintain accurate documentation of changes to edits could result in unauthorized or erroneous changes occurring and not being detected promptly.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid strengthen controls over computer edits by ensuring changes to the edits are accurately documented in the system. The agency should review the RG010 report to determine the disposition of the discrepancies between the information on the report and the claims exception control screens.

## **ALLOWABLE COSTS/COST PRINCIPLES**

### ***Reportable Condition***

93.778 Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004

04-16 Controls Should Be Strengthened over Recipient Service Limits

#### ***Finding:***

The Mississippi Medicaid State Plan (State Plan) documents the recipient service limits and other claims payment policies (i.e., dispensing of generic drugs) for medical services covered by the Office of the Governor - Division of Medicaid. The Medicaid Management Information System (MMIS) includes computer edit functions which are intended to ensure claims which exceed the service limits or are not within the claims payment policies are denied. We requested the agency run exception reports to identify instances in which recipient service limits for several medical service types (i.e., inpatient hospital, physician, inpatient physician, pharmacy and outpatient hospital) may have been exceeded or other claims payment policies may not have been followed. Our testwork on these exception reports revealed claims were being paid which exceeded the recipient service limits or were not in accordance with other claims payment policies. We also noted agency personnel were not running and reviewing exception reports to ensure recipient service limits were not being exceeded or other claims payment policies were being followed.

Good internal controls require the computer system accurately process claims according to the service limits and other claims payment policies set forth in the State Plan in order to ensure compliance with federal regulations. Good internal controls also require that claims payments be adequately monitored to ensure payments are within the limits and policies set by the State Plan. The failure to monitor claims payments for adherence to service limits and other claims payment policies could result in unnecessary costs to the agency.

#### ***Recommendation:***

We recommend the Office of the Governor - Division of Medicaid strengthen internal controls over recipient service limits and other claims payment policies. Exception reports on claims payment data should be run and reviewed periodically for significant medical service types and follow up should be performed to ensure that edits for service limits and other payment policies are functioning properly so that claims will be paid in accordance with the State Plan. Documentation of these exception reports and follow-up procedures, including adjustments, should be maintained for audit purposes.

## **ALLOWABLE COSTS/COST PRINCIPLES**

### ***Immaterial Noncompliance***

93.778 Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004  
Questioned Costs: \$816,607

04-18

Agency Should Ensure Paid Hospital Claims Do Not Exceed Service Limits

*Finding:*

The Mississippi Medicaid State Plan (State Plan) documents the reimbursement service limits for medical services covered by the Office of the Governor - Division of Medicaid. The service limits for medical service types covered by the agency are as follows:

- Inpatient Hospital Days - Attachment 3.1-A, Exhibit 1 of the State Plan sets a reimbursement limit of 30 inpatient days per fiscal year.
- Outpatient Hospital Visits - Attachment 3.1-A, Exhibit 2 of the State Plan sets a reimbursement limit of six outpatient visits per fiscal year.

Computer edits within the Medicaid Management Information System (MMIS) should ensure claims which exceed the service limits are not paid. We requested the agency run exception reports for the service types above, documenting all recipients whose paid claims exceeded the service limits for the period July 1, 2003, to June 30, 2004. Our testwork on these reports revealed the following:

- We reviewed claims data for 25 out of 467 recipients whose inpatient hospital days exceeded the service limits. Testwork indicated the service limits were exceeded without a valid policy exception for 24 out of 25 of the recipients. This resulted in an overpayment to providers of \$1,019,716, of which the federal share is \$814,906.
- We reviewed claims data for 11 out of 113 recipients whose paid outpatient hospital visits exceeded the service limit. Testwork indicated the service limits were exceeded without a valid policy exception for nine of the recipients. This resulted in an overpayment to providers of \$2,128, of which the federal share is \$1,701. Due to the complexities involved in calculating outpatient hospital reimbursements, we did not project the error to the population.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid ensure the edits for service limits in the Medicaid Management Information System are working properly so hospital claims will be paid in accordance with the State Plan. We further recommend the agency determine the disposition of the claims listed on the exception reports and make the appropriate adjustments to the claims history. Documentation that adjustments were made should be provided to the auditors by the agency for follow-up purposes.

**ALLOWABLE COSTS/COST PRINCIPLES**

*Immaterial Noncompliance*

93.778

Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004  
Questioned Costs: \$33,673

04-19

Agency Should Ensure Physician Visit Claims in Excess of Service Limits Are Denied

*Finding:*

The Mississippi Medicaid State Plan (State Plan) documents the reimbursement service limits for medical services covered by the Office of the Governor - Division of Medicaid. The service limits for two of the medical service types provided by the agency are as follows:

- 1) Physician Visits - Attachment 3.1-A, Exhibit 5 of the State Plan sets a reimbursement limit of 12 physician visits per fiscal year.
- 2) Inpatient Physician Visits - Attachment 3.1-A, Exhibit 5 of the State Plan sets a limit of one physician visit per inpatient hospital day, or 30 per fiscal year, except visits to patients in Intensive or Coronary Care Units (ICU or CCU) are limited to two per day and nursing home visits are limited to thirty-six per fiscal year (no daily limit).

Per documentation in the Medicaid Management Information System (MMIS), there are computer edits which should ensure claims which exceed the service limits identified above are not paid. Service limit files within the MMIS contain the current procedural terminology (CPT) and revenue codes which are accumulated by the system to determine if recipients have exceeded set service limits. We requested the agency run exception reports for these service types, documenting all recipients whose claims exceeded the service limits for the period July 1, 2003, to June 30, 2004. Our testwork on these reports revealed the following:

- We reviewed claims data for 25 recipients out of 5,732 recipients whose paid physician visits exceeded the service limit. Testwork indicated the service limits were exceeded without a valid policy exception for all 25 recipients. This resulted in an overpayment to providers of \$20,222, of which the federal share is \$16,161. We calculated an average amount paid per claim of approximately \$62 using total paid amounts and total paid units as identified in the exception report. Using this average physician visit rate of \$62 multiplied by a total of 20,724 units paid over the service limit as identified in the exception report, we estimate the agency overpaid \$1,284,888, of which the federal share is \$1,028,296.
- We reviewed claims data for 25 recipients out of 253 recipients whose paid inpatient physician visits exceeded the service limit. Testwork indicated the service limits were exceeded without a valid policy exception for 21 recipients. This resulted in an overpayment to providers of \$21,913, of which the federal share is \$17,512. Due to the complexities of determining whether recipients were nursing home residents and whether or not the charges were for intensive or coronary care, we did not project the error to the population.

- We noted four CPT codes, 99241-99244, which were included in the physician service limit file in the old computer system, were not included in the physician service limit file in the new computer system which was implemented in October 2003. Per discussion with agency personnel from the Bureau of Policy, the four CPT codes should be included in the physician service limit file and should accumulate toward a recipient's physician visit service limit. Due to the complexity of determining the claims paid containing these four codes which could have caused recipients to exceed their service limits, we did not determine the amount of questioned costs.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid ensure the edits for service limits in the Medicaid Management Information System are working properly so inpatient physician claims and physician claims will be paid in accordance with the State Plan. The agency should review all service limit files within the new computer system to determine if all CPT and revenue codes are appropriately included in the files to ensure recipients do not receive services in excess of the service limits set forth in the State Plan. The agency should also determine the disposition of the claims listed on the exception reports and make the appropriate adjustments to the claims history. Documentation that adjustments were made should be provided to the auditors by the agency for follow-up purposes.

**ALLOWABLE COSTS/COST PRINCIPLES**

*Immaterial Noncompliance*

93.778

Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004  
Questioned Costs: \$6,117

04-20

Agency Should Ensure Pharmacy Claims in Excess of Service Limits Are Denied

*Finding:*

The Mississippi Medicaid State Plan (State Plan) details the pharmacy service limit for prescriptions reimbursed each month. A total of seven prescriptions are allowed per month for each recipient. Five prescriptions are allowed on a monthly basis; however, a prior authorization should be obtained to extend benefits for up to two additional prescriptions per month. The Medicaid Management Information System (MMIS) includes computer edit functions which are intended to ensure claims which exceed the service limits are denied.

We requested the Office of the Governor - Division of Medicaid run an exception report documenting all recipients whose paid claims contained eight or more prescriptions for the period July 1, 2003, to June 30, 2004. We reviewed pharmacy claims data for 15 out of 4,372 recipients for whom paid claims exceeded seven prescriptions per month. We noted ten instances in which the MMIS allowed claims to be paid in excess of the service limits without a valid policy exception. This resulted in an overpayment of \$7,654 to providers, of which the federal share is \$6,117. Due to the complexities involved in calculating pharmacy reimbursements, we did not project the error to the population.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid verify edits in the computer system are functioning properly to ensure pharmacy claims are paid in accordance with the State Plan. We further recommend the agency determine the disposition of the claims listed on the exception report and make the appropriate adjustments to the claims history. Documentation that adjustments were made should be provided to the auditors by the agency for follow-up purposes.

## OTHER AUDIT FINDINGS

In planning and performing our audit of the federal awards received by the Office of the Governor - Division of Medicaid for the year ended June 30, 2004, we considered internal control over compliance with requirements that could have a direct and material effect on the major federal programs. Matters which require the attention of management were noted. These matters which do not have a material effect on the agency's ability to administer major federal programs in accordance with applicable laws, regulations, or provisions of contracts or grant agreements involve other internal control weaknesses and instances of noncompliance with laws and regulations.

### IMMATERIAL WEAKNESSES IN INTERNAL CONTROLS

**CFDA/Finding  
Number**

**Finding and Recommendation**

#### ALLOWABLE COSTS/COST PRINCIPLES

##### *Immaterial Weakness*

93.778

Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004

Oth-7

Claims Should Be Reprocessed for Updated Rates and Fee Schedule Changes in a Timely Manner

##### *Finding:*

The Medicaid Management Information System (MMIS) is used to process claims for the Office of the Governor - Division of Medicaid. When a provider submits a claim, the MMIS compares the procedure and/or revenue codes submitted on the claim to applicable tables contained within the system to determine the amount to be paid based on the service date of the claim. Outpatient claims are paid using the cost-to-charge ratio table and/or the fee schedule table, physician claims are paid using the fee schedule table and/or the encounter rate table, and nursing home claims are paid using a per-diem rate table. Rates and fee schedule amounts are updated in the tables on a regular basis (ex: once a year). At times, these updates can not be performed prior to claims being submitted and processed for the service dates represented by the update. When this occurs, previously processed claims should be reprocessed after the rates and fee schedule amounts are updated. The fiscal agent is directed by the agency when to enter these updates into the tables and reprocess claims.

Our review of claims from prior year testwork which required follow-up to determine if reprocessing had occurred noted five outpatient claims, one physician claim, and one nursing home claim which had not been reprocessed to reflect the updated amounts per the applicable tables as of November 16, 2004. The amount overpaid on the five outpatient claims was \$17, the amount underpaid on the physician claim was \$9, and the amount underpaid on the nursing home claim was \$255. The net error was an underpayment of \$246. Good internal controls require that claims previously processed with service dates relating to these updates be reprocessed in a timely manner to ensure correct payments are made to providers.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid review the status of claims reprocessing for all claim types to determine if all claims have been reprocessed for changes made to cost-to-charge ratios, fee schedules, encounter rates and per-diem rates. We further recommend the agency make the appropriate adjustments to the claims and provide documentation to the auditors that these adjustments were made.

**ALLOWABLE COSTS/COST PRINCIPLES**

*Immaterial Weakness*

93.778 Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004

Oth-8 Controls over Third Party Liability Audit Assessments Should Be Strengthened

*Finding:*

The Office of the Governor - Division of Medicaid's Bureau of Third Party Recovery (Bureau) performs audits annually of providers to ensure third party payments are properly identified for reducing Medicaid payments. During our testwork on these audits, we noted the Bureau does not have a system in place to track the recovery of assessments generated by the audits performed. Good internal controls require the agency have a system in place to track the recovery of assessments generated by audits of providers. Failure to track the recovery of audit assessments could result in the undercollection of funds by the agency.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid strengthen internal controls at the Bureau of Third Party Recovery to ensure personnel track assessments generated by audits.

**ALLOWABLE COSTS/COST PRINCIPLES**

*Immaterial Weakness*

93.778 Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004

Oth-9 Controls Should Be Strengthened over Desk Reviews of Hospital Cost Reports

*Finding:*

The Mississippi Medicaid State Plan (State Plan), Attachment 4.19-A, page 1, requires each hospital participating in the Mississippi Medicaid Hospital Program to submit a cost report which is to be used in calculating the hospital's per diem rate. Personnel from the Office of the Governor - Division of Medicaid's Bureau of Reimbursement prepare a desk review for each cost report submitted. The desk review form compiles information from the individual hospital's cost report and is used to prepare the calculations for each hospital's per diem rate.

We selected ten out of 192 Medicaid hospital providers in order to test controls over the calculation of fiscal year 2004 inpatient hospital per diem rates. We noted two instances in which the desk review was signed by the preparer; however, there was no documentation of a supervisory review. Good internal controls require a supervisory review be performed on desk reviews by someone other than the preparer. Failure to perform a supervisory review could allow errors to occur and not be detected promptly.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid strengthen controls over desk reviews of hospital cost reports to ensure a supervisory review is performed as evidenced by the signature of the reviewer.

**REPORTING**

*Immaterial Weakness*

93.778

Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004

Oth-10

Controls Should Be Strengthened over Federal Reporting

*Finding:*

The Office of the Governor - Division of Medicaid receives federal grant awards from a federal grantor agency under the Medical Assistance Program for medical services and administrative costs. As a condition of the grant awards, the federal grantor agency requires reports reflecting the financial information related to the grant be submitted to it on a quarterly basis. The agency uses a cost allocation plan approved by the federal grantor agency to determine the federal match rate for expenditures.

Testwork performed on the June 30, 2004, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS 64) report revealed the agency had made an adjustment to reclassify \$2,213,491 in administrative expenditures incurred during the quarter ended June 30, 2004, from a category reported at 50 percent federal match to a category reported at 75 percent federal match. These expenditures related to additional operational charges paid monthly to the fiscal agent which were authorized by an amendment to the contract with the fiscal agent. The auditor reviewed the federal cost allocation plan effective October 1, 2003, and determined the expenditures did not appear to be eligible for a 75 percent federal match rate. Per our discussion with federal grantor agency personnel, communication has been sent to the agency recommending the Division of Medicaid amend the cost allocation plan to allow for a 75 percent match rate for the expenditures reclassified above. As of December 20, 2004, the revision had not been submitted.

In addition, our review of the Federal Cash Transaction Reports (PSC 272 report) revealed two instances in which there was no evidence of supervisory review of the report. In one instance, the agency could not locate the report for the quarter ended December 31, 2003. The agency requested an electronic copy from the federal grantor agency for our review. Therefore, it could not be determined if supervisory approval was present. In the other instance, the preparer had signed the report for the quarter ended September 30, 2003; however, there was no documentation of supervisory review.

Good internal controls require a supervisory review of federal reports be performed and that federal reports be accurate. The failure to properly report expenditure information on quarterly reports to the federal grantor agency could affect future funding. The failure to perform and document supervisory review of reports could allow errors to occur and not be detected promptly.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid ensure all expenditures are reported at the proper match rate as documented in the approved cost allocation plan. If changes in expenditures occur due to contract amendments, the agency should submit a revision of the cost allocation plan to the federal grantor agency for review and approval. We further recommend the agency ensure a supervisory review is performed and documented on federal reports, and that copies of all reports be maintained on file.

**SPECIAL TESTS AND PROVISIONS**

*Immaterial Weakness*

93.778

Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004

Oth-11

Controls Should Be Strengthened over Provider Enrollment

*Finding:*

Healthcare providers seeking participation in the Medicaid Program must submit a provider enrollment application to the Provider Enrollment Unit of the fiscal agent for the Office of the Governor - Division of Medicaid. Once the Provider Enrollment Unit ensures the applications are complete, they are forwarded to Provider Relations at the Division of Medicaid for distribution to various departments for their approval. Final approval is given by the Executive Director of the Division of Medicaid. The approved application is then returned to the fiscal agent to be input to the Medicaid Management Information System (MMIS) and filed. Information such as provider number, reimbursement rate, social security number and tax identification number are entered into the MMIS by the Provider Enrollment Unit. The MMIS produces the "Provider Duplicate SSN Report" (RP016) weekly which lists social security and/or tax identification numbers which match with two or more names and/or provider numbers. Our review of the controls over provider enrollment revealed the RP016 report was not reviewed by fiscal agent personnel. Good internal controls require a review of the RP016 report be performed periodically to ensure providers are not issued multiple provider numbers.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid strengthen controls over provider enrollment to ensure a review is performed of the RP016 report periodically by fiscal agent personnel to ensure providers are not issued multiple numbers. This review should be documented with the reviewer's initials and date.

**SPECIAL TESTS AND PROVISIONS**

*Immaterial Weakness*

93.778 Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004

Oth-12 Controls Should Be Strengthened over Recipient Investigations

*Finding:*

Testwork performed on 30 recipient cases at the Office of the Governor - Division of Medicaid's Bureau of Program Integrity (Bureau) revealed the following:

- Six instances were noted in which there was no evidence of supervisory approval for closure of the case.
- Two instances were noted in which the Bureau failed to close the case. Per agency personnel, the employee responsible for these cases had resigned. The cases were located in the former employee's office when requested by the auditor, and it appeared that no one was following up on these cases.

Good internal controls require a supervisory review be performed and documented in the recipient case files to ensure appropriate decisions are made in closing cases. Good internal controls also require that adequate safeguards be in place to ensure all cases are followed up on in the event of employee resignations. The failure to ensure internal controls are in place could result in improper decisions or failure on the part of the Bureau to receive recoupment from recipients.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid strengthen controls at the Bureau of Program Integrity to ensure a supervisory review is performed and documented on all cases prior to closure. We further recommend the agency implement controls to ensure proper tracking of recipient cases.

**ALLOWABLE COSTS/COST PRINCIPLES**

*Immaterial Noncompliance*

93.778 Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004  
Questioned Costs: \$4,121

Oth-13

Agency Should Ensure Nursing Home Rates Are Accurate

*Finding:*

The Mississippi Medicaid State Plan (State Plan), Attachment 4.19-D, Chapter 7, documents the methodology which should be used to calculate the trend factor which is used in the preparation of per diem rates for nursing and intermediate care facilities for people with mental retardation (ICF/MR). The State Plan, Attachment 4.19-D, page 15, requires each nursing facility and ICF/MR participating in the Medicaid Program to submit a cost report which is to be used in calculating the facility's per diem rate. Personnel from the Office of the Governor - Division of Medicaid's Bureau of Reimbursement prepare a desk review for each cost report submitted. The desk review is a form used to compile information from the individual facility's cost report to prepare the calculations for each facility's per diem rate. We selected nine out of 186 nursing facilities and one out of 13 ICF/MR facilities for testwork. Our testwork revealed the following:

- The desk review for one nursing facility failed to detect the facility had incorrectly included \$11,763 in depreciation over cost basis. This caused the per diem rate to be overstated by \$.33 for the period January 1, 2004, to June 30, 2004. Agency personnel provided the total number of days paid by the agency for claims submitted by this nursing facility. Based on this information, an overpayment of \$5,150 was made to the provider, of which the federal share is \$4,121.
- The agency uses a spreadsheet to prepare a trend factor calculation which is used when preparing each facility's per diem rate. We noted the spreadsheet contained a transposition error. The agency had incorrectly recorded one of the numbers used in the calculation as 5.01 percent instead of 5.10 percent. This error did not affect the calculation of the trend factor due to rounding in the agency spreadsheet; however, an error of this nature has the potential to cause all of the per diem rates to be incorrect.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid ensure personnel performing desk reviews verify the accuracy of information provided by facilities. In addition, the agency should ensure a supervisory review is performed on the trend factor calculation to ensure clerical accuracy. We further recommend the agency make the appropriate adjustments to the claims history. Documentation that adjustments were made should be provided to the auditors by the agency for follow-up purposes.

**ALLOWABLE COSTS/COST PRINCIPLES**

*Immaterial Noncompliance*

93.778

Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004

Oth-14                    Reimbursements for the Upper Payment Limit (UPL) Program Should Be Made in Accordance with the State Plan

*Finding:*

The Office of the Governor - Division of Medicaid makes payments to hospitals and nursing home facilities under the Upper Payment Limit (UPL) Program. The *Code of Federal Regulations* (42 CFR 447.272) defines upper payment limits as "...a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles...." In accordance with this federal regulation, the Mississippi Medicaid State Plan (State Plan), Attachment 4.19A, page 15, states, "...hospitals located within Mississippi may be reimbursed in accordance with the applicable regulations regarding the Medicaid upper payment limit. For each specified class of hospital...the amount that Medicare would have paid for the previous year will be calculated and compared to the payments actually made by Medicaid during that same time period. This calculation may then be used to make payments to hospitals for the current year. Any payment made under this provision will be made bi-monthly." During our review of UPL payments made by the Division of Medicaid for fiscal year 2004, we noted the payments were made quarterly. Failure to make UPL payments bi-monthly results in non-compliance with the State Plan.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid ensure UPL payments are made bi-monthly in accordance with the State Plan. If other payment arrangements are deemed to be more reasonable, the agency should revise the State Plan to require such payments.

**ALLOWABLE COSTS/COST PRINCIPLES**

*Immaterial Noncompliance*

93.778                    Medical Assistance Program

Federal Award Number and Year: 05-0405MS5028, 2004  
Questioned Costs: \$7

Oth-15                    Agency Should Ensure Outpatient Claims Are Paid in Accordance with the State Plan

*Finding:*

The Mississippi Medicaid State Plan (State Plan) Attachment 4.19-B, page 2a, documents the methodology which is to be used to calculate payment for outpatient claims. State Plan Attachment 4.18-A, page 1, documents the appropriate co-payment amounts to be collected by the provider based on claim type. Some common exceptions to the co-payment requirement are "true emergencies", pregnancy, and children under the age of 18. A co-payment exception indicator code should be included on the claim by the provider when submitting it for payment if an exception exists. Our review of 12 outpatient claims at the Office of the Governor - Division of Medicaid revealed one claim for which the reimbursement had not been calculated according to the State Plan. We also noted one outpatient claim for which the co-payment amount was not deducted from the payment to the provider, and no co-payment exception was present on the claim.

The error on the outpatient claim which had not been calculated according to the State Plan was the result of the system calculating the charge for two revenue codes incorrectly based on the prior year's cost-to-charge ratio. This resulted in an overpayment to the provider of \$6, of which the federal share is \$5. The error on the outpatient claim for which a co-payment amount was not deducted resulted in an overpayment to the provider of \$3, of which the federal share is \$2. Due to the complexity of determining all outpatient claims involving codes requiring a calculation using the cost-to-charge ratio and those requiring co-payment, we did not determine the amount of questioned costs.

*Recommendation:*

We recommend the Office of the Governor - Division of Medicaid ensure the Medicaid Management Information System is computing the payment for outpatient claims in accordance with the State Plan and that co-payment amounts are properly deducted from claims.