STATE OF MISSISSIPPI
OFFICE OF THE STATE AUDITOR
SHAD WHITE
STATE AUDITOR

March 16, 2021

Financial Audit Management Report

Mr. Drew Snyder, Executive Director
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201

Dear Mr. Snyder:

Enclosed for your review is the financial audit finding for the Mississippi Division of Medicaid for the Fiscal Year 2020. In this finding, the Auditor's Office recommends the Mississippi Division of Medicaid:

1. Strengthen controls over the preparation and review of the Schedule of Expenditures of Federal Awards and Estimated Claims Payable.

Please review the recommendation and submit a plan to implement it by March 31, 2021. 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.

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the result of that testing, and not to provide an opinion on the effectiveness of the Mississippi Division of Medicaid's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Mississippi Division of Medicaid's internal control and compliance. Accordingly, this communication is not suitable for any other purpose. However, this report is a matter of public record and its distribution is not limited.

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

Sincerely,

Stephanie C. Palmertree

Stephanie C. Palmertree, CPA, CGMA
Director, Financial Audit and Compliance Division
Enclosures

FINANCIAL AUDIT MANAGEMENT REPORT

The Office of the State Auditor has completed its audit of selected accounts included on the financial statements of the Mississippi Division of Medicaid for the year ended June 30, 2020. These financial statements will be consolidated into the State of Mississippi's *Comprehensive Annual Financial Report*. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. The Office of the State Auditor's staff members participating in this engagement included Ashley Jolly, CPA, Richard Aultman, CPA, Allen Case, CPA, Levi Hill and Hector Tanco.

Our 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 of the Division of Medicaid as of and for the year ended June 30, 2020, in accordance with auditing standards generally accepted in the United States of America, we considered the Mississippi Division of Medicaid's internal control over financial reporting (internal control) as a basis for designing the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on these accounts, but not for the purpose of expressing an opinion on the effectiveness of internal control. In addition, because of the inherent limitations in internal control, including the possibility of management override of controls, misstatements due to error or fraud may occur and not be detected by such controls. Accordingly, we do not express an opinion on the effectiveness of the Mississippi Division of Medicaid's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may exist that were not identified. However, as discussed below, we did identify a certain deficiency in internal control, identified in this letter as item **2020-011**, that we consider to be a material weakness.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether selected accounts included on the financial statements of the Mississippi Division of Medicaid are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, 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.

The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Finding and Recommendation

MATERIAL WEAKNESS

2020-011 Controls Should Be Strengthened Over the Preparation and Review of the Schedule of Expenditures of Federal Awards and Estimated Claims Payable.

Repeat Finding No.

Criteria *The Internal Control – Integrated Framework,* published by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) and the *U.S. Government Accountability Office Standards for Internal Control in the Federal Government* (Green Book) specify that a satisfactory control environment is only effective when there are adequate control activities in place. Effective control activities dictate that a review is performed to verify the accuracy and completeness of financial information reported. The Federal Grant Activity Schedule captures amounts that must be accurate and complete in order to ensure the accuracy of financial and federal information reported on such schedule to verify the accuracy and completeness of financial information reported.

The Mississippi Agency Accounting Policies and Procedures (MAAPP) manual Section 27.30.60 states, "The Federal Grant Activity schedule supports amounts reported on the GAAP packet for federal grant revenues, receivables, deferred revenues and expenditures. The schedule is also used for preparing the Single Audit Report required by the Single Audit Act, Office of Management and Budget Circular A-133 and the State's audit requirements. The amounts on this schedule should be reconciled by the agency with amounts reported on federal financial reports."

Condition During the audit of the Mississippi Division of Medicaid for fiscal year ended June 30, 2020, we became aware of ineffective processes and/or procedures relating to internal controls over financial reporting. The following exceptions were noted on the Schedule of Expenditures of Federal Awards and the Estimated Claims Payable calculation.

- One instance in which the Catalog of Federal Domestic Assistance (CFDA) number did not agree to the Agency Program Index located in the *2020 Catalog of Federal Domestic Assistance* at beta.sam.gov.
- Two instances in which the "Grant Period Start Date" per the Schedule of Expenditures of Federal Awards did not agree with the "Grant Start Date" per the Grant Award.
- Two instances in which the "Grant Period End Date" per the Schedule of Expenditures of Federal Awards did not agree with the "Grant End Date" per the Grant Award.
- Two instances in which the amount listed in the grant award section of the Schedule of Expenditures of Federal Awards did not agree with the Grant

Award.

- Five instances in which expenditures per the Schedule of Expenditures of Federal Awards did not agree to the Mississippi Accountability System for Government Information and Collaboration (MAGIC), resulting in adjustments of $61,553,632 to the Schedule of Expenditures of Federal Awards.
- Agency does not perform a reconciliation of the Schedule of Expenditures of Federal Awards to MAGIC.
- The incorrect percentage was used for the adjustment for change in total medical service payments in the original and revised Claims Payable calculations.
- The COVID reduction in claims was calculated incorrectly in the Claims Payable calculation.
- The amount of claims payable to other state agencies was not included in the Claims Payable calculation.

The lack of adequate controls over the Schedule of Expenditures of Federal Awards and the Claims Payable calculation resulted in the following:

- Accounts Payable was understated by $4,884,341
- Subsidies Loans and Grants was understated by $4,884,341
- Due from Federal Government was understated by $65,616,427
- Federal Revenue was understated by $65,616,427

Cause

Agency did not possess or enforce proper internal control structures. Additionally, Agency did not properly review and reconcile grant schedule information and did not perform review over crucial aspects of financial reporting.

Effect

Without proper internal control structures over financial reporting, erroneous financial statements and corresponding schedules could be compiled, resulting in a misrepresentation of the financial standing of the Mississippi Division of Medicaid. Failure to properly ensure the CFDA numbers and amounts are correct on the Federal Grant Activity Schedule could result in reporting errors on the State's Single Audit Report.

Recommendation

We recommend the Mississippi Division of Medicaid strengthen controls over the preparation and review of the Schedule of Expenditures of Federal Awards and Claims Payable calculation to ensure all grant award information and amounts reported are accurate and correct.

End of Report

OFFICE OF THE GOVERNOR
Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF MEDICAID

FINANCIAL AUDIT FINDINGS

Shad White, State Auditor
Office of the State Auditor
State of Mississippi
P. O. Box 956
Jackson, MS 39205-0956

March 31, 2021

Dear Mr. White:

We have reviewed the single audit findings in reference to our fiscal year 2020 audit. Listed below are our individual responses and plans for corrective action:

AUDIT FINDINGS:

2020-011 Controls Should Be Strengthened Over the Preparation and Review of the Schedule of Expenditures of Federal Awards and Estimated Claims Payable.

Response:

The Division agrees with the exceptions noted on the Schedule of Expenditures of Federal Awards and the Estimated Claims Payable calculation.

Corrective Action Plan:

A. The Division understands the importance of this information and will strengthen controls over the preparation and review of the year end reports. The Office of Financial Reporting is now fully staffed and trained and has an additional Budget Director reporting to the Comptroller. This will allow the responsibility for creation and review of the GAAP packet and associated entries, the agency budget, and the federal expenditure reports, which are all due at the end of July, to be better allocated across staff.

   To provide further controls over the preparation of these reports, the Division is creating a schedule of GAAP reporting duties, allowing those to be assigned and completed earlier and providing for a thorough review and rework, if necessary. Additionally, the agency has

identified reports that can be used from the Payment Management System (PMS) to ensure all grant information is correct prior to submission of the grant schedule.

B. Christine Woodberry

C. June 30, 2021

Sincerely,

Drew Snyder

Drew L. Snyder
Executive Director

STATE OF MISSISSIPPI

OFFICE OF THE STATE AUDITOR

SHAD WHITE

AUDITOR

July 20, 2021

Single Audit Management Report

Drew L. Snyder, Executive Director
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201

Dear Mr. Snyder:

Enclosed for your review are the single audit findings and other audit findings for the Mississippi Division of Medicaid for Fiscal Year 2020. In these findings, the Auditor's Office recommends the Mississippi Division of Medicaid:

Single Audit Findings:

1. Strengthen Controls to Ensure Compliance with the Allowable Costs Requirements of the Children's Health Insurance Program (CHIP).
2. Strengthen Controls to Ensure Compliance with Eligibility Requirements of the Medical Assistance Program and the Children's Health Insurance Program (CHIP).
3. Strengthen Controls to Ensure Compliance with the Provider Eligibility Requirements of the Children's Health Insurance Program CHIP.
4. Strengthen Controls to Ensure Compliance with Utilization Control and Program Integrity Requirements.
5. Strengthen Controls to Ensure Compliance with Automatic Data Processing (ADP) Risk Analysis and System Security Review Requirements.
6. Ensure Compliance with Medicaid National Correct Coding Initiative (NCCI) Confidentially Agreement Requirements.

Please review the recommendations and submit a plan to implement them by July 23, 2021. 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.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of Office of Management and Budget's Uniform Guidance. Accordingly, this report is not suitable for any other purpose. However, this report is a matter of public record and its distribution is not limited.

I hope you find our recommendations enable the Mississippi Division of Medicaid to carry out its mission more efficiently. I appreciate the cooperation and courtesy extended by the officials and employees of the

Mississippi Division of Medicaid throughout the audit. If you have any questions or need more information, please contact me.

Sincerely,

Stephanie Palmertree, CPA, CGMA
Director, Financial and Compliance Audit Division

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 the State's major federal programs administered by the Mississippi Division of Medicaid for the year ended June 30, 2020.

Our 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.

Report on Compliance for Each Major Federal Program

We have audited the Mississippi Division of Medicaid's compliance with the types of compliance requirements described in the Office of Management and Budget (OMB) *Uniform Guidance Compliance Supplement* that could have a direct and material effect on the federal programs selected for audit that are administered by the Mississippi Division of Medicaid for the year ended June 30, 2020.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations, and the terms and conditions of its federal awards applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for each of the State of Mississippi's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) *Uniform Administrative Requirements, Cost Principles,* and *Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Mississippi Division of Medicaid's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. However, our audit does not provide a legal determination of the Mississippi Division of Medicaid's compliance.

Results of Compliance Audit Procedures

The results of our auditing procedures disclosed instances of noncompliance with those requirements, which are required to be reported in accordance with OMB Uniform Guidance and which are identified in this letter as items 2020-041, 2020-042, 2020-043, 2020-044, 2020-045 and 2020-046.

Internal Control over Compliance

Management of the Mississippi Division of Medicaid is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Mississippi Division of Medicaid's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal controls over compliance in accordance with OMB Uniform Guidance,

but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of Mississippi Division of Medicaid's internal control over compliance.

Our consideration of internal control over compliance was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. However, as discussed below, we identified certain deficiencies in internal control over compliance that we consider to be material weaknesses and significant deficiencies.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. We consider the deficiencies in internal control over compliance identified in this letter as items 2020-041, 2020-042, 2020-043, 2020-044 and 2020-045 to be material weaknesses.

Findings and Recommendations

ALLOWABLE COSTS

Material Weakness
Material Noncompliance

2020-041 Strengthen Controls to Ensure Compliance with the Allowable Costs Requirements of the Children's Health Insurance Program (CHIP).

CFDA Number 93.767 Children's Health Insurance Program (CHIP)

Federal Award No. 1805MS5021
1905MS5021
2005MS5021
2005MS5021 COVID

Federal Agency United States Department of Health and Human Services (HHS)

Questioned Costs N/A

Criteria *The Code of Federal Regulations (42 cfr 457.505)* states, "The State plan must include a description of (a) The amount of premiums, deductibles, coinsurance, copayments, and other cost sharing imposed."

The Code of Federal Regulations (42 cfr 457.515) states, "To impose copayments, coinsurance, deductibles or similar charges on enrollees, the State plan must describe— (a) The service for which the charge is imposed; (b) The amount of the charge; (c) The group or groups of enrollees that may be subject to the cost-sharing charge."

Per *Mississippi Children's Health Insurance Program State Plan Section 8.2.3 (State Plan Amendment MS-19-0011-CHIP),* children whose annual family income is less than or equal to 150 percent of the Federal Poverty Level are not subject to any co-payments or co-insurance.

Per *Mississippi Children's Health Insurance Program State Plan Section 8.2.3 (State Plan Amendment MS-19-0011-CHIP),* children whose annual family income is between 151 percent and 175 percent of the Federal Poverty Level are subject to co-payments of $5.00 per doctor visit, $15.00 per emergency room visit, and an out-of-pocket maximum of $800.00.

Per *Mississippi Children's Health Insurance Program State Plan Section 8.2.3 (State Plan Amendment MS-19-0011-CHIP),* children whose annual family income is between 176 percent and 209 percent of the Federal Poverty Level are subject to co-payments of $5.00 per doctor visit, $15.00 per emergency room visit, and an out-of-pocket maximum of $950.00.

Condition

During testwork performed over allowable costs requirements for the Children's Health Insurance Program (CHIP) as of June 30, 2020, the auditor tested 60 total recipients and noted the following:

- 20 of the 60 (or 33.33 percent) CHIP recipients tested, or 33 percent, in which beneficiaries were not placed in the correct CHIP sub-group that determines the beneficiary's co-payments and out-of-pocket maximums.
    - 10 instances (or 16.67 percent) in which the family of the beneficiary had an annual income at or below 150 percent of the Federal Poverty Level, but the beneficiary was placed in the CHIP sub-group for children whose family had an annual income between 151 percent and 175 percent of the Federal Poverty Level.
    - 10 instances (or 16.67 percent) in which the family of the beneficiary had an annual income at or below 175 percent of the Federal Poverty Level, but the beneficiary was placed in the CHIP sub-group for children whose family had an annual income between 176 percent and 209 percent of the Federal Poverty Level.

Cause

The Federal Poverty Level was not correctly entered into the computer system and co-payments and out-of-pocket expenses were not calculated correctly.

Effect

Beneficiaries paid incorrect co-payments and out-of-pocket expenses.

Recommendation

We recommend the Mississippi Division of Medicaid strengthen the controls to ensure correct calculation of co-payments and out-of-pocket expenses.

Repeat Finding

No.

Statistically Valid

This sample is considered statistically valid.

ELIGIBILITY

Material Weakness
Material Noncompliance

2020-042 Strengthen Controls to Ensure Compliance with Eligibility Requirements of the Medical Assistance Program and the Children's Health Insurance Program (CHIP).

CFDA Number 93.767 Children's Health Insurance Program (CHIP)
93.778 Medical Assistance Program (Medicaid, Title XIX)

Federal Award No.

1805MS5021	1905MS5021	2005MS5021
1905MS5ADM	2005MS5ADM	
1905MS5MAP	2005MS5MAP	
1905MSIMPL	2005MSIMPL	
1905MSINCT	2005MSINCT	

Federal Agency United States Department of Health and Human Services (HHS)

Questioned Costs $75,795

Criteria *The Code of Federal Regulations 42 cfr 435.945(d)* states, "All State eligibility determination systems must conduct data matching through the Public Assistance Reporting Information System (PARIS)."

The Mississippi Division of Medicaid MAGI-Based Eligibility Verification Plan states, "The state uses quarterly PARIS data matches to resolve duplicate Medicaid participation in another state and residency discrepancies."

Per the *Mississippi Medicaid State Plan Attachment 4.32-A*, quarterly file transmissions of Medicaid recipients active in the previous quarter are submitted for matching purposes with applicable federal databases (PARIS) to identify benefit information on matching Federal civilian employees and military members, both active and retired, and to identify duplicate participation across state lines.

Miss. Code Ann (1972) Section 43-13-116.1(2) states, "In accordance with Section 1940 of the federal Social Security Act (42 USCS Section 1396w), the Division of Medicaid shall implement an asset verification program requiring each applicant for or recipient of Medicaid assistance on the basis of being aged, blind or disabled, to provide authorization by the applicant or recipient, their spouse, and by any other person whose resources are required by law to be disclosed to determine the eligibility of the applicant or recipient for Medicaid assistance, for the division to obtain from any financial institution financial records and information held by any such financial institution with respect to the applicant, recipient, spouse or such other person, as applicable, that the division determines are needed to verify the financial resources of the applicant, recipient or such other person in connection with a determination or redetermination with respect to eligibility for, or the amount or extent of, Medicaid assistance. Each aged, blind or disabled Medicaid applicant or recipient, their spouse, and any other applicable person described in this section shall provide authorization (as specified by 42 USCS Section 1396w(c)) to the division to obtain from any

financial institution, any financial record, whenever the division determines that the record is needed in connection with a determination or redetermination of eligibility for Medicaid assistance."

The Mississippi Division of Medicaid Eligibility Policy and Procedure Manual Section 303.03 states, "Section 1940 of the Social Security Act and Mississippi state law requires the verification of liquid assets held in financial institutions for purposes of determining Medicaid eligibility for applicants and beneficiaries in programs with an asset test, i.e., Aged, Blind, and Disabled (ABD) Medicaid programs.

Per *The Mississippi Division of Medicaid Eligibility Policy and Procedure Manual Section 303.03*, implementation of MDOM's Asset Verification System (AVS) is on/after November 1, 2018. The AVS contractor will perform electronic matches with financial institutions to detect and verify bank accounts based on identifiers including Social Security Numbers for the following COEs: 010 through 015, 019, 025, 045, 062 through 066, and 094 through 096. At each application and redetermination, a request will be submitted through AVS for information on an individual's financial accounts. The AVS must be used as a primary data source when verifying resources."

The Code of Federal Regulations (42 cfr 435.948(a)(1)) states, "The agency must in accordance with this section request the following information relating to financial eligibility from other agencies in the State and other States and Federal programs to the extent the agency determines such information is useful to verifying the financial eligibility of an individual: Information related to wages, net earnings from self-employment, unearned income and resources from the State Wage Information Collection Agency (SWICA), the Internal Revenue Service (IRS), the Social Security Administration (SSA), the agencies administering the State unemployment compensation laws, the State-administered supplementary payment programs under section 1616(a) of the Act, and any State program administered under a plan approved under Titles I, X, XIV, or XVI of the Act."

The Code of Federal Regulations (42 cfr Part 435.949(b)) states, "To the extent that information related to eligibility for Medicaid is available through the electronic service established by the Secretary, States must obtain the information through such service, subject to the requirements in subpart C of part 433 of this chapter, except as provided for in §435.945(k) of this subpart."

The CMCS Informational Bulletin - Subject: MAGI-Based Eligibility Verification Plans states, "To the extent that information related to Medicaid or CHIP eligibility is available through the electronic data services hub established by the Secretary, states must obtain the information through this data services hub. Subject to Secretarial approval and the conditions described in §435.945(k) and 457.380(i), states can obtain information through a mechanism other than the data services hub."

Per the *Mississippi Division of Medicaid MAGI based Eligibility Verification Plan*, Mississippi Division of Medicaid has determined TALX and MDES to be useful electronic data sources.

Per the *Mississippi Medicaid State Plan Attachment 4.32-A*, applicants are submitted weekly to Mississippi Department of Employment Security (MDES) to verify wage and unemployment benefits. Renewals are submitted once per month for the same data. Renewal files are processed in the month prior to the scheduled review due date.

The Mississippi Division of Medicaid Eligibility Policy and Procedure Manual Section 400.60 states, "For Medicaid purposes, an adjustment in family size is made for a pregnant woman's or pregnant minor's household."

The Mississippi Division of Medicaid Eligibility Policy and Procedures Manual Section 201.03.04A requires the use of the individual's most recent tax return to verify income for individuals considered self-employed, a shareholder in an S Corporation, a partner in a business or one who has income from a partnership, LLP, LLC or S Corporation.

Condition

During testwork performed over eligibility requirements for the Medical Assistance Program and the Children's Health Insurance Program (CHIP) as of June 30, 2020, the auditor tested 300 total recipients (180 Modified Adjusted Gross Income (MAGI) recipients and 120 aged, blind, and disabled (ABD) recipients) and noted the following:

- Mississippi Division of Medicaid (MDOM) did not use federal tax and/or state tax data to verify income, including self-employment income, out-of-state income, and various types of unearned income. The Medicaid State Plan requires the verification of all income for MAGI-based eligibility determinations, and MDOM's *Eligibility Policy and Procedure Manual (Section 201.03.04a)* requires the use of an individual's most recent tax return to verify self-employment income. This section further states, if tax returns are not filed, not available, or if there is a change in income anticipated for the current tax year, refer to Chapter 200, Net Earnings from Self-Employment at 200.09.08, for policy on estimating net earnings from self-employment. The MDOM's State Plan does not allow for accepting self-attested income. Therefore, if an applicant indicates zero for self-employment income, the amount of zero must be verified like any other income amount.

- On 14 of the 180 MAGI recipients (or 7.78 percent), self-employment income, out-of-state income, or unearned income was reported on the recipient's Mississippi income tax return, but the income was not reported on the recipient's application. Of the 14 instances, nine instances (or 64.29 percent) were noted in which the total income per the most recent tax return available at the time of determination exceeded the applicable income limit for the recipient's category of eligibility.

  Due to MDOM's failure to verify self-employment income on the applicant's tax return, MDOM was not aware income exceeded eligibility limits, and did not request any additional information that might have explained why income was not self-reported; therefore, auditor could not determine with certainty that individuals are, in fact, ineligible. However, information that MDOM used at the time of the eligibility determination did not support

eligibility. The auditor acknowledges that the self-employment income reported on the income tax returns does not, in and of itself, make the nine sited recipients ineligible, it does indicate that they had self-employment income during the year of eligibility determination that was, potentially, not accurately reported on their application. Furthermore, MDOM did not perform any procedures to verify that the self-employment income reported on the applications was accurate.

MDOM's policy requires the use of the individual's most recent tax return to verify income for individuals considered self-employed, a shareholder in an S Corporation, or a partner in a business or one who has income from a partnership, LLP, LLC or S Corporation. Due to the timing of tax returns filings, including allowable extensions, MDOM requires the use of prior year income verification in these circumstances. For determinations from July 2019 to February 2020, the most recent tax return information available would have been the 2018 return if no tax extensions were filed, and the applicant filed his or her return before the tax deadline. Due to the COVID-19 pandemic, the due date for Mississippi tax returns was extended past the end of the fiscal year 2020; therefore, in most cases the 2018 tax return was still the most recent tax return required or filed. Additionally, due to the pandemic, MDOM was restricted from removing individuals from receiving benefits, and no redeterminations were performed for existing beneficiaries. Again, in those instances, the most recent tax return that would have been available for determination was the 2018 tax return.

The fiscal year payments for these nine recipients that might not have been eligible to receive the benefits totaled $35,345 of questioned costs.

Based on the error rate calculated using the capitation payments of our sample, the projected amount of capitation payments made to recipients who it is reasonably possible were ineligible would fall between $127,698,080 (projected costs based on actual month payment sampled) and $144,369,372 (projected costs based on average monthly payments sampled).

The following is a breakdown of these costs by category:

CHIP: Between $5,604,505 (average monthly) to $5,654,410 (actual monthly)
MAGI Managed Care: Between $119,625,411 (average monthly) to $120,103,866 (actual monthly)
MAGI Fee for Service: $1,939,804 (actual monthly) to $19,139,456 (average monthly)

- On two of the 180 MAGI recipients (or 1.11 percent), self-employment income was incorrectly reported on the application as wages; therefore, MDOM did not request a tax return from the recipient.

- For eight of the 180 MAGI recipients (or 4.44 percent), it could not be determined if income was verified through Work Number – Equifax Verification (TALX) at the time of redetermination.

  - Of the eight instances, seven instances (or 87.50 percent) in which income was not verified through Department of Employment Security (MDES) at the time of redetermination, resulting in questioned costs of $16,332. Questioned costs were not projected for this item due to the inability to statistically validate the sample.

- Three of the 180 MAGI recipients (or 1.67 percent) in which the recipient was assigned to the incorrect category of eligibility (COE).

  - Two instances in which family size was not updated at redetermination for a pregnancy, or the birth of a child, that occurred before the redetermination date, resulting in questioned costs of $1,280. Questioned costs were not projected for this item due to the inability to statistically validate the sample.

  - One instance in which incorrect countable income and incorrect family size were used to determine eligibility, resulting in questioned costs of $655. Questioned costs were not projected for this item due to the inability to statistically validate the sample.

- Two of the 180 MAGI recipients (or 1.11 percent) in which incorrect countable income was used to determine eligibility.

- 25 of 120 ABD recipients (or 20.83 percent), in which resources were not verified through Asset Verification System (AVS) at the time of redetermination.

  - Of the 25, one instance in which countable resources exceeded the applicable limit, resulting in questioned costs of $12,769. Questioned costs were not projected for this item due to the inability to statistically validate the sample.

- 277 out of 300 recipients (or 92.33 percent) were not included on all of the required quarterly Public Assistance Reporting Information System (PARIS) file transmissions for fiscal year 2020.

  - Of the 277 recipients, 220 recipients were not included on any quarterly PARIS file transmissions during fiscal year 2020.

- Based on inquiry during the audit, MDOM informed auditors of two instances that were identified as possible fraud cases by MDOM's Program Integrity Division. In both cases, recipients reported false earnings on their applications. Both recipients reported self-employment earnings at substantially lower amounts than the reported income on the Mississippi income tax returns. In one instance, the individual reported less than 1 percent of the actual self-employment earnings. The individual's taxable self-employment income exceeded $300,000. In the other instance, the individual's taxable self-employment income exceeded $100,000. In both instances, based on the verified income on the tax return, the individuals would not be eligible for MDOM services as the individuals are receiving MAGI benefits. Further, auditors were able to verify that both individuals

own homes with fair market values exceeding $1,000,000. According to MDOM's policy, both individuals should have been required to supply the most recent tax return during the redetermination process since self-employment income was reported, albeit at false levels. MDOM personnel failed to require copies of the returns, and instead used photo images of check stubs to verify income. If proper policies and procedures had been followed, neither individual would have been initially deemed eligible for benefits. Both individuals are still receiving benefits as of the date of this audit report and have been receiving benefits for over a year. It should be noted that, as stated earlier, MDOM identified both cases as possible fraud risks and is currently investigating.

The fiscal year payments for these two instances that might not have been eligible to receive the benefits totaled $9,414 of questioned costs. These instances were not discovered during a statistically valid sample; therefore, an error rate cannot be reasonably calculated and projected.

Cause MDOM did not have adequate internal controls to ensure compliance with eligibility requirements. Additionally, MDOM did not have policies in place to verify certain types of income on applicant's tax returns, as required by its own policy and procedures, for eligibility determinations.

Effect Failure to comply with eligibility requirements could result in ineligible recipients being determined eligible, resulting in questioned costs and the possible recoupment of funds by the federal granting agency.

Recommendation We recommend the Mississippi Division of Medicaid strengthen controls to ensure compliance with eligibility requirements of the Medical Assistance Program and the Children's Health Insurance Program (CHIP).

Repeat Finding Yes – 2019-027 in 2019.

Statistically Valid Portions of these findings were based on statistically valid samples.

PROVIDER ELIGIBILITY

Material Weakness
Material Noncompliance

2020-043 Strengthen Controls to Ensure Compliance with the Provider Eligibility Requirements of the Children's Health Insurance Program CHIP.

CFDA Number 93.767 Children's Health Insurance Program (CHIP)

Federal Award No. 1805MS5021
1905MS5021
2005MS5021
2005MS5021 COVID

Federal Agency United States Department of Health and Human Services (HHS)

Questioned Costs N/A

Criteria

Medicaid Provider Enrollment Compendium Section 1.4.1.A.1.a states, "Under the requirement at 438.602, State Medicaid Agencies (SMAs) may delegate screening activities required under Part 455 Subpart E to a network plan. However, based upon privacy and security concerns including data breaches that include personally identifiable information (PII), we are not allowing SMAs to delegate the collection of disclosures under Subpart B in a manner that results in a single provider entity disclosing the information to more than one entity. A provider that is providing services on behalf of the state Medicaid plan should not be required to disclose PII to multiple entities with which the SMA contracts. In an effort to mitigate the risk that PII will be compromised in a data breach, we further believe the SMA should store PII in the fewest number of locations necessary to meet the requirement of the regulations at Subparts B and E."

Medicaid Provider Enrollment Compendium Section 1.5.B states, "A SMA may, but is not required to, delegate screening activities required under 455 Subpart E to third parties, including networks. (See section 1.4.1.A.1.a. for limitations on delegating the collection of disclosures under Subpart B). In the event the SMA opts to delegate screening under Subpart E, the SMA should make sure third parties are carrying out activities consistently and should make sure redundant screening is not conducted for a provider participating in multiple networks. In addition, the SMA should make sure the third party is documenting screening."
For those states delegating screening activities to third party entities, the State should consider any conflicts of interest that may arise. For example, some managed care entities (MCEs) may have delegated credentialing agreements that allow providers to "credential themselves" and submit the appropriate certification needed to participate in a MCE plan. Once the provider attests and submits they have completed all credentialing requirements, the MCE determines whether they will approve of the provider's participation in the plan. This arrangement is not permissible in complying with the screening requirements at 455 Subpart E as it not only creates a conflict of interest but also we do not believe it allows the state to maintain appropriate oversight of the screening activities.

Medicaid Provider Enrollment Compendium Section 1.5.3.B.1 states, "For the provider screening requirements under Subpart E and based on the disclosures under Subpart B, to the extent that a SMA delegates responsibility for provider screening and enrollment to a contractor, the SMA remains fully responsible for compliance with the requirements at Subpart B and Subpart E."

Code of Federal Regulations (42 §455.414) states "The State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years."

Code of Federal Regulations (42 §438.364(c)) states "(1) The State must contract with a qualified external qualify review organization (EQRO) to produce and submit to the State an annual EQR technical report in accordance with paragraph (a) of this section. The State must finalize the annual technical report by April 30th of each year. (2) The State must …(i) Post the most recent copy of the

annual external quality review (EQR) technical report on its required website by April 30th of each year."

Condition

For the Medicaid Assistance Program, the Mississippi Division of Medicaid (MDOM) performs the screening of providers for both the fee-for-service program and the managed care programs. However, for the Children's Health Insurance Program (CHIP), MDOM delegates the screening of providers to each of the CHIP managed care organizations (MCOs). During fiscal year 2020, MDOM had contracts with three CHIP managed care organizations (MCOs). United Health Care (United) was a provider for the entire year, and Molina replaced Magnolia on November 1, 2019. Due to MDOM performing the screening for Medicaid programs, providers potentially were required to disclose personally identifiable information (PII) to multiple entities. As noted above, federal regulations require that MDOM limit this disclosure of PII to only one entity for credentialing in order to reduce the possibility of data breaches, and to eliminate redundant screening being conducted for a provider participating in more than one CHIP MCO and/or the Medicaid Assistance Program.

As required by regulations, MDOM contracts with an External Quality Review Organization (EQRO) vendor to review MCO credentialing files. This report from the EQRO is due to be filed each year by April 30th. For fiscal year 2020, the EQRO did not begin reviewing MDOM's MCO's until October 2020 (Initial notice was sent to MCO's in July 2020), and the final report was not filed until May 26, 2021. Additionally, the fiscal year EQRO report for fiscal year 2020-2021 noted multiple findings regarding provider eligibility and provider requirements, including, but not limited to:

- Errors in member benefit information documented in member and provider materials were noted for Magnolia and United. Note, this was a repeat finding for United;
- Missing verification of malpractice insurance coverage and expired provider licensure at the time of the re-credentialing decision date.

Furthermore, during testwork auditors noted the following:

- Twenty-three providers have re-credentialing dates longer than 5 years in the data provided by the MCO; and
- Nineteen thousand, six hundred and three (19,603) providers did not have a credentialing date listed in the data.

The EQRO did require the MCO's to submit Corrective Action Plans (CAPs) that were reviewed and accepted by the EQRO; however, due to the timing of the report, none of these corrective actions could have been fully implemented during the year under audit.

MDOM stated that the MCO's are reviewed through the monthly Reporting Manual review and through reviews of MCO communications, educational materials, vendor contract reviews, network status, quality metrics, etc. However, when auditors requested information on how provider eligibility is reviewed, auditors were provided a copy of the EQRO and provided no further

documentation.

The number of findings the EQRO noted in its review of providers indicate MDOM is not maintaining sufficient oversight of the MCO's. Furthermore, if additional reviews are being performed by MDOM, sufficient documentation should be maintained to support these reviews.

Cause MDOM staff felt that the documented EQRO demonstrated sufficient oversight. Also, the outsourcing of the CHIP provider eligibility screening caused redundant screening from providers.

Effect Payments could be made to ineligible providers, resulting in unallowable costs. Redundant screening can place PII at risk for data breaches.

Recommendation We recommend the Mississippi Division of Medicaid strengthen controls to ensure compliance with the provider requirements of the Children's Health Insurance Program (CHIP) by eliminating redundant reviews and documenting the monitoring of managed care organizations throughout the year.

Repeat Finding No.

Statistically Valid This sample is not considered statistically valid.

SPECIAL TEST UTILIZATION CONTROL AND PROGRAM INTEGRITY

Material Weakness
Material Noncompliance

2020-044 Strengthen Controls to Ensure Compliance with Utilization Control and Program Integrity Requirements.

CFDA Number 93.778 Medical Assistance Program (Medicaid; Title XIX)

Federal Award No.

1905MS5001	2005MS5001
1905MS5ADM	2005MS5ADM
1905MS5MAP	2005MS5MAP
	2005MS5MAP COVID
1905MSIMPL	2005MSIMPL
1905MSINCT	2005MSINCT

Federal Agency United States Department of Health and Human Services (HHS)

Questioned Costs N/A

Criteria *The Code of Federal Regulation (42 cfr 456.22-23),* requires the State Medicaid Agency to promote the most effective and appropriate use of available services and facilities. Additionally, the Medicaid agency must have procedures for the on-going evaluation, on a sample basis, of the need for, the quality of, and timeliness of Medicaid services.

Lastly, the State Medicaid Agency is required to have a post payment review process that:

a) Allows State personnel to develop and review:
   i. Beneficiary utilization profiles;
   ii. Provider service profiles; and
   iii. Exceptions criteria; and

b) Identifies exceptions so that the agency can correct mis-utilization practices of beneficiaries.

Medicaid State Plan p. 47 requires that the Medicaid agency have a system in place that meets the requirements of *42 cfr 456, Subpart C*, control of the utilization of inpatient hospital services. Furthermore, the Medicaid agency must have utilization and medical reviews that are performed by a Utilization and Quality Control Peer Review Organization, designated under *42 cfr 462* that has a contract with the agency to perform these reviews.

Per *Section 1.4 of Mississippi Medicaid Provider Billing Handbook*, Alliant Health Solutions is the fee-for-service (FFS) Utilization Management and Quality Improvement Organization (UM/QIO) contracted with the Division of Medicaid to review FFS services except for Advanced Imaging Services provided to Medicaid beneficiaries in the State of Mississippi. Under this contract, Alliant Health Solutions assures that all Medicaid services meet medical guidelines for medical necessity, appropriateness and length of service.

Condition

The Mississippi Division of Medicaid (MDOM) contracted with a Utilization Management/Quality Improvement Organization (UM/QIO) to provide methods and procedures to safeguard against unnecessary or improper utilization of care and services.

On February 1, 2019, MDOM contracted with a new UM/QIO. Per *RFP #20170811, section 1.9.2.*, upon commencing the operations phase, the contractor must be fully capable and prepared to perform the responsibilities described in this RFP. Additionally, the RFP required that there be no lapse in services performed during the transition with the new UM/QIQ. The operation phase of the contract began on September 1, 2019 per the RFP. However, during fiscal year 2020, the following ongoing reviews were not performed by Mississippi Division of Medicaid (MDOM) nor the contracted Utilization Management/Quality Improvement Organization (UM/QIO):

- Durable Medical Equipment reviews were not performed for the months of July 2019 thru January 2020.

- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Quality of Care reviews were not performed for the months of July 2019 thru May 2020.

- Private duty nursing reviews were not performed during the months of July 2019 thru March 2020.

- Independent verification and validation (IV&V) reviews to determine if services were medically necessary and appropriate for the diagnosis and condition of the patient for inpatient hospital services were not performed during fiscal year 2020.

- Quality of care reviews were not performed during the months of July 2019 thru February 2020 or the months April 2020 thru June 2020.

Federal requirements require "ongoing" reviews of each type listed above. For context, the former UM/QIQ were contracted to perform a minimum five (5) percent sample of all certifications and reviews performed by the Contractor, unless otherwise instructed in writing by MDOM. The new UM/QIQ was contracted to perform a minimum representative sample of all authorizations and reviews performed by the Contractor, unless otherwise instructed in writing by MDOM. It is important to also note that neither MDOM or the current UM/QIQ could provide any type of sampling methodology to justify the reasonableness of the number of reviews performed.

Personnel at MDOM stated that there is no lapse in reviews for dates of service during the transition due to the requirement for reviews be only "ongoing" with no time frame referenced. However, auditors could not verify that sufficient reviews were performed during the audit period to qualify as ongoing monitoring.

Cause MDOM staff feel that the post payment review process performed by the UM/QIQ is adequate and meets federal requirements.

Effect Lack of ongoing post-payment reviews could result in the unnecessary or inappropriate use of Medicaid services and excess payments.

Recommendation We recommend the Mississippi Division of Medicaid strengthen controls to ensure compliance with Utilization Control and Program Integrity requirements.

Repeat Finding No.

Statistically Valid This sample is not considered statistically valid.

SPECIAL TEST ADP RISK ANALYSIS AND SYSTEM SECURITY REVIEW

Material Weakness
Material Noncompliance

2020-045 Strengthen Controls to Ensure Compliance with Automatic Data Processing (ADP) Risk Analysis and System Security Review Requirements.

CFDA Number 93.778 Medical Assistance Program (Medicaid; Title XIX)

Federal Award No.

1905MS5ADM	2005MS5ADM
1905MS5MAP	2005MS5MAP
1905MSIMPL	2005MSIMPL

1905MSINCT 2005MSINCT

Federal Agency United States Department of Health and Human Services (HHS)

Questioned Costs N/A

Criteria *The Code of Federal Regulations (45 cfr 95.621)* states, "State agencies must establish and maintain a program for conducting periodic risk analyses to ensure that appropriate, cost effective safeguards are incorporated into new and existing systems. State agencies must perform risk analyses whenever significant system changes occur. State agencies shall review the ADP system security of installations involved in the administration of HHS programs on a biennial basis. At a minimum, the reviews shall include an evaluation of physical and data security operating procedures, and personnel practices. …The State agency shall maintain reports of their biennial ADP system security reviews, together with pertinent supporting documentation, for HHS on-site review."

The Mississippi Division of Medicaid (MDOM)'s *Risk Analysis Policy* states, "In the case of ADP systems involved in the administration of Health and Human Services (HHS) programs, MDOM will follow the MARS-E 2.0 Risk Assessment (RA-3) Control which requires the Administering Entities (AEs) to conduct, document, annually review, and disseminate a Risk Assessment of the security and privacy of the systems, and review the Service Organization Control (SOC) reports annually or whenever provided by fiscal agent."

Condition The Mississippi Division of Medicaid (MDOM) is not in compliance with *45 cfr 95.621* and its own Risk Analysis Policy; each requires a Risk Analysis Report be produced every 2 years. MDOM provided no evidence of a biennial risk analysis of all ADP Systems involved in the administration of HHS programs. The agency did submit a risk analysis for Mod MEDS, a subsystem of Medicaid Management Information System (MMIS) in compliance with MARS-E v.2 Security and Privacy Controls framework; however, a risk analysis was not performed on the MMIS.

Cause The agency has not implemented the corrective action plan for the prior year finding.

Effect Failure to properly establish and maintain a process for conducting periodic risk analyses could result in the compromise of the confidentiality, integrity and reliability of the data associated with HHS programs.

Recommendation We recommend Mississippi Division of Medicaid strengthen controls to ensure compliance with the Automatic Data Processing (ADP) risk analysis and system security review requirements.

Repeat Finding Yes - 2019-028 in 2019; 2018-060 in 2018; 2017-034 in 2017; and 2016-033 in 2016.

Statistically Valid This sample is not considered statistically valid.

SPECIAL TESTS AND PROVISIONS

Immaterial Noncompliance

2020-046 Ensure Compliance with Medicaid National Correct Coding Initiative (NCCI) Confidentially Agreement Requirements.

CFDA Number 93.778 Medical Assistance Program (Medicaid, Title XIX)

Federal Award No.

1905MS5ADM	2005MS5ADM
1905MS5MAP	2005MS5MAP
1905MSIMPL	2005MSIMPL
1905MSINCT	2005MSINCT

Federal Agency United States Department of Health and Human Services (HHS)

Questioned Costs N/A

Criteria *The Medicaid National Correct Coding Initiative (NCCI) Technical Guidance Manual, Section 7.1.1* states, "Access to the complete quarterly Medicaid NCCI edit files that are posted on the Medicaid Integrity Institute (MII) on the RISSNET portal is limited to a state's Medicaid agency. These state Medicaid NCCI edit files contain information that is not included in the Medicaid NCCI edit files that are available to the public on the Medicaid NCCI webpage. … A state Medicaid agency may share these quarterly state Medicaid NCCI edit files which are posted on the MII on the RISSNET portal with the contracted fiscal agent that processes its fee-for service claims or with any of its contracted Medicaid managed-care entities that is using the Medicaid NCCI methodologies in its processing of claims or encounter data, if appropriate confidentiality agreements are in place. … Contracted Parties is defined as a fiscal agent that has a contract with the state Medicaid agency for processing its claims, or any Medicaid managed care entities, its contractor or subcontractor (including COTS software vendors) which assist with implementation of claims processing or encounter data, and who must use these edit files for processing purposes."

The Medicaid National Correct Coding Initiative (NCCI) Technical Guidance Manual, Section 7.1.2 states, "At a minimum, the following elements must be included in the confidentiality agreements for any contracted party using the Medicaid NCCI files posted on the Medicaid Integrity Institute (MII):

- Disclosure shall be limited to only those responsible for the implementation of the quarterly state Medicaid NCCI edit files. Disclosure shall not be made prior to the start of the new calendar quarter.

- After the start of the new calendar quarter, a Contracted Party may disclose only non-confidential information contained in the Medicaid NCCI edit files that is also available to the general public found on the Medicaid NCCI webpage.

- The Contracted Party agrees to use any non-public information from the quarterly state Medicaid NCCI edit files only for any business purposes directly related to the implementation of the Medicaid NCCI methodologies in the particular state.

- New, revised, or deleted Medicaid NCCI edits shall not be published or otherwise shared with individuals, medical societies, or any other entities unless it is a Contracted Party prior to the posting of the Medicaid NCCI edits on the Medicaid NCCI webpage.

- Implementation of New, revised, or deleted Medicaid NCCI edits shall not occur prior to the first day of the calendar quarter.

- Only a state Medicaid agency has the discretion to release additional information for selected individual edits or limited ranges of edits from the files posted on the MII.

- State Medicaid agencies must impose penalties, up to and including loss of contract, for violations of any confidentiality agreement relating to use of the MII edit files."

Condition The Mississippi Division of Medicaid's confidentiality agreement with the contracted fiscal agent does not contain any of the minimum elements required per the Medicaid National Correct Coding Initiative Technical Guidance Manual.

Cause Mississippi Division of Medicaid (MDOM) does not utilize separate confidentiality agreements with MDOM's fiscal agent, related to the NCCI edit files. The Legal Department of the Division of Medicaid (MDOM) determined that existing comprehensive confidentiality agreements were sufficient. They have advised, "*In the 2005 RFP, incorporated in the 2006 Contract, the 2010 Contract, and the 2014 Emergency Contract, we had confidentiality requirements for Conduent.*"

Effect Without all parties agreeing to the required confidentially agreement elements, non-public Medicaid NCCI data could be released. In addition, the lack of a confidentiality agreement with Conduent could result in Conduent using non-public information from the quarterly state Medicaid NCCI edit files for non-business purposes without any penalties being imposed.

Recommendation We recommend the Mississippi Division of Medicaid ensure compliance with Medicaid National Correct Coding Initiative confidentially agreement requirements.

Repeat Finding No.

Statistically Valid This sample is not considered statistically valid.

End of Report

OFFICE OF THE GOVERNOR
Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF
MEDICAID

Attachment B

SINGLE AUDIT FINDINGS

July 23, 2021

Shad White, State Auditor
Office of the State Auditor
State of Mississippi
P. O. Box 956
Jackson, MS 39205-0956

Dear Auditor White:

Thank you for providing the Single Audit Findings for the Mississippi Division of Medicaid for our review and response, which we received on July 20, 2021. Our responses are below.

Sincerely,

Drew Snyder
Executive Director
Mississippi Division of Medicaid

AUDIT FINDINGS:

93.767 Children's Health Insurance Program (CHIP)

Allowable Costs

2020-041 Strengthen Controls to Ensure Compliance with the Allowable Costs Requirements of the Children's Health Insurance Program (CHIP).

DOM Response:

DOM Concurs. The CHIP co-payment table, which is a part of the Wholesale Change Packet (WCP) that includes all updates required when Federal Poverty Levels (FPL) change, was inadvertently left out of the WCP sent to the DOM fiscal agent during a time of staff turnover in fiscal year 2020. However, DOM has already provided its fiscal agent with the updated household size and FPL limits used for the CHIP co-payment determinations. The fiscal agent already completed the required updates and notified DOM that the updates were completed. DOM Information Technology (iTech) staff assigned to the Eligibility Program Area already verified the update for completeness and accuracy. DOM has opened a change of service request (CSR) to ensure the WCP contains all the required updates, including automation of the calculation of the table/values needed for CHIP co-payment determinations. The CHIP co-payments will also be added to the required annual accuracy testing performed by DOM prior to the March production run by the fiscal agent.

DOM Corrective Action Plan:

Based on the above response, DOM has largely corrected this issue and will ensure CHIP co-pay testing is part of the annual testing done by the iTech Program Area each March prior to the production run sent to the fiscal agent. This correction is anticipated to be completed by 2022, and ongoing annually thereafter.

93.767 Children's Health Insurance Program (CHIP)
93.778 Medical Assistance Program (Medicaid, Title XIX)

Eligibility

2020-042 Strengthen Controls to Ensure Compliance with Eligibility Requirements of the Medical Assistance Program and the Children's Health Insurance Program (CHIP).

DOM Response:

DOM Does Not Concur. It appears that OSA has attempted to evaluate DOM eligibility determinations using standards that are not approved by CMS and a data source unavailable to DOM under current state law. DOM maintains that for determining eligibility, it has complied with the CMS-approved state plan. Using the approved CMS MAGI Based Verification plan in effect during the audit time period, the state sought to verify the reported income to the standard of reasonable compatibility, as defined by CMS, through all **available** electronic data sources. While DOM is only required to use tax return information in certain circumstances, the agency

continues to pursue the authority to review state and/or federal tax return information. To date, DOM has not been provided statutory authority to access Mississippi Department of Revenue tax information and is still awaiting IRS approval of the Safeguard Security Risks document. Once approval is received and all required testing is completed, DOM "go live" access for this IRS data should occur in September 2021. DOM plans to continue to follow the approved federal/state plan for eligibility determination as it has done, and as additional resources are authorized for DOM's use, the agency will also begin to use those resources as well.

DOM Does Not Concur. According to 42 CFR 435.603(h) and the CMS-approved state plan, DOM is required to base eligibility on **current** income and family size for new applicants and current beneficiaries. The tax information used by OSA in its audit procedures is from a time period more than a year prior to the application for eligibility determination. Financial information that far out of date may not accurately reflect the current circumstances of applicants.

While tax returns can be used as one form of verification, as required by federal regulations and the approved state plan, income attestations reflective of the client's present situation must be considered. Further, tax return information does not solely determine eligibility for applicants or current beneficiaries. This information, along with all other available data sources, is used as a part of the standard of reasonable compatibility. DOM has not been granted access to either state tax data or IRS tax data for the time period being audited; therefore, these options are not currently available electronic data sources.

In addition, not following state-approved processes, including the reasonable compatibility standard, can result in a federal audit finding by CMS or other federal auditors.

Since DOM was presented the extrapolated questioned costs fewer than 72 hours before the response deadline, DOM is still reviewing calculations based on the methodology OSA provided.

DOM Does Not Concur. DOM did not incorrectly identify self-employment income as wages as the finding states. A review of each record indicates no self-employment income was reported at applications or renewal after 2015. Each case indicates the income source was a job with wages that were verified by an employer.

DOM Does Not Concur. All eight cases identified were in fact verified through TALX; none of the recipients had income information returned that was applicable to the review period. In these cases, TALX is not designed to document the request beyond a screenshot that would not contain a date or time stamp.

DOM Concurs. Of the seven cases identified, two cases were verified through the Mississippi Department of Employment Security (MDES). One was a COVID-19 batch reinstatement for the OSA review period of May 9, 2020 and did not require an MDES request or response. Another was a redetermination with an OSA review date of April 23, 2019. The vendor included the request for parental income on the file sent to MDES on February 11, 2019. No response was received from MDES.

As it relates to MDES requests, DOM regularly requests income verification on applicants and beneficiaries. In the past, DOM was always aware that MDES did not include any person(s) on their response file who did not have information in their system. DOM understands that this gave the appearance that no verification was performed on some recipients. Going forward, MDES will ensure all recipients listed in the request file from DOM will be returned in the response file regardless of whether MDES has information on the client or not. This will provide DOM documentation to show that each person in DOM's request file was processed by MDES.

To alleviate future omissions, DOM's third-party vendor is changing the criteria used to pull individuals into the outgoing request file sent to MDES for income verification. Additionally, DOM's third-party vendor will provide an automated verification to DOM when the outgoing request file has been sent to MDES and another when the MDES response file has been received by the vendor.

DOM Concurs. In both instances that were cited, the tax dependent information was not entered into the system when a newborn was added to the case as a deemed eligible infant. When actions were later taken on other household members, the tax dependent information was not updated. As a result, the correct COE was not assigned because the family size did not include the newborn in the budgeting process.

Eligibility staff has been reminded in writing of the need to ensure that newborn information is updated prior to processing an application or redetermination for any other household members. In addition, Eligibility is working with the vendor on a system change to alert the case worker that a newborn is included in the case being processed. A warning message that must be acknowledged by the employee processing the case will be displayed when the relationship or tax dependent status on a newborn is missing and a budget is being processed for any household member; thus, allowing for correction prior to processing eligibility.

DOM Concurs. Staff members were reminded in writing of the steps for the handling of wages, as well as, ensuring correct family size when eligibility is being determined. Eligibility is working with the vendor on a system change to alert the worker that a newborn is included in the case being processed. A warning message that must be acknowledged by the employee processing the case will be displayed when the relationship or tax dependent status on a newborn is missing and a budget is being processed for any household member; thus, allowing for correction prior to processing eligibility.

DOM Concurs. An Asset Verification System (AVS) geo search was initiated for the time period under review on the 25 recipients identified above. Twenty-four of the responses did not affect eligibility of the beneficiary.

In June 2020, the eligibility system change request list was updated to include asset checks within the system processing workflow to eliminate the manual request process and facilitate asset verification through AVS. This system change is in process.

Meanwhile, all staff members have received a written reminder about the resource policy and AVS requirements. In addition, new hires will receive resource training using a curriculum that includes the AVS process. This curriculum will also be used in annual AVS refresher training for all staff.

DOM Concurs. This resulted from incorrect criteria being used by DOM's third-party vendor to pull the population for the outgoing PARIS files. DOM provides specific parameters to the vendor to ensure that the appropriate beneficiaries are included in the report to be sent to the Mississippi Department of Human Services (MDHS) for the PARIS upload. The parameters requested by DOM for the outgoing PARIS file were not implemented correctly by the vendor resulting in the above beneficiaries being omitted from the file prior to transmission to MDHS.

To ensure that DOM knows that all beneficiaries are reported, DOM has implemented the following:

- Elimination of parameters – The vendor has removed all filters from the PARIS quarterly file beginning with the file on August 1, 2021. Therefore, the outgoing request file will contain all cases that are active in the month of July 2021. The recipients noted above will also be included with the August 1, 2021, PARIS outgoing file request.

- Confirmation –
  1. The vendor will provide written confirmation to DOM when the PARIS outgoing file is sent to MDHS. They will provide DOM with written confirmation whether responses were received.

  2. MDHS will provide DOM with written confirmation when the DOM PARIS outgoing file has been received and processed or notify DOM immediately if no file or an empty file is received from DOM. DOM will eliminate the parameters from the PARIS quarterly file to ensure that an updated file containing all beneficiaries is provided to MDHS prior to the required PARIS upload. Additionally, if MDHS fails to process the DOM PARIS file, an explanation will be provided to DOM from MDHS.

DOM does not comment on open investigations.

DOM Corrective Action Plan:
Based on the above response, including actions already underway, DOM believes no other corrective action is needed for these findings. DOM is following approved guidelines and has sufficient controls in place, which include ongoing and periodic training, as necessary.

93.767 Children's Health Insurance Program (CHIP)

Provider Eligibility

2020-043 Strengthen Controls to Ensure Compliance with the Provider Eligibility Requirements of the Children's Health Insurance Program CHIP.

DOM Response:
DOM Does Not Concur. Per the CCO/DOM contract Section 7.E., Provider Credentialing and Qualifications, to meet federal, state, and agency mandates, coordinated care organizations

(CCOs) are required to ensure that the credentialing and qualifications screening process includes a review of certain databases for each provider enrolled or seeking to enroll as a CHIP provider. Because there had been no federal exception for providers that enroll with different CCOs, providers may have been screened by multiple CCOs to meet all other federal requirements.

In May 2018, DOM sought clarity from CMS. The CMS representative stated that "CHIP providers would not need to enroll directly with the state if the CCO is conducting all required screening pursuant to 42 CFR 455 Subparts B and E. If screening is not fully completed for any provider, the state would be the entity held accountable in the event of a review finding." The Medicaid Provider Enrollment Compendium (MPEC) has been revised since that time, with the most recent effective date of March 22, 2021. It states that all references to the Medicaid Program in this compendium are inclusive of CHIP.

In late summer 2020, as a part of its continuous internal reviews and comparisons of changes to Federal laws, rules, and regulations, DOM identified the issue of duplicate screenings for providers participating in multiple networks as an issue needing to be addressed. DOM immediately began the process of making changes to the provider screening requirements. As DOM worked with a third-party vendor to centralize the screening and credentialing process, the updated requirements were included in that work in the fall of 2020. DOM continues to work with the vendor to design, develop, and implement the new integrated system, and plans to begin the new process prior to the end of State Fiscal Year 2022.

DOM Concurs. The individual CCO EQR technical reports were completed prior to April 30, 2021; however, the annual comprehensive technical report was not finalized and posted to the DOM website until May 26, 2021. In a meeting with the EQRO on June 21, 2021, DOM requested that the review schedule be adjusted to ensure that in the future the comprehensive report is finalized by April 30th annually to comply with federal regulations.

DOM Does Not Concur. The findings listed in the EQRO report were addressed in CCO corrective action plans based on the EQR reports of CCO audits conducted between June 2020 and May 2021. According to the EQRO, "all deficiencies were addressed in the health plans' Corrective Action Plans, and all Corrective Action Plans have been reviewed and accepted. Follow-up is conducted for all deficiencies during quarterly CAP follow-ups and during the next EQR." DOM continues to work with the EQRO to review and test the CAP issues to ensure mitigation. Further, DOM considers these to have been addressed prior to the beginning of the OSA audit based on the accepted CAP responses and follow-up efforts.

However, while the EQRO report was provided at the request of the auditors, additional documentation was available that supports DOM CCO oversight and was offered during management response. A DOM Managed Care Reporting Manual is maintained for CCO reports with monthly, quarterly, and annual deliverables; including Provider Credentialing Report, Provider Investigations and Complaints, Provider Complaints and Appeals Logs, Provider Satisfaction Survey Results, Claims Denials, as well as Member reports and Quality Reports. As member, provider, claims, encounter, and other issues are identified, they are referred to an appropriate DOM program area for response and needed corrective action on an on-going basis.

Additionally, since 2015, the DOM requires the CCOs to submit CHIP Provider data to our fiscal agent. This information is uploaded into the DOM MMIS system and converted into usable data and reports, which provide additional insight into CHIP provider services. DOM uses all the data mentioned above to communicate to the EQR vendor-specific areas of concern that require more detailed review.

DOM also reviews policies submitted by the CCOs prior to implementation for approval or disapproval, which include quality, clinical, and reimbursement policies. DOM reviews Member and Provider communications for approval or disapproval. DOM meets regularly with CCOs to discuss problems, issues of concerns, policy changes, improvements and corrections required, and CMS updates. These include the CCO Monthly Management Meetings, Quality Task Force Meetings, Quality Leadership Meetings, CCO Executive Meetings, and Ad Hoc meetings.

DOM Corrective Action Plan:
With the following exception, DOM believes that based on the responses above, no additional corrective action is needed at this time: Prior to the implementation of the centralized credentialing program, DOM will review a process to verify providers who are enrolled in both the Medicaid and CHIP programs to ensure that the disclosure forms and screenings are limited to DOM capturing this information. This centralized credentialing program is expected to be completed in 2022 and will be managed by Provider Solutions.

93.778 Medical Assistance Program (Medicaid; Title XIX)

Special Test Utilization Control and Program Integrity

2020-044 Strengthen Controls to Ensure Compliance with Utilization Control and Program Integrity Requirements.

DOM Response:

DOM Does Not Concur. Four Durable Medical Equipment (DME) provider type reviews were initiated by DOM Program Integrity between the months of July 2019 through January 2020. Additionally, each month, and as an additional oversight function, DOM's Office of Medical Services conducts program area claim/utilization reviews including, but not limited to, DME claims, providers, and services. Further, when DME is authorized through a 1915(c) waiver, prepayment reviews are conducted by a DOM Program Manager prior to payment.

The prior third-party vendor whose contract was ending stopped its post-payment and quality reviews in May 2019 because the reviews required providers be notified in writing of the document requests and the document submission would have fallen outside the end of the first vendor contract. The new vendor began the operational phase of their contract on September 1, 2019. After the vendor developed a review process and received DOM approval for these processes, quality reviews of DME began in February 2020 (for January claims), the reviews continued throughout the rest of the fiscal year.

DOM Concurs. It is accurate that the first ICF/IID reviews were performed by the new vendor in June 2020 during the fiscal year that ended June 30, 2020. DOM procured a vendor to conduct the ICF/IID reviews to ensure reviews were conducted according to federal regulations. The new vendor began the operational phase of their contract on September 1, 2019, which included implementation of the ICF/IID reviews, but required time to adequately set up policies, procedures, their system, and enroll providers in their web portal. ICF/IID reviews were a new requirement under the UM/QIO contract, with the challenge being that it was also a new process for the providers and required training prior to final implementation. The vendor began a soft review in June of 2020 and full reviews in July 2020 after training was completed.

DOM has met with the vendor regularly to set up policies and procedures, and currently conducts monthly ICF/IID Quality of Care Issues meetings to discuss any concerns with quality of care. In addition, DOM and its vendor contact each other via e-mail or telephone frequently for any questions or concerns that come up prior to the standing monthly ICF/IID Quality of Care Issues meeting and a general standing meeting to discuss all issues with the vendor.

DOM Does Not Concur. Seven Private Duty Nursing (PDN) reviews were initiated between the months of July 2019 through March 2020. However, the Public Health Emergency (PHE) impacted the care-giver engagement and quality of care reviews. DOM did not conduct any PDN reviews from April through June 2020 due to the PHE.

DOM Does Not Concur. Quality of Care reviews were performed during FY 2020. Program Integrity reviews are performed by the vendor at DOM's request to determine appropriate coding, quality of care, medical necessity, etc. DOM sent seven quality of care requests (consisting of hundreds of claims) in March 2020 to the vendor who then performed the reviews.

As required by 42 CFR 456.23, DOM and its third-party vendor have post-payment review *procedures* that allow state personnel to develop and review beneficiary utilization profiles, provider service profiles, exceptions criteria, and identifies exceptions throughout the year, so that DOM can correct misutilization practices of beneficiaries and providers. Also, as required, DOM ensures that each CCO with which it contracts is evaluated annually on quality, timeliness, and access to the health care services by an external quality review organization (EQRO) and ensures that the EQRO conducting such reviews is competent and independent. Further, DOM works with the EQRO throughout the year, including in the planning, selection, and implementation of the EQRO work effort.

DOM Does Not Concur. There has been no lapse in inpatient hospital post-payment review coverage for dates of service during the transition from one vendor to another. The CFR cited in the finding does not speak to required time frames for conducting in-patient hospital post-payment reviews (daily, weekly, monthly, etc.), but only requires that *procedures* be in place to ensure on-going, sample-based evaluations. Both DOM and the third-party vendor have viable processes in place for on-going, sample-based evaluations and have worked to ensure continuous reviews based on inpatient hospital dates of service. While there may have been a transition period from one vendor to another for the new vendor's reviews to start, there was no lapse in review coverage or DOM oversight of such reviews.

Federal regulations cited have no frequency specification for "ongoing reviews" as referenced in 42 CFR 456.22 – 23. As such, DOM distinguishes the difference between the time of the audit and the period being audited. DOM maintains that there is no deficiency on the period being audited or in the annual completion of the audits. DOM has internal quality assurance processes that require DOM review and approval prior to the vendor beginning its work. DOM believes it is reasonable for a new vendor to develop and test comprehensive and reliable processes to ensure audit coverage is sufficient throughout the life of the contract and for DOM to evaluate and approve such processes and procedures.

DOM Concurs that no IV and V reviews occurred during fiscal year 2020. However, the new vendor processes have been approved, the reviews have been implemented and are underway. Additionally, even though there was a break in IV and V field work, there has been no lapse in audit coverage.

DOM Does Not Concur. OSA requested via email and interviews information about processes and procedures, DOM has no documentation where methodology was requested. Had there been requests for methodology, DOM and the third-party vendor would have supplied that information. This information is still available for review.

DOM Corrective Action Plan:
Based on the management response above, DOM does not believe any additional corrective action is needed because lapses in the audit timing have been mitigated since the new vendor became fully operational. DOM maintains appropriate oversight over these reviews to ensure they are occurring properly.

93.778 Medical Assistance Program (Medicaid; Title XIX)

Special Test ADP Risk Analysis and System Security Review

2020-045 Strengthen Controls to Ensure Compliance with Automatic Data Processing (ADP) Risk Analysis and System Security Review Requirements.

DOM Response:

DOM Concurs. DOM hired a Chief Security Officer (CSO) in September 2020, filling a vacancy of over a year. In January 2021, the CSO performed an enterprise-wide risk assessment ensuring the security and privacy of DOM systems. Although the risk assessment was not completed during the time period being audited, upon hiring the CSO, the assessment was performed and will continue to be conducted annually, thus satisfying the requirements of 45 CFR 95.621 and DOM's Risk Analysis Policy.

DOM Corrective Action Plan:
Based on the management response above, there is no additional corrective action needed.

93.778 Medical Assistance Program (Medicaid; Title XIX)

Special Test & Provisions

2020-46 Ensure Compliance with Medicaid National Correct Coding Initiative (NCCI) Confidentially Agreement Requirements.

DOM Response:

DOM Does Not Concur. DOM acknowledges that the confidentiality provision in place with the contracted fiscal agent does not contain all of the elements listed in the Technical Guidance Manual. However, DOM does contest the Auditor's findings of the Effect. The Auditor has acknowledged that the contract existing between DOM and its fiscal agent contains a contractual confidentiality provision which requires the fiscal agent to maintain the confidentiality of DOM's confidential information, which would include the NCCI edit materials. In addition, that contract between DOM and the fiscal agent contains penalty provisions in the event the fiscal agent breaches the contract, including the confidentiality provision. Thus, the lack of all elements listed in the Technical Guidance Manual does not extinguish the fiscal agent's duty to maintain the confidentiality of these materials, nor does it prohibit penalties against the fiscal agent if any such breach of confidentiality occurs. However, to achieve all elements listed in the technical manual, DOM will enter into a separate confidentiality agreement with the fiscal agent and any other affected parties for purposes of the NCCI materials that expressly includes those terms.

DOM Corrective Action Plan:

Even though DOM does not concur, the agency will create and execute a separate confidentiality agreement with the fiscal agent and any other affected parties to include the specific elements required *in The Medicaid National Correct Coding Initiative (NCCI) Technical Guidance Manual, Section 7.1.2.*