STATE OF MISSISSIPPI

OFFICE OF THE STATE AUDITOR
SHAD WHITE
STATE AUDITOR

March 31, 2022

Financial Audit Management Report

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

Dear Mr. Snyder:

Enclosed for your review are the financial audit finding for the Mississippi Division of Medicaid for the Fiscal Year 2021. In these findings, the Auditor's Office recommends the Mississippi Division of Medicaid:

1. Strengthen Controls Over Financial Reporting and the Schedule of Expenditures of Federal Awards.

Please review the recommendations and submit a plan to implement them by April 14, 2022. 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 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 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, 2021. These financial statements will be consolidated into the State of Mississippi's *Annual Comprehensive 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.

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 Mississippi Division of Medicaid as of and for the year ended June 30, 2021, 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) to determine 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. 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 preceding paragraph 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, we identified certain deficiencies in internal controls, identified in this letter as item **2021-007** 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

2021-007 Strengthen Controls Over Financial Reporting and the Schedule of Expenditures of Federal Awards.

Repeat Finding Yes; 2020-011

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) specifies that a satisfactory control environment is only effective when control activities exist. This includes a review performed 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…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, 2021, we became aware of ineffective processes and/or procedures relating to internal controls over financial reporting and the Schedule of Expenditures of Federal Awards. In the aggregate, these instances result in a material weakness in the agency's overall control environment. The following exceptions were noted:

- One instance 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. Incorrect dates could lead to monies being expended past the period of performance of the grant.

- 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.

- Three 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 $23,849,744 to the Schedule of Expenditures of Federal Awards.

- Three instances in which federal expenditures were recorded as state expenditures in Mississippi Accountability System for Government Information and Collaboration (MAGIC) and were not included on the Schedule of Expenditures of Federal Awards, resulting in adjustments of $15,684,719.

- One instance in which the State's portion of an accrual was not recorded in Mississippi Accountability System for Government Information and Collaboration (MAGIC), resulting in adjustments of $29,235,528.

- Agency does not perform a reconciliation of the Schedule of Expenditures of Federal Awards to MAGIC.

The lack of adequate controls over financial reporting and the Schedule of Expenditures of Federal Awards resulted in the following:

- Accounts Receivable was understated by $42,129,340

- Subsidies Loans and Grants was overstated by $42,129,340

- Due from Federal Government was overstated by $10,545,495

- Unearned Federal Revenue was overstated by $5,881,659

- Federal Revenue was overstated by $4,663,836

Cause

The Mississippi Division of Medicaid ("Medicaid") did not possess or enforce proper internal control structures over financial reporting. Additionally, Medicaid 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 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 financial reporting and the Schedule of Expenditures of Federal Awards 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

April 14, 2022

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

Dear Mr. White:

We have reviewed the single audit findings below in reference to our fiscal year 2021 audit. Listed below are our individual responses and plans for corrective action.

AUDIT FINDINGS:

2021-007 Strengthen Controls Over Financial Reporting and the Schedule of Expenditures of Federal Awards.

Response:

The Division of Medicaid (DOM) concurs with this finding. DOM understands the importance of maintaining accurate records for all grant awards and will strengthen controls over financial reporting and the preparation and review of the grant schedule, to include the preparation of DOM's portion the SEFA.

Corrective Action Plan:

A. The agency plans to contract with an experienced GAAP contractor to train the Office of Federal Reporting and the Comptroller on the GAAP reporting process. This additional training, along with increased scrutiny within the department over financial reporting and the SEFA, will alleviate the reporting issues found in this audit. DOM is instituting a formal review and approval process to ensure the correct recording of all information (including dates) for all grant awards. The agency will ensure a reconciliation of the Schedule of Expenditures of Federal Awards to MAGIC

is implemented by Federal Reporting and reviewed by the Comptroller. The agency will use all available resources to identify accruals, including a schedule of federal reporting adjustments and a schedule of Managed Care Organizations' outstanding balances.

B. Christine Woodberry

C. August 1, 2022

Sincerely,

Drew L. Snyder
Executive Director

STATE OF MISSISSIPPI

OFFICE OF THE STATE AUDITOR
SHAD WHITE
STATE AUDITOR

October 10, 2022

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 for the Mississippi Division of Medicaid for Fiscal Year 2021. 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 the Allowable Costs Requirements of the Medical Assistance Program.
3. Strengthen Controls to Ensure Compliance with Eligibility Requirements of the Children's Health Insurance Program (CHIP) and the Medical Assistance Program.
4. Strengthen Controls to Ensure Compliance with Provider Eligibility Requirements of the Children's Health Insurance Program (CHIP).

Please review the recommendations and submit a plan to implement them by October 17, 2022. 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 on each major federal program 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. If you have any questions or need more information, please contact me.

Sincerely,

Stephanie C. Palmertree, CPA, CGMA
Deputy State Auditor
Enclosures

SINGLE AUDIT FINDINGS

In conjunction with our audit of federal assistance received by the State of Mississippi, the Office of the State Auditor has completed its audit of the State's major federal programs administered by the Mississippi Division of Medicaid for the year ended June 30, 2021.

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, Mississippi Code Annotated (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, 2021.

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 the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *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 *Uniform Guidance* and which are identified in this letter as items **2021-039**, **2021-040**, **2021-041** and **2021-042**.

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 *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 was for the limited purpose described in the preceding paragraph 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, we identified certain deficiencies in internal controls 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 does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct noncompliance 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 noncompliance with a type of compliance requirement 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 **2021-039**, **2021-041** and **2021-042** to be material weaknesses.

A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance. We consider the deficiency in internal control over compliance identified in this letter as item **2021-040** to be a significant deficiency.

Findings and Recommendations

ALLOWABLE COSTS

Material Weakness
Material Noncompliance

2021-039	Strengthen Controls to Ensure Compliance with the Allowable Costs Requirements of the Children's Health Insurance Program (CHIP).
ALN Number	93.767 – Children's Health Insurance Program (CHIP)
Federal Award No.	All Current Active Grants
Federal Agency	United States Department of Health and Human Services (HHS)
Pass-through Entity	N/A
Questioned Costs	N/A
Criteria	*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." *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."

Mississippi Children's Health Insurance Program State Plan Section 8.2.3 states that 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.

Mississippi Children's Health Insurance Program State Plan Section 8.2.3 states that 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.

Mississippi Children's Health Insurance Program State Plan Section 8.2.3 states that 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, 2021, the auditor tested 60 total beneficiaries and noted the following:

- 20 (or 33 percent) of the CHIP beneficiaries tested in which the beneficiary was not placed in the correct CHIP sub-group that determines the beneficiary's co-payments and out-of-pocket maximums.
    - Seven instances (or 12 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.
    - 13 instances (or 22 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 maximums were not calculated correctly.

Effect

Failure to record the correct Federal Poverty Level may result in beneficiaries paying incorrect co-payments and out-of-pocket expenses.

Recommendation

We recommend the Mississippi Division of Medicaid strengthen the controls to ensure compliance with the allowable costs requirements of the Children's Health Insurance Program (CHIP).

Repeat Finding

Yes, 2020-041.

Statistically Valid

Yes.

ALLOWABLE COSTS

Significant Deficiency
Immaterial Noncompliance

2021-040 Strengthen Controls to Ensure Compliance with the Allowable Costs Requirements of the Medical Assistance Program.

ALN Number 93.778 – Medical Assistance Program (Medicaid; Title XIX)

Federal Award No. All Current Active Grants

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

Pass-through Entity N/A

Questioned Costs $3,863

Criteria

Code of Federal Regulations (42 CFR § 438.2) defines a capitation payment as "a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the state plan."

Code of Federal Regulations (42 CFR § 438.2) defines a rate cell as a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the contract.

Milliman's State Fiscal Year 2021 MississippiCAN Capitation Rate Development Report states, "The MississippiCAN state fiscal year (SFY) 2021 capitation rates are developed using Mississippi FFS Medicaid data, CCO encounter data, and CCO financial reporting data for a comparable population to that enrolled in CCOs. DOM calculates state-set rates by rate category on a statewide basis with area adjustments based on an enrolled member's county of residence."

Milliman's State Fiscal Year 2021 MississippiCAN Capitation Rate Development Report states Coordinated Care Organizations (CCO) capitation payments will vary based on their members' county of residence. We assigned each county to one of the following regions: North, Central, or South.

Condition

During testwork performed over allowable costs requirements for the Medical Assistance Program as of June 30, 2021, the auditor tested 120 managed care beneficiaries' capitation rates and noted the following:

- Three instances (or 2.5 percent) in which the incorrect county of residence was used to determine the beneficiaries' capitation rate. Of the three, two instances in which the incorrect county of residence resulted in Medicaid paying a higher capitation rate for the beneficiaries, resulting

in questioned costs of $3,863. Questioned costs were not projected for this item due to the different locations of the instances.

Cause The county code was not changed from the default code in the computer system.

Effect Using the incorrect county code resulted in the Mississippi Division of Medicaid paying higher capitation rates, resulting in questioned costs.

Recommendation We recommend the Mississippi Division of Medicaid strengthen controls to ensure compliance with allowable cost requirements of the Medical Assistance Program.

Repeat Finding No.

Statistically Valid Yes.

ELIGIBILITY

Material Weakness
Material Noncompliance

2021-041 Strengthen Controls to Ensure Compliance with Eligibility Requirements of the Medical Assistance Program and the Children's Health Insurance Program (CHIP).

ALN Number 93.767 – Children's Health Insurance Program (CHIP)
93.778 – Medical Assistance Program (Medicaid; Title XIX)

Federal Award No. All Current Active Grants

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

Pass-through Entity N/A

Questioned Costs $66,926

Criteria *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."

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."

Code of Federal Regulations (42 CFR § 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 MDES to be a useful electronic data source.

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 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, 2021, the auditor tested 300 total beneficiaries (180 Modified Adjusted Gross Income (MAGI) beneficiaries and 120 aged, blind, and disabled (ABD) beneficiaries) 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 the *Mississippi Division of Medicaid'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.

- 19 of the 180 MAGI beneficiaries (or 11 percent) reported self-employment income, out-of-state income, or unearned income on the

Mississippi income tax return, but the income was not reported on the recipient's application. Of the 19 instances, nine instances (or 47 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 beneficiaries 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. Additionally, due to the COVID-19 pandemic, some beneficiaries did not have a redetermination performed in FY 2021, so the auditor tested the prior year redetermination (which made the beneficiary eligible as of June 30, 2021). The due dates for Mississippi tax returns were extended to May 15, 2020 for 2019 tax returns and May 17, 2021 for 2020 tax returns. Based on the extended due dates, and the assumption that the beneficiaries filed their tax returns before these due dates, the auditor used tax return data from the following years: 2018 for determinations prior to May 15, 2020, 2019 for determinations from May 15, 2020 to May 16, 2021, and 2020 for determinations on or after May 17, 2021.

The fiscal year payments for these nine beneficiaries that might not have been eligible to receive the benefits totaled $23,221 of questioned costs.

Based on the error rate calculated using the capitation payments of our sample, the projected amount of capitation payments made to beneficiaries who it is reasonably possible were ineligible would fall between $66,046,582 (projected costs based on actual month payment sampled) and $69,910,510 (projected costs based on average monthly payments sampled).

The following is a breakdown of these costs by category:

CHIP: Between $11,746,594 (average monthly) to $13,800,910 (actual monthly)

MAGI Managed Care: Between $52,245,672 (actual monthly) to $58,163,916 (average monthly)

- For 19 of the 180 MAGI beneficiaries (or 11 percent), income was not verified through Mississippi Department of Employment Security (MDES) at the time of the redetermination for the eligibility period that covered June 30, 2021. This resulted in questioned costs of $43,705. Questioned costs were not projected for this item due to the inability to statistically validate the sample.

- 85 ABD beneficiaries required resource verifications through the Asset Verification system (AVS). Of the 85, seven instances (or 8 percent) in which resources were not verified through AVS at the time of redetermination.

- 293 out of 300 beneficiaries (or 98 percent) were not included on all of the required quarterly Public Assistance Reporting Information System (PARIS) file transmissions for fiscal year 2021.

    - Of the 293 beneficiaries, 249 beneficiaries (or 85 percent) were not included on any quarterly PARIS file transmissions during fiscal year 2021.

Cause The Mississippi Division of Medicaid (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 beneficiaries 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, 2020-042 and 2019-027.

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

SPECIAL TESTS AND PROVISIONS – PROVIDER ELIGIBILITY

Material Weakness
Material Noncompliance

2021-042 Strengthen Controls to Ensure Compliance with Provider Eligibility Requirements of the Children's Health Insurance Program (CHIP).

ALN Number 93.767 – Children's Health Insurance Program (CHIP)

Federal Award No. All Current Active Grants

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

Pass-through Entity N/A

Questioned Costs N/A

Criteria

Code of Federal Regulations (42 CFR 455.432) states the State Medicaid agency must conduct pre-enrollment and post-enrollment site visits of providers who are designated as "moderate" or "high" categorical risks to the Medicaid program. The purpose of the site visit will be to verify that the information submitted to the State Medicaid agency is accurate and to determine compliance with Federal and State enrollment requirements.

Code of Federal Regulations (42 CFR 438.602(b)) states, "The State must screen and enroll, and periodically revalidate, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E of this chapter. …This provision does not require the network provider to render services to FFS beneficiaries."

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 1.5.1.B.1 states, "Many Medicaid-enrolled hospitals employ hospitalists or contracted emergency room physicians who are not separately enrolled as Medicaid providers. Services/items/prescriptions that are ordered/referred/written by these hospitalists/contracted physicians are ineligible for payment unless the hospitalist/physician is enrolled in Medicaid, to the extent the claim does not qualify for an exception under 1.5.1.B.2. "When the SMA is not required to Enroll ORPs."

Condition

For the Children's Health Insurance Program (CHIP), the Mississippi Division of Medicaid (MDOM) delegates the screening of providers to each of the CHIP managed care organizations (MCOs). During fiscal year 2021, MDOM had contracts with two CHIP managed care organizations (MCOs). United Health Care (United) and Molina were healthcare network providers for the entire year. Due to MDOM delegating screening for CHIP, providers were potentially required to disclose personally identifiable information (PII) to multiple entities. 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.

Per review of the Molina's 2021 External Quality Review (EQRO) report and discussion with Molina officials, Molina has not completed any required site visits for moderate risk or high risk providers since becoming a CHIP MCO in 2019. Molina has been working with contractors to establish a procedure to complete the required site visits.

Per review of Molina policies and discussion with Molina officials, Molina is not screening and credentialing all providers individually. Providers are screened and credentialed by Molina, a delegated provider entity, at the facility level or not required to be screened or credentialed.

Per *Molina Healthcare Credentialing Program Policy (Policy CR 01)*, "Molina does not require credentialing for some types of practitioners who are credentialed by the organization(s) that employ or contract with them. If a practitioner meets any one of the following criteria, Molina does not require them to be credentialed:

- Practitioners who practice exclusively in an inpatient setting and provide care for Molina Members due to being directed to the hospital or another inpatient setting. Examples may include pathologists, radiologists, anesthesiologists, neonatologists, emergency room physicians, critical care medicine and hospitalists.
- Practitioners who practice exclusively in freestanding facilities and provide care for Molina Members due to being directed to the facility."

Per *Molina Healthcare Credentialing Program Policy (Policy CR 01)*, "When a practitioner or organizational provider has a direct contract with Molina and is also credentialed by and under contract with an entity Molina has delegated credentialing to, Molina does not need to credential the practitioner or

organizational provider. The credentialing done by the delegated entity applies to the practitioner for any location in which they are working. Molina receives regular reports from each delegated entity and if agreement between the practitioner and the delegated entity terminates, Molina credentials the practitioner as indicated below."

Delegating the credentialing allows providers to "credential themselves" which creates a conflict of interest and does not allow the state appropriate oversight maintain appropriate oversite of the screening and credentialing activities.

Cause

The Mississippi Division of Medicaid (MDOM) delegated the screening and credentialing of CHIP providers to managed care organizations.

Effect

Failure to properly credential providers could result in payments being made to ineligible providers, resulting in unallowable costs. In addition, redundant screening can place personally identifiable information (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).

Repeat Finding

Yes, 2020-043.

Statistically Valid

No.

End of Report

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

MISSISSIPPI DIVISION OF
MEDICAID

SINGLE AUDIT FINDINGS

October 17, 2022

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. Our responses are below.

Sincerely,

Drew Snyder

Drew Snyder
Executive Director
Mississippi Division of Medicaid

AUDIT FINDINGS:

93.767 Children's Health Insurance Program (CHIP)

Allowable Costs

2021-039 Strengthen Controls to Ensure Compliance with the Allowable Costs Requirements of the Children's Health Insurance Program

DOM Response:

DOM Concurs. Although DOM concurs with this finding, this is a repeat finding that was immediately addressed at the conclusion of the Single Audit of fiscal year 2021. A manual update to the CHIP table was made by DOM, submitted to Conduent, and became effective 7/1/2021. The most recent CHIP co-payment table was automatically updated and put into production on March 11, 2022, when the Wholesale Change Packet was processed. When samples are selected by the Auditor's Office that post-date July 2021, the change will be evident, and this will no longer be an issue.

DOM Corrective Action Plan:

Based on the above response, this issue has been corrected and no further action is needed.

93.778 Medical Assistance Program (Medicaid; Title XIX)

Allowable Costs

2021-040 Strengthen Controls to Ensure Compliance with the Allowable Costs Requirement of the Medical Assistance Program

DOM Response:

DOM Concurs. The Office of the State Auditor compared county information from the RH480 report from June 2021 to current county information in the MMIS system. When a new address is entered into the MEDS system, a complete override occurs in the MMIS system without record of the previous address. Because of this, comparing information from a past time period (June 2021) to current information in a real time system (MMIS) may result in what appears to be a conflict in county and/or region codes, resulting in the perception of payment of an improper capitation rate.

DOM determined that the three cases identified by OSA were not coded according to the county of residence in June 2021, which is the time period of the report utilized by OSA. However, one of the three did not result in improper capitation payments, as the geographic region, which determines the capitation payment, was accurate.

DOM Corrective Action Plan:

a. Training was held with all Regional Office Eligibility Staff in July 2022, on the importance of having the correct county code in the computer system when updating an address or processing an action on a case.

b. Nathan Wilson

c. Corrected as of August 1, 2022

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

Eligibility

2021-041 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 is still working on the SSR (System Security Report) for the IRS. Approval of the SSR is needed in order to complete testing of the code for using the IRS data in the reasonable compatibility calculations. The code is completed, and harness testing was done, but due to Authority to Connect (ATC) work and the MESA upgrade, the SSR completion has been delayed. Until such time that DOM is permitted to access tax return information, DOM plans to continue to follow the approved federal/state plan for eligibility determination.

DOM Does Not Concur. OSA identified 19 instances of applicants reporting self-employment income, out-of-state income, or unearned incomed on tax returns. The applications received by DOM for these applicants did not reflect income from any of these sources. Further, as stated above, DOM does not have access to state tax return information to refute the information on the applications in questions. DOM utilized all available, CMS-approved state plan data sources to evaluate and determine eligibility for the applicants identified.

In addition, the nine instances of income exceeding applicable income limits are based on tax returns that may or may not reflect the current situation of an applicant. 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. 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.

Further, because of the public health emergency, which began in March 2020, no beneficiaries could be removed from Medicaid coverage. As a result, and based on DOM's determination of eligibility, the nineteen instances that were used to calculate the questioned costs would, in fact, have retained coverage, thus, legitimizing any costs associated with those beneficiaries during the time period audited.

DOM Does Not Concur. There were only five beneficiaries whose income was not verified through Mississippi Department of Employment Security. the remaining beneficiaries' income was either verified or verified automatically to attempt an administrative renewal though renewals were suspended at this time due to the public health emergency. Upon notification of this issue, DOM did verify the income of the five beneficiaries mentioned above, and it was determined that all five were, in fact, eligible during the time period audited, eliminating any associated questioned costs.

DOM Concurs. DOM did not perform resource verification through AVS for the beneficiaries in question. However, after being notified of this oversight, DOM ran AVS for all seven applicants, which resulted in no change in the eligibility determination.

DOM Concurs. Although, DOM agrees with this finding, this is a repeat issue that was corrected after the Single Audit of FY2021. Once OSA reviews PARIS files submitted after August 2021, this will no longer be an issue.

DOM Corrective Action Plan:

a. A training PowerPoint was submitted to all RO Eligibility employees addressing MDES in July 2022.

b. Nathan Wilson

c. Corrected as of August 1, 2022

93.767 Children's Health Insurance Program (CHIP)

Special Tests and Provisions – Provider Eligibility

2021-042 Strengthen Controls to Ensure Compliance with Provider Eligibility Requirements of the Children's Health Insurance Program (CHIP)

DOM Response:

DOM Concurs. The Mississippi Division of Medicaid (MDOM) delegated the screening and credentialing of CHIP providers to managed care organizations. Additionally, DOM officially discontinued the requirement of MCOs to obtain disclosures to eliminate redundancy in the MississippiCAN Contract Amendment #9. However, if the provider is enrolled in CHIP-only, then the MCO is required to obtain the disclosure.

DOM Concurs. The CHIP MCO identified confirmed that they have not conducted required site visits for moderate risk or high-risk providers since becoming a CHIP MCO in 2019. Additionally, the MCO did advise that they had contacted providers to conduct site visits but had been unable to secure a contract prior to implementation of the DOM centralized credentialing process.

DOM Does Not Concur. DOM requires the MCO to conduct screenings of all providers; however, the MCO may delegate provider credentialing activities, which includes provider screening. Services/items/prescriptions that are ordered/referred/written by hospitalists/contracted physicians are eligible for payment if the hospitalist/physician is enrolled in Medicaid or the claim qualifies for an exception under Medicaid Provider Enrollment Compendium (MPEC) Section 1.5.1.B.2. titled *When the SMA is Not Required to Enroll ORPs*. If the hospitalist/contracted physician is not enrolled in Medicaid, then credentialing is not required.

DOM Corrective Action Plan:

a. In response to concerns for proper credentialing and provider concerns, DOM began the design and implementation of a centralized credentialing process, which is administered by DOM for managed care providers in the MississippiCAN and CHIP programs. This process includes provider enrollment, screening, credentialing, and site visits by DOM and its fiscal agent. In addition, DOM will delegate credentialing services to a minimum number of large healthcare systems. The providers will continue to contract with MCOs for enrollment in their respective networks.

b. Sharon Jones

c. Corrected as of July 1, 2022

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

Auditor's note to the Corrective Action Plan from Mississippi Division of Medicaid (MDOM) Management

Division of Medicaid – Eligibility - *Material Weakness/Material Noncompliance*

2021-041 **Strengthen Controls to Ensure Compliance with Eligibility Requirements of the Medical Assistance Program and the Children's Health Insurance Program (CHIP)**

This finding is a repeat finding for MDOM since the Fiscal Year 2019 Single Audit. MDOM's State Plan requires the verification of all income for MAGI-based eligibility determinations, and, as stated in the finding, MDOM's Eligibility Policy and Procedure Manual requires the use of an individual's most recent tax return to verify self-employment income. In multiple instances, applicants either misreported self-employment income or failed to report self-employment income. MDOM's failure to adequately capture and verify self-employment income led to 9 instances were individuals who may not have been eligible to receive benefits were awarded benefits. In a similar case reported in last year's audit, two individuals fraudulently applied for and received Medicaid benefits, namely by concealing self-employment income on their tax returns. These instances resulted in over $70,000 in unentitled benefits being paid. In order to attempt to reduce ineligible individuals from receiving benefits, MDOM should strengthen their controls and perform due diligence to ensure that self-employment income is properly verified. MDOM repeatedly states that they do not have access to state tax return information; however, their own policy states that they will use tax return data to verify self-employment income.

As explained to MDOM by auditors, the questioned costs remained even though MDOM was unable to remove individuals from the program due to COVID-19. The auditor asserts that, if MDOM had performed proper due diligence when initially evaluating these individuals, they may have never been accepted into the program; therefore, the questioned costs remain. The auditor concurs that OSA is not able to know the recipients were actually ineligible; conversely, MDOM is not able to know the recipients are actually eligible due to their own failed compliance with policies. Eligibility for these individuals is, at best, questionable, which is why the payments made are questioned costs.

Additionally, MDOM stated that they do not concur with the section of the finding regarding MDES verifications. To date MDOM has offered no documentation to support their assertion that these individuals were verified through the MDES system.

Division of Medicaid – Special Tests & Provisions – Provider Eligibility - *Material Weakness/Material Noncompliance*

2021-042 **Strengthen Controls to Ensure Compliance with Provider Eligibility Requirements of the Children's Health Insurance Program (CHIP)**

In the corrective action plan, MDOM states "MDOM requires the MCO to conduct screenings of all providers; however, the MCO may delegate provider credentialing activities, which includes provider screening." As noted in the finding, Molina delegates credentialing and allows providers to "credential themselves". The Medicaid Provider Enrollment Compendium (MPEC) states that allowing managed care organizations to delegate provider credentialing activities to allow providers to "credential themselves" is not in compliance with 42 CFR 455. This arrangement creates a conflict of interest and does not allow the MDOM to maintain appropriate oversite.

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