Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Mississippi Focused Program Integrity Review:

Medicaid Managed Care Oversight

May 2023

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review to assess Mississippi's program integrity oversight efforts of its Medicaid managed care program for Fiscal Years (FYs) 2019-2021. This focused review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided by the state in response to questions posed by CMS in a managed care review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the state Medicaid agency and evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency.

This report includes CMS' findings and resulting recommendations, as well as observations, that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified two findings that create risk to the Mississippi Medicaid program related to managed care program integrity oversight. In response to the finding, CMS identified two recommendations that will enable the state to come into compliance with federal and/or state Medicaid requirements related to managed care program integrity oversight. These recommendations include the following:

MCO Contract Compliance

> **Recommendation #1:** In accordance with § 438.608(d)(2), Mississippi should amend the MCO general contract to include language specifying that each MCO should have a mechanism in place for network providers to report to the MCO when it has received an overpayment, to return the overpayment to the MCO within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.

Encounter Data

> **Recommendation #2:** In accordance with § 438.602(e), the state should conduct, or contract for the conduct of an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified four observations related to Mississippi's managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, they identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

MCO Contract Compliance

Observation #1: CMS encourages Mississippi to develop an effective monitoring tool for the annual submission, review, and approval of MCO compliance plans by the Office of Program Integrity (OPI). Such a tool may include a template or checklist outlining the required compliance plan requirements under CMS regulations and the Mississippi MCO general contract.

Observation #2: CMS encourages Mississippi to strengthen its MCO general contract language regarding beneficiary verification activities, consistent with § 438.608(a)(5). In addition, the state should ensure that MCOs have consistent beneficiary verification policies and procedures that comply with the contractual requirement, and a process in place to monitor this process.

Interagency and MCO Program Integrity Coordination

Observation #3: CMS encourages Mississippi, in conjunction with the Medicaid Fraud Control Unit (MFCU) when possible, to develop and provide program integrity training to MCO staff on a routine basis to enhance case referrals from, and oversight practices of, the MCOs. This includes ensuring that MCO staff, primarily the SIU and/or compliance officer, is receiving adequate training in identifying, investigating, referring, and reporting potential fraudulent billing practices by providers.

MCO Investigations of fraud, waste, and abuse

Observation #4: CMS encourages Mississippi to collaborate with the MCOs to develop and enhance suspected fraud case referrals. This includes collaborating with the MCOs to ensure the SIU staff are adequately identifying, investigating, and referring suspected fraud to the state and the MFCU.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts Focused Program Integrity Reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the Mississippi Managed Care Program and the Focused Program Integrity Review

The Mississippi Division of Medicaid (DOM) is responsible for the administration of the Mississippi Medicaid program, titled Mississippi Coordinated Access Network or MississippiCAN. Within DOM, the Office of Coordinated Care is responsible for the overall operations and oversight of program integrity-related functions and under the Division of Accountability and Compliance, the Office of Program Integrity is the organizational unit tasked with oversight of SIU program integrity-related functions for the managed care program.

During the review period, Mississippi contracted with three Coordinated Care Organizations (referred to as MCOs within this report) to provide health services to the Medicaid population. As part of this review, CMS interviewed three MCOs: Magnolia Health (Magnolia), a wholly owned subsidiary of Centene; Molina Healthcare of Mississippi (Molina), owned by Molina Healthcare, Inc.; and UnitedHealthcare (UHC) Community Plan of Mississippi, a subsidiary of

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

UnitedHealth Group. Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In June 2022, CMS conducted a focused program integrity review of Mississippi's managed care program. This focused review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by selected MCOs under contract with the state Medicaid agency. CMS interviewed key staff and reviewed other primary data. Because Mississippi did not have an open corrective action plan from a prior managed care review, there were no unimplemented corrective actions for CMS to review.

During this review, CMS identified a total of two recommendations and four observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix A. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to: data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.
B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.
C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.
D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.
E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and

completeness of the encounter data submitted by, or on behalf of, each MCO.

III. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under § 438.608.

In Mississippi, these oversight and monitoring requirements are met by the Office of Coordinated Care (OCC), the OPI, Office of Compliance and several other offices within the DOM. The OCC serves as the primary contact for all managed care activities. The OCC holds monthly and ad hoc meetings with the MCOs. The OPI is primarily responsible for monitoring and oversight of MCO SIU program integrity activities. The OPI coordinates audit and oversight activities involving the MCO and other entities auditing on behalf of the OPI to ensure there is no duplication of effort.

The DOM has contracted with Carolina Centers for Medical Excellence to perform external quality review activities. The DOM also relies on the annual EQRO technical report for detailed information regarding the regulatory and contractual compliance of the MCOs, the results of performance improvement projects, and performance measures. Results from this report include information regarding the effectiveness of the MCO program, identified strengths and weaknesses, and potential opportunities for improvement. The information is incorporated into the Managed Care Quality Strategy, which is used for initiating and developing quality improvement projects. The Managed Care Quality Strategy is assessed annually for effectiveness and updated to reflect state and federal mandates related to managed care as significant changes occur, but no less frequently than every three years.

CMS did not identify any findings or observations related to these requirements.

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, the MCO general contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

The MCO general contract for Mississippi is developed by DOM. The Executive Director, or

their designee, serves as the Contract Officer. All statewide policy decisions or contract interpretation are made through the Executive Director or their designee. The Executive Director or their designee is responsible for the interpretation of all federal and state laws and regulations governing or in any way affecting the contract.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors
3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements under the contract
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract
5. Effective lines of communication between the compliance officer and employees
6. Enforcement of standards through well-publicized disciplinary guidelines
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract

Section 12.B. Program Integrity - Fraud and Abuse Compliance Plan of Mississippi's MCO general contract explicitly addresses the requirement that all seven compliance plan elements listed above be addressed. Mississippi's Standard Operating Procedures require MCO compliance plans to include systems, procedures, and policies that the MCO will utilize to prevent, identify, and recover improper payments, and detect fraud and abuse of its network providers and subcontractors. It must also detail how the MCO will carry out the program integrity provisions outlined in the contract. In addition, Section 12.B. Program Integrity – Fraud and Abuse Compliance Plan requires the MCO to submit its compliance plan, including fraud and abuse policies and procedures, to the OPI for written approval within thirty days before those plans and procedures are implemented. A review of the MCOs' compliance plans and programs found that the required elements were addressed in each MCO's Fraud and Abuse Compliance Plan. It was noted, however, that DOM does not utilize a template or checklist for review and approval of the MCO's Fraud and Abuse Compliance Plan; however, Mississippi indicated it

would implement this practice in the future.

> **Observation #1:** CMS encourages Mississippi to develop an effective monitoring tool for the annual submission, review, and approval of MCO compliance plans by the OPI. Such a tool may include a template or checklist outlining the required compliance plan requirements under CMS regulations and the Mississippi MCO general contract.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

In Mississippi, this requirement is met through MCO general contract Section 11.V. Reporting Requirements – Fraud and Abuse Reporting, which states that the MCO must, on a regular basis, verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members. While Mississippi's MCO general contract meets CMS' regulatory requirements, in practice, the MCO's only send an explanation of benefits as a verification of services to all or a significant number of members that receive services. Overall, this process appears to be ineffective, and Mississippi conducts no oversight of this process. Magnolia reported they are not required to submit a report of all beneficiary verifications to the state and reported a zero-return rate on beneficiary verifications that were sent. Molina reported minimal tips/leads from this process. The UHC was unable to provide the number of beneficiary verifications sent out prior to March 1, 2021 and does not currently have a process in place to identify clearly what fraud, waste, and abuse tips are the result of a member viewing their explanation of benefits and, therefore, were unable to identify a percentage, return on investment, or a list of returned beneficiary verifications.

> **Observation #2:** CMS encourages Mississippi to strengthen its MCO general contract language regarding beneficiary verification activities, consistent with § 438.608(a)(5). In addition, the state should ensure that MCOs have consistent beneficiary verification policies and procedures that comply with the contractual requirement, and a process in place to monitor this process.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act (the Act), including information about rights of employees to be protected as whistleblowers.
The state is compliant with this requirement. The MCO general contract Section 11.V. Reporting Requirements – Fraud and Abuse Reporting states that in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, the MCO must have written policies for all employees of the entity, and of any contractor or agent, that provide detailed information

about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

CMS did not identify any findings or observations related to these requirements.

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

Mississippi Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The MCO general contract Section 11.V.7. addresses MCO's suspension of payments to a network provider for which the state determines there is a credible allegation of fraud. When DOM sends notice that payments to a provider have been suspended, the MCO must also suspend payments to the provider within 24 hours of the notification. Upon notification, DOM expects the MCO to immediately suspend all payments to providers, including any claims that may be ready for payment, unless otherwise stated by DOM. When notice of a payment hold or a payment hold lift is received, the MCO must respond to the notice within 24 hours and inform DOM of actions taken. The MCO shall require its subcontractors, when applicable, to suspend payments to providers for all claims the subcontractor has or may have against any entity that directly or indirectly receives funds under the contract. The MCO is responsible for the return of any money paid in error for services provided to a suspended provider. If the MCO does not suspend payments to the provider, or if the MCO does not correctly report the amount of adjudicated payments on hold, DOM may impose contractual or other remedies.

CMS did not identify any findings or observations related to these requirements.

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for network providers to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

CMS found that Mississippi is in compliance with the requirements at §§ 438.608(a)(2) and (d). In accordance with MCO general contract Section 12.A. Program Integrity - General Requirements, the DOM OPI is required to be notified in writing within 30 days of the discovery of any overpayments made by DOM due to billing errors, system errors, or human error. The MCO must confer with DOM OPI before initiating any recoupment or withhold of any funds to ensure that the recovery recoupment or withhold is permissible. In the event the MCO obtains funds in cases where recovery recoupment or withhold is prohibited, the MCO will return the funds to DOM. If an investigation by the MCO is approved by DOM, the MCO will retain any overpayments identified and collected. If DOM OPI conducts the investigation, DOM will retain any overpayments identified and collected. In the event DOM is unable to recoup overpayments that result from audits performed on managed care encounter data, the MCO must withhold funds from the provider and return the funds to DOM upon request from DOM OPI. The MCOs are to withhold funds from the provider until all funds have been recovered and return recovered funds to DOM OPI. Providers for which DOM is unable to recover funds owed because of an audit will be terminated. This section of the contract also requires submission of data on the basis of which the state certifies the actuarial soundness of capitation rates, and an annual report of overpayment recoveries from the MCOs. **However, the MCO general contract did not include language addressing the requirement for MCOs to have a process for network providers to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days, as required by § 438.608(d)(2).**

> **Recommendation #1:** In accordance with § 438.608(d)(2), Mississippi should amend the MCO general contract to include language specifying that each MCO should have a mechanism in place for network providers to report to the MCO when it has received an overpayment, to return the overpayment to the MCO within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. The state has a Memorandum of Understanding (MOU) in place with the MFCU that meets the regulatory criteria. Specifically, there is a MOU that contains procedures by which the MFCU will receive referrals of potential fraud from MCOs

as required by § 455.21(c)(3)(iv). Additionally, the state does meet with the MFCU at least quarterly to discuss case referrals.

While there is no requirement for SMAs to meet on a regular basis with its MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The SMA does hold quarterly collaborative sessions with its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions. The OPI attends monthly MCO management meetings conducted by the OCC, and the state managed care staff attends the quarterly OPI/MCO SIU meetings conducted by the OPI. However, neither DOM nor the MFCU conduct training for MCOs on program integrity topics during the review period.

> **Observation #3:** CMS encourages Mississippi, in conjunction with the MFCU when possible, to develop and provide program integrity training to MCO staff on a routine basis to enhance case referrals from, and oversight practices of, the MCOs. This includes ensuring that MCO staff, primarily the SIU and/or compliance officer, is receiving adequate training in identifying, investigating, referring, and reporting potential fraudulent billing practices by providers.

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Mississippi has implemented such a process in accordance with 438.608(a)(7) and §§ 455.13-17. Mississippi requires MCO provider reviews and audits to be consistent with DOM program integrity review and auditing standards and instructions and/or guidance in accordance with the Program Integrity/MSCAN Fraud and Abuse Standard Operating Procedures and the Mississippi Administrative Code. The MCO must submit for review by DOM all policies and procedures relating to provider reviews and audits related to fraud, waste, and abuse activities, procedures defining desk audits and payment review processes by the MCO and any subcontractors, processes for reviewing all tips, complaints, and referrals, and any policies and procedures that outline how the MCO provides mandatory and ongoing training and education of all program integrity staff.

In accordance with federal regulations, the OPI must refer any and all cases of credible allegations of fraud to MFCU. Upon receipt of a complaint of fraud or abuse, the MCO shall follow their internal procedures for investigation of the complaint. If the complaint is found to be a credible allegation of fraud the MCO must immediately report it via email to OPI and copy the designated contact within the OCC. The staff within OPI determines if the MCO should submit a

credible allegation of fraud referral or if the case will remain with the MCO for further investigation. Once the appropriate documentation is received, the OPI will take the necessary steps to initiate the case referral to the MFCU. If the case is to be referred to the MFCU, OPI follows standard operating procedures for this process. The OPI will notify the MCO of the outcome of the referral to the MFCU and the MFCU investigation outcome, if applicable, as well as any actions taken against the provider. Written notification of any additional referrals made to agencies other than DOM must be submitted to the OPI within twenty-four (24) hours of referral.

CMS did not identify any findings or observations related to these requirements.

MCO Oversight of Network Providers

CMS verified whether each Mississippi MCO had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's contract requirements.

Magnolia: The Magnolia SIU conducts a preliminary review when it receives information that causes concern about potential fraud, waste, and abuse. All preliminary reviews receive a case number, are tracked in the SIU case tracking system, and are completed within 40 working days unless otherwise specified by federal/state regulations or contract terms. Once a preliminary review has been completed, the SIU staff prepares a preliminary report detailing its findings and providing next-step recommendations. Full investigations include prepayment review, post-payment review, and provider onsite audits. Results of those audits include corrective actions such as provider education, recovering of overpayments, and reporting cases to regulatory authorities. Magnolia refers all Medicaid cases to DOM for permission to pursue an investigation or any next steps related to a pre-payment or post-payment audit. All provider correspondence for a Medicaid case is sent to DOM. Credible allegations of fraud are routed to the MFCU through DOM. The SIU conducts announced/unannounced provider site visits.

Molina: The Molina SIU triages tips to determine if there is sufficient information present to develop a lead for a case investigation. All information related to a case is tracked in an investigative case management database for regulatory reporting and key performance indicator tracking. Tips are generally turned into a case or closed out as unsupported within 7 days. Once a lead has been established and initial data analytics are run, Molina promptly conducts a preliminary review, which is the precursor to determining if a full, in-depth case investigation should move forward. Cases are transferred from investigators to subject matter experts over the course of the audit to best utilize expertise in the team. Nurses and certified coders play a key role in records reviews. Investigators work collaboratively with the MFCU and Attorney General's offices, where applicable. All suspected or confirmed instances of fraud and abuse are referred to DOM immediately. Molina's SIU can conduct announced or unannounced site visits. However, there were no site visits conducted in 2020 due to the onset of the Public Health Emergency, and there were no unannounced site visits conducted during the review period.

UHC: The UHC program integrity activities are supported by various UnitedHealth Group functions responsible for fraud, waste, and abuse detection, prevention, and investigation. The oversight of program integrity functions resides with the plan's Compliance Officer. Oversight

functions include, but are not limited to, specialized SIUs and payment integrity activities. The UHC maintains one full-time investigator dedicated 100% to Mississippi Medicaid investigations. Investigations are reported to DOM OPI, and other regulatory agencies, as required in accordance with federal, state, and contractual requirements. The UHC cooperates with law enforcement and regulatory agencies in the investigation and prevention of fraud and abuse. The UHC SIU maintains a staff of over 70 individuals who handle program integrity of fraud, waste, and abuse activities for the state Medicaid program. The UHC is required to complete the required case approval request form when submitting cases to DOM OPI. Referral to the MFCU is determined and completed by DOM. The SIU conducts announced/unannounced provider site visits as appropriate for the investigation of fraud allegations.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to meet CMS requirements and state contract requirements.

Figure 1 below describes the number of investigations referred to Mississippi by each MCO. As illustrated, the number of investigations referred by the MCOs appears low. **The DOM expressed some concerns as to the low number of fraud referrals by the MCOs but indicated there has been an increase of cases recently.** DOM is working with the MCOs and the MFCU and has recently been conducting more analyses of overpayments to determine if there should be a fraud referral.

Figure 1. Number of Investigations Referred to Mississippi by each MCO

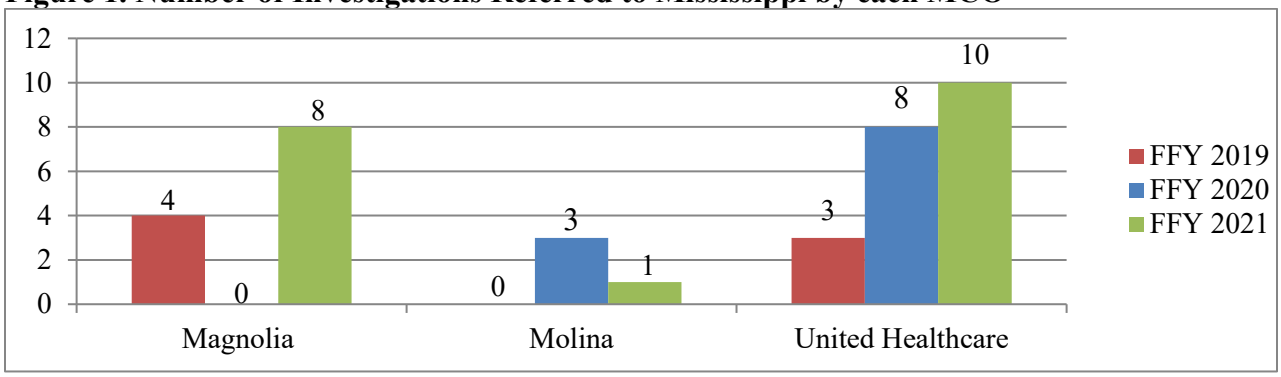

Table 1, below, describes each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month.

Table 1: MCO Recoveries from Program Integrity Activities

Magnolia's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	27	27	$9,030,311.72	$166,505.65
2020	5	13	$8,082,399.24	$284,759.51
2021	6	19	$1,768,342.59	$219,051.70

**"Identified" overpayments for Magnolia may not be the actual amount of the overpayment. The health plan advised during interviews that some of the overpayments were estimated or misclassified.

Molina's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	13	13	$2,484,949.30	$0.00
2020	26	26	$360,389.91	$40,547.66
2021	17	17	$222,539.22	$21,501.74

UHC's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	56	117	$87,366.28	$0.00
2020	37	131	$251,220.24	$121,976.91
2021	33	105	$9,075,016.38	$26,147.32

Observation #4: CMS encourages Mississippi to collaborate with the MCOs to develop and enhance suspected fraud case referrals. This includes collaborating with the MCOs to ensure the SIU staff are adequately identifying, investigating, and referring suspected fraud to the state and the MFCU.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Through a review of the Mississippi MCO general contract and interviews with each of the MCOs, CMS determined that Mississippi was in compliance with § 438.242. Specifically, the contract language in MCO general contract Section 11.S. Reporting Requirements – Member Encounter Data states that the MCO must submit complete, accurate, and timely member encounter data to DOM that meets federal requirements and allows DOM to monitor the program at least monthly following the month in which the claims were adjudicated (paid, amended or denied status). The MCO must provide member encounter data in the format required by DOM to support comprehensive financial reporting and utilization analysis necessary for capitation rate development, program oversight, and reporting requirements. Further, in MCO general contract Section 11.R. Reporting Requirements – Health Information System, the MCO must maintain a health information system that collects, analyzes, integrates, and reports encounter data. The system must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. The data submitted is posted to the state's website, as required by § 438.10(c)(3). The data, documentation, or information submitted must be certified by either the MCO's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. The certification provided must attest that, based on best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful, and is submitted concurrently with the submission of the data, documentation, or information.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. The DOM requires each MCO to submit encounter data to the DOM's fiscal agent, Conduent. To ensure complete encounter data is being received, Myers and Stauffer performs bi-monthly encounter data reconciliations. In addition, DOM engaged with Myers and Stauffer to perform a comparison of MCO encounter data to cash disbursements for the three MCOs for the period July 1, 2019 through June 30, 2021. **However, CMS noted that Myers and Stauffer specified in their reports for the three MCOs that it was not required to perform an audit, examination, or review of the accuracy, truthfulness, and completeness of the encounter data**. Therefore, it was determined that Mississippi was not in compliance with the requirements at § 438.602(e).

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by MCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. Mississippi has a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, the DOM using a system called Cognos generates monthly data mining reports on types of services, amounts paid by the managed care plans, and error reports. In addition, DOM conducts ad hoc data mining of encounter data. The fiscal agent, Conduent, as well as OPI staff conducts data mining of both fee-for-service and encounter data. The DOM uses a variety of algorithms to analyze data, including but not limited to, spike reports, date after death reports, and reports to identify duplicate claims and excessive billing of services. The DOM vendor Myers and Stauffer provides bi-monthly encounter reconciliations with the MCOs cash

disbursement journals.

Recommendation #2: In accordance with § 438.602(e), the state should conduct, or contract for the conduct of an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

IV. Conclusion

CMS supports Mississippi's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified two recommendations and four observations that require the state's attention.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should explain how the state will ensure that the recommendations have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place, and identify which area of the SMA is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

CMS looks forward to working with Mississippi to build an effective and strengthened program integrity function.

V. Appendices

Appendix A: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix B Enrollment and Expenditure Data

Table B-1 and Table B-2 below provide enrollment and expenditure data for each of the selected MCOs.

Table B-1. Summary Data for Mississippi MCOs

Mississippi MCO Data	Magnolia	Molina	UHC
Beneficiary enrollment total	197,760	95,072	182,804
Provider enrollment total	3,522 providers (based on unique TINs) 18,990 practitioners (based on unique NPIs)	19,080	21,753
Year originally contracted	2011	2017	2011
Size and composition of SIU	1*	68	Approximately 70
National/local plan	National/Local Magnolia is incorporated in Mississippi and is a wholly owned subsidiary of Centene	National - Molina is owned by Molina Healthcare, Inc.	National/Local UnitedHealthcare Community Plan of Mississippi is a subsidiary of UnitedHealth Group

*** -** Magnolia has one full-time investigator dedicated to Mississippi. The investigator is supported by clinical staff, Centene leadership, counsel, and other investigators, including pharmacy, if needed.

Table B-2. Medicaid Expenditure Data for Mississippi MCOs

MCOs	FY 2019	FY 2020	FY 2021
Magnolia	$1,466,792,300.62	$1,448,968,433.39	$1,380,401,811.96
Molina	$167,425,627.38	$437,044,873.75	$504,080,767.46
UHC	$1,177,699,980.26	$1,190,428,516.39	$1,198,469,110.84
Total MCO Expenditures	$2,811,917,908.26	$3,076,441,823.53	$3,082,951,690.26

Appendix C: State Response

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	In accordance with § 438.608(d)(2), Mississippi should amend the MCO general contract to include language specifying that each MCO should have a mechanism in place for network providers to report to the MCO when it has received an overpayment, to return the overpayment to the MCO within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.	**X**	
Recommendation #2	In accordance with § 438.602(e), the state should conduct, or contract for the conduct of an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.	**X**	

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)