



STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

SINGLE AUDIT FINDINGS

Phil Bryant, State Auditor
Office of the State Auditor
State of Mississippi
Post Office Box 956
Jackson, MS 39205-0956

June 13, 2007

Dear Mr. Bryant:

Our responses and corrective action plan, relative to your letter dated May 17, 2007, are as follows:

ALLOWABLE COSTS/COST PRINCIPLES

Immaterial Noncompliance

93.778 Medical Assistance Program

06-08 Claims for Inpatient Psychiatric Services Should Be Denied for Recipients Age 21 and Older

Response: When the Envision MMIS system went into production in October 2003, place of service 51 - Inpatient Psychiatric Facility and 56 - Psychiatric Residential Treatment Facility were new. The system did not edit for these places of service against the beneficiary's age. The Division and its fiscal agent have taken the appropriate action to ensure computer edits are in place.

Corrective Action: CSR #DO05004214 was submitted on February 17, 2006 to create an edit to deny claims billed with these places of service for beneficiaries age 21 and older. The CSR was completed and put in production for new claims about May 8, 2006. Claims since May 2006 for beneficiaries age 21 and older will now deny for edit 3958 IP Psych and Bene Age Restriction. Providers were reminded about the policy in the Mississippi Medicaid Provider Bulletin May 2006. Claims with dates of service back to October 1, 2004 were mass adjusted on April 16, 2007 and payments were recovered.

ALLOWABLE COSTS/COST PRINCIPLES

Immaterial Noncompliance

93.778 Medical Assistance Program

06-10 Hospital Claims in Excess of Service Limits Should Be Denied

Response: Upon further review of the claims in question, one beneficiary had inpatient hospital claims totaling 47 inpatient days; however, one claim for 17 days was voided on October 30, 2006. This leaves a total of 30 inpatient days paid, which is in accordance with policy. In regards to the other claim, the beneficiary in question had inpatient hospital services totaling 58 inpatient days. Edit 3648 – Maximum Inpatient Days Exceeded for Fiscal Year was not set to deny Medicare Part A crossover claims at the time these claims processed.

Corrective Action: CSR 5472 was implemented on October 5, 2006 to correct this problem. The two claims referenced were voided and were special batched on February 5, 2007 to pay.

ALLOWABLE COSTS/COST PRINCIPLES

Immaterial Noncompliance

93.778 Medical Assistance Program

06-11 Outpatient Hospital Claims Should Be Paid in Accordance with the State Plan

Response: Due to system complexities, the claims system does not collect a co-pay on revenue codes 450-459. These revenue codes indicate emergency services which in accordance with the State Plan (4.18A, page 3) are exempt from a co-pay.

Corrective Action: The Division is researching this issue; however, designing the required computer edits will be a complex task. The Division will continue to examine this issue and take appropriate corrective action.

ALLOWABLE COSTS/COST PRINCIPLES

Immaterial Noncompliance

93.778 Medical Assistance Program

06-12 Outpatient Rates Should Be Calculated in Accordance with the State Plan

Response: DOM wishes to dispute this finding. The Division submitted State Plan Amendments (SPAs) in the second quarter of SFY

2006 related to reimbursement of hospital inpatient and outpatient services. The hospital outpatient SPA is currently being held by CMS due to questions related to hospital outpatient UPL payments. These issues are currently being addressed and the Division believes we will receive approval for the outpatient SPA in the near future.

Corrective Action: Upon notification from CMS, the Division will forward sufficient documentation for follow-up purposes.

ALLOWABLE COSTS/COST PRINCIPLES

Immaterial Noncompliance

93.776 Hurricane Katrina Relief

06-13 Payments for Uncompensated Care Should Be Reviewed for Duplication and Clerical Accuracy

Response: DOM wishes to dispute the reporting of this finding. On August 29, 2005, Hurricane Katrina caused severe destruction in south Mississippi and adversely affected the delivery of health care. CMS provided Mississippi, along with Louisiana and Alabama with a Section 1115 waiver that expedited health care coverage to meet the needs of low-income beneficiaries who needed health care and eliminated barriers in an effort to support evacuees. The states were granted waivers of Federal requirements to allow for flexibility, administrative efficiency, and additional coverage needed to ensure that the most vulnerable citizens received the health care they required.

DOM worked very closely with CMS and developed methodologies to prevent fraud which were approved by CMS. In accordance with approved CMS procedures DOM performed the following for all claims submitted under the Uncompensated Care Plan:

- Medicaid and Medicare status was verified by means of system query.
- Medical providers were required to attest that the services provided were: a) medically necessary; b) that they had not received payment from any other source; c) that they would not subsequently bill any other source for the services; d) that they were unaware of any other source of payment; and e) payment would be accepted as payment in full for the claim.
- All claims went through a review process for assessment and pricing. DOM staff looked up the allowed amount for each service billed and calculated the correct reimbursement rates for each claim. All requests for payment were entered into a database and queried before approval of payment in order to prevent duplicate payment for services. These requests were

then forwarded to the fiscal agent for processing as a financial transaction. Since these claims were not processed, nor should they have been, with claims through the regular Medicaid program, there was not a means available to compare the claims billed through the Section 1115 waiver with regular Medicaid claims. In addition, at no time did CMS require that these claims be compared on the front end in such a manner.

When this data was provided to the State Auditor's office, it was made with the understanding that the auditor was reviewing unaudited records. It is our opinion that the actions taken by DOM are in compliance with the CMS approved Mississippi Uncompensated Care Pool plan, specifically, Section VI, whereby it states that DOM will perform retrospective reviews and recoup payments for inappropriate claims.

Corrective Action:

DOM will take the appropriate steps to retrospective reviews and DOM will ensure payments are recouped for inappropriate claims. DOM will provide the State Auditor's office with the results of the retrospective reviews for purposes of follow-up. However, given the fact that DOM has followed the guidelines established by CMS and that DOM has not had the opportunity to schedule the retrospective review, we are requesting that this finding be removed.

CASH MANAGEMENT REPORTING

Immaterial Noncompliance

93.778

Medical Assistance Program

06-07

Adjustments to Administrative Costs Should Be Correctly Calculated

Response:

The actions taken by DOM were in accordance with the information provided by CMS at that time. The sequence of events that led to the adjustment is described below.

DOM submitted a revised cost allocation plan to CMS in January of 2005. The revised cost allocation plan incorporated the changes in costs associated with all fiscal agent contract amendments in effect at the time and was not dependent on the certification of the new MMIS system by the federal grantor. The Division did not receive final approval to apply the 75% enhanced match rate to a portion of these contract amendments until September of 2006. CMS reviewed the calculations related to the \$5,407,232.40 adjustment for additional federal enhanced match funds on the June 30, 2006 federal CMS-64 report. The Division submitted copies of supporting fiscal agent invoices for 2.5 years to CMS as part of their review.

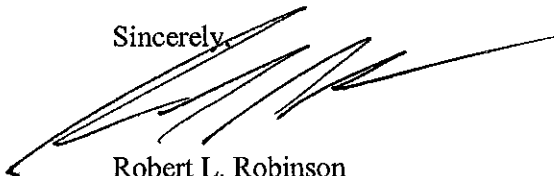
It was later discovered that fiscal agent costs associated with contract amendment #3 for the months of June, July, and August 2004 and amendment #5 for the months of June and July 2004 were reported at the enhanced match rate of 75% and were not reversed in subsequent reporting periods. They were not reversed because the Division fully believed these costs were entitled to the enhanced match rate. Since it took approximately 21 months for a decision to be reached on what fiscal agent contract amendment costs would qualify for the enhanced match rate, this prior adjustment was not considered in calculating the final settlement.

Corrective Action:

The Division has subsequently reduced the prior final settlement amount by \$509,199.51 on the federal CMS-64 report for the quarter ended March 31, 2007.

If you have any questions, please contact Janet Mann at 601.359.6528.

Sincerely,

A handwritten signature in black ink, appearing to read 'Robert L. Robinson', with a long, sweeping horizontal line extending to the right.

Robert L. Robinson
Executive Director



STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

OTHER FINDINGS

Phil Bryant, State Auditor
Office of the State Auditor
State of Mississippi
Post Office Box 956
Jackson, MS 39205-0956

June 13, 2007

Dear Mr. Bryant:

Our responses and corrective action plan, relative to your letter dated May 17, 2007, are as follows:

ALLOWABLE COSTS/COST PRINCIPLES

Immaterial Weakness

93.778

Medical Assistance Program

Oth-09

Controls over Provider Rate and Claims Adjustment Transmittals Should Be Improved

Response:

DOM believes that there was a misunderstanding as to what was being requested during the audit. We incorrectly believed that what was being requested was a formal letter from DOM to ACS stating which specific transmittals we had outstanding near the end of SFY 2006. DOM has made a concerted effort to work with ACS to complete the outstanding transmittal work. We have evidence in the way of hundreds of e-mails and numerous meetings between DOM and ACS regarding either groups or individual transmittals.

The transmittals forms in question span several different provider types, hundreds of providers, as well as varying time periods. DOM decided in SFY 2006 to pursue targeting adjustments by provider group and certain time periods. This targeting effort has proven to be much more successful than our past efforts.

Corrective Action: DOM has gone to great lengths to improve the process for rate changes and claims adjustments with ACS. DOM has and is willing to discuss this matter in greater detail and provide documentation of our meetings with ACS to the State Auditor's office. In regards to timely completion of rate changes and claims adjustments and given the complexities of making these changes, DOM is of the opinion that our new processes are much more efficient and no additional corrective action is required.

ALLOWABLE COSTS/COST PRINCIPLES

Immaterial Weakness

93.778 Medical Assistance Program

Oth-1 Controls Should Be Strengthened to Ensure Supporting Documentation is Maintained and Payments Comply with Contracts

Response: Bullet Number 1 – Copier leases are located in a contracts database on the Accounting shared drive of the DOM LAN. This database contains all DOM contracts and leases. The charge per copy component for 1 of the 49 copiers leased from Southern Duplicating was billed and paid incorrectly. Refunds totaling \$8,295.98 were requested and received by the Accounts Payable Division immediately after the discrepancy was identified

Bullet Number 2 – DOM concurs with this finding and corrective action is detailed below.

Corrective Action: Bullet Number 1 – DOM received two payments in the amounts of \$738.65 and \$7,557.33 in March of 2007 from Southern Duplicating of Clarksdale. No other corrective action is required.

Bullet Number 2 – Bureau of Accounting and Finance staff are in the process of reviewing these leases and the vendor will be contacted to provide clarification as needed.

ALLOWABLE COSTS/COST PRINCIPLES

Immaterial Noncompliance

93.778 Medical Assistance Program

Oth-2 Physician Services for Long Term Care Recipients in Excess of Service Limits Should be Denied

Response: DOM reviewed the claims in question. For the majority of the items in the sample, it appears that the claims submitted that had

paid over the 36 physician visit limit were Part B crossover claims. CSR6500 was requested on May 29, 2007 to research potential issues with crossover claims.

Corrective Action: Upon completion of CSR6500, DOM will take appropriate corrective action and provide documentation for follow-up purposes.

SPECIAL TESTS AND PROVISIONS

Immaterial Noncompliance

93.778 Medical Assistance Program

Oth-3 Documentation Should Be Maintained for Provider Enrollment

Response: The four provider applications that could not be found were temporary Hurricane Katrina applications. While the procedure for processing these applications was similar to the normal process, there were some exceptions, such as the application only being one page in length.

An expedited provider enrollment process was enacted following Hurricane Katrina in August of 2005 to facilitate access to care. ACS processed over 6,000 provider enrollment applications during the expedited period that lasted through the first quarter of SFY 2006. Upon the conclusion of the expedited provider enrollment period, the established process was reinstated.

Corrective Action: DOM believes that this is an isolated incident and not reflective of ACS and their process of enrolling providers. Given that these were emergency enrollment forms and one page in length, most likely these forms were misfiled at ACS or DOM. It is our opinion that no corrective action is needed.

ALLOWABLE COSTS/COST PRINCIPLES

Immaterial Noncompliance

93.778 Medical Assistance Program

Oth-08 Pharmacy Claims Should Be Paid in Accordance with the State Plan

Response: Bullet Number 1 – On July 1, 2005, pharmacy reimbursement for brand name or sole source drugs changed from AWP-12% to the lower of AWP-12% or WAC+9%. Prior to the change in reimbursement, it was determined that the monetary difference between AWP-12% and WAC+9% was/is small. Pharmacy reimbursement was correct, i.e. lower of AWP-12% or WAC+9% from July 1, 2005 to at least November 11, 2005, and

incorrect from on and/or about November 26, 2005 to July 25, 2006. During this time frame, several CSRs were implemented, all of which involved reimbursement. Any and/or all of these CSRs could have affected the main pricing adjudication module PDMS8530, wherein the "lower of" logic for brand name drugs is found.

Bullet Number 2 – DOM is aware of this issue and has taken steps to ensure that data from claims which activated Edit Code 4630 is appropriately captured and reported to the Bureau of Recovery.

Corrective Action:

Bullet Number 1 – This was corrected on July 25, 2006 when CSR 4078 was implemented.

Bullet Number 2 – CSR 5180 was submitted to ACS on August 9, 2006 and implemented on March 13, 2007.

If you have any questions, please contact Janet Mann at 601.359.6528.

Sincerely,



Robert L. Robinson
Executive Director

OFFICE OF THE STATE AUDITOR
AUDITOR'S NOTES
In Rebuttal to Division of Medicaid's Response

Finding 06-12 Outpatient Rates Should Be Calculated in Accordance with the State Plan

Auditor's Notes

The Division of Medicaid disputes the finding. However, in the response, the agency acknowledges that the hospital outpatient State Plan Amendment (SPA) is currently being held by CMS and has not been approved. There is no tentative date for the SPA to be approved. The Office of the State Auditor felt it was our responsibility to note that the methodology used for determining hospital outpatient rates for fiscal year 2006 had not been approved as of the completion of fieldwork; therefore, we could not conclude that the hospital outpatient rates were computed in compliance with the approved State Plan.

Finding 06-13 Payments for Uncompensated Care Should Be Reviewed for Duplication and Clerical Accuracy

Auditor's Notes

The Division of Medicaid disputes the finding. The Division's response contains the procedures utilized in processing claims. One of the procedures states that "...all requests for payment were entered into a database and queried before approval of payment in order to prevent duplicate payment for services." The procedures also included "...a review process for assessment and pricing." Audit procedures performed by the Office of the State Auditor revealed errors in pricing as well as duplicate payments through the database. Therefore, it appears the finding is warranted. The Division also disputes the part of the finding where it is noted that duplicate payments were noted in which a provider was paid once from the manual database and again through a claim submitted to the MMIS computer system. The Division bases their dispute on the fact that CMS did not require the Division to compare systems prior to processing claims. The finding was written to point out that duplicate payments were noted in the audit work and to recommend the Division implement procedures to identify duplicates. The Division's corrective action plan states that appropriate steps will be implemented to ensure payments are recouped for inappropriate claims. Therefore the Office of the State Auditor and the Division of Medicaid appear to be in agreement that duplicate payments were made and the Division should implement procedures to identify duplicate payments and recoup funds which were paid in error. For this reason, the Office of the State Auditor believes the finding is valid.