Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Mississippi Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Mississippi Medicaid program. The MIG review team conducted the onsite portion of the review at the offices of the Bureau of Program Integrity (BPI) in the Division of Medicaid (DOM), which is the State Medicaid agency. The review team also visited the office of the State's Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of BPI, which is responsible for program integrity in Mississippi. This report describes two effective practices, five regulatory compliance issues, and six vulnerabilities in the State's program integrity operations.

The CMS is concerned that the review identified three uncorrected or partially uncorrected repeat findings from its 2009 review of Mississippi. The CMS plans on working closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Mississippi improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Mississippi's Medicaid Program

The BPI is responsible for program integrity operations as part of the Office of Audits and Recovery in DOM. As of January 1, 2012, Mississippi Medicaid served 717,012 beneficiaries. Approximately 7 percent of beneficiaries were enrolled in managed care. The managed care program, called MississippiCAN, was implemented in January 2011 and enrolls only special populations (including disabled children and the working disabled). Two managed care entities (MCEs), organized as comprehensive managed care organizations, are on contract with the State. The MCE providers are required to enroll in Mississippi Medicaid through the State agency and are subject to additional credentialing at the plan level.

At the time of the review, the Mississippi Medicaid program had 24,715 participating Medicaid providers. Medicaid expenditures in Mississippi for the State fiscal year (SFY) ending June 30, 2011 totaled $4,444,314,628.

Program Integrity Section

The BPI is the organizational component dedicated to anti-fraud and abuse activities within the State agency. At the time of the review, it had approximately 20 full-time equivalent staff. This represents a 20 percent loss in staff (investigators and nurses) from the time of the last review. The table below represents the total number of investigations and overpayments identified and collected in the past four SFYs as a result of program integrity activities.

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified Through Program Integrity Activities	Amount of Overpayments Collected Through Program Integrity Activities***
2008	34	13	Not calculated	$2,979,546
2009	103	25	$3,680,001	$1,434,532
2010	68	21	$2,183,226	$12,726,381
2011	70	15	$1,745,301	$3,605,351

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.
*** In some cases, these figures are larger than the amount of overpayments identified because they include significant global settlements. Global settlements comprised 68 percent in SFY08, 12 percent in SFY09, 73 percent in SFY10 and 57 percent in SFY11.

Methodology of the Review

In advance of the onsite visit, the review team requested that Mississippi complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, managed care and the MFCU. A three-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of June 12, 2012, the MIG review team visited the DOM and MFCU offices. The team conducted interviews with numerous DOM staff, the State's provider enrollment staff and contractor, and MFCU staff. The MCEs were interviewed by telephone the week prior to the onsite review. To determine whether non-emergency medical transportation (NEMT) providers were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed DOM staff who oversee the NEMT program and the NEMT broker. The MIG team also interviewed staff who oversee Mississippi's home and community-based services waiver programs. In addition, the team conducted sampling of provider enrollment applications, selected case files, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of BPI as they relate to program integrity but also considered the work of other components and contractors responsible for a range of program

integrity oversight and related operational functions, including provider enrollment, managed care, waiver programs and NEMT.

Mississippi operates its Children's Health Insurance Program as a stand-alone Title XXI program. The stand-alone program operates under the authority of Title XXI and is beyond the scope of this review.

Unless otherwise noted, Mississippi provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information provided.

RESULTS OF THE REVIEW

Effective Practices

As part of its comprehensive review process, CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Mississippi reported the use of targeted audit procedures as well as a centralized enrollment process for fee-for-service (FFS) and managed care providers.

Implementation of targeted audits

In the last three years, BPI has implemented Current Procedural Terminology (CPT)-based reviews and audits that have saved millions and resulted in improvements in State policy. Examples of such activities and the resulting outcomes include:

- Through data mining, the State noted that providers were billing procedure code H2012 for Behavioral Health Day Treatment for beneficiaries between the ages of 0-5. It was determined that most of the services provided to this age group were not medically necessary, and the children were merely receiving day care services versus actual treatment. To address this situation, the Bureau of Mental Health implemented a prior authorization process in 2011. Within a year, the State saw a $14 million reduction in payments from the previous SFY. The State reported that six active cases remain open in this area, and one provider is also under review by the MFCU. However, there were no recoveries on these cases at the time of the CMS review.
- In March 2010, the State found that providers were submitting claims for procedure code 59430 (postpartum care only - separate procedure) or evaluation and management codes (office visit and inpatient) following deliveries otherwise billed under two common CPT codes which explicitly include postpartum care. After an analysis of this billing pattern, the State agency determined that double-billing was taking place and developed a strategy to prevent providers from being paid twice for the same service. The State sent a series of demand letters in September 2010 and recouped a total of $501,908 from this project.

- Also in 2010, the State found that many Medicaid beneficiaries in hospice care were living past the six-month expected time period to qualify for this service. Further review revealed that providers were enrolling individuals who did not qualify for hospice care. The BPI worked with DOM's Long Term Care Unit to establish a prior authorization process for hospice services. In addition, State policy was changed so that the admitting physician could not be the medical director of the hospice provider except when the medical director was already the individual's personal physician. As a result, hospice payments decreased by an estimated $8.5 million from SFY 2010 to SFY 2011.

The State directly enrolls all FFS, waiver and managed care network providers
The State enrolls all FFS and managed care network providers centrally. By having one focal point of enrollment, the Medicaid agency ensures that all provider types are subject to the same enrollment processes in which required disclosures are requested, license verifications conducted and exclusion searches performed. This standardization has eliminated essential discrepancies found in many other States, especially for providers participating in managed care networks who may be subject to different credentialing standards. However, notwithstanding the State's efforts to enroll all FFS and managed care network providers, the review team found problems in the collection of provider disclosures. These problems are discussed below under Regulatory Compliance Issues.

Regulatory Compliance Issues

Mississippi is not in compliance with five Federal regulations related to program integrity. These issues are significant and represent risk to the Mississippi Medicaid program. Ranked in order of risk to the program, these compliance issues include: not suspending payments in cases where the State determines that a credible allegation of fraud exists, not performing the required exclusion and debarment searches, and not collecting all required ownership and control, health care-related criminal conviction, and business transaction disclosures.

The State does not suspend payments in cases of credible allegations of fraud.
The Federal regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part. Under 42 CFR 455.23(d) the State Medicaid agency must make a fraud referral to either a MFCU or to an appropriate law enforcement agency in States with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

Mississippi referred only two cases to the MFCU on or after March 25, 2011. These referrals occurred in February and April 2012, respectively. The CMS review team determined that the February referral was not in compliance with Federal regulation because the State did not suspend payments at the time of the referral. Even though the MFCU requested a law enforcement exception to the payment suspension requirement, it was requested a week after the

referral was made and the provider was paid almost $100,000 after the referral. The April case followed Federal requirements.

Recommendations: Develop and implement policies and procedures consistent with Federal regulations to suspend payments to providers when an investigation determines there is a credible allegation of fraud, or document a timely good cause exception not to suspend. Refer such cases to the MFCU and comply with the documentation and notification requirements of 42 CFR 455.23(b).

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on U.S. Department of Health and Human Services, Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS)[1] no less frequently than monthly.

At initial enrollment, the fiscal agent checks providers and entity names, and the State Medicaid agency's provider enrollment unit checks persons with ownership and control interests, agents and managing employees against the LEIE. The EPLS is not currently used. In addition, not all persons with ownership and control interests are identified at the time of enrollment. For example, information on nonprofit board members and disclosures from for-profit corporate owners, limited liability companies, and partnerships are inconsistently collected. Therefore, at least some persons and entities that fall under the regulation are not routinely checked.

For monthly and ongoing checks, the fiscal agent has created a database housing all the names submitted and is supposed to run automated checks against the LEIE. At the time of the review, however, ongoing exclusion checks were not being performed due to technical difficulties. The State indicated that Mississippi has contracted with a new vendor that will implement a full scale check at enrollment, re-enrollment and monthly against a variety of criminal background, professional and exclusion databases. The new vendor was not yet on board while the review team was onsite.

In the managed care program, the State's Bureau of Coordinated Care (BCC) checks the exclusion and debarment status of names disclosed by MCEs at the point of contracting but does not check the LEIE or EPLS monthly. In addition, the managed care contract does not direct the plans to check persons with an ownership or control interest in the MCE or agents and managing employees against the LEIE and EPLS at least on an ongoing monthly basis as required. One MCE reported that it checks its employees and managers against the LEIE on an annual basis, and both MCEs reported that they did not conduct monthly exclusion and debarment checks.

[1] On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

Recommendations: Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the Medicare Exclusion Database [MED]) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Modify the managed care contract to require MCEs to search the LEIE and EPLS upon contract execution and monthly thereafter by the names of any person with an ownership or control interest in the MCE, or who is an agent or managing employee of the MCE.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Repeat Finding)

Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date of birth, and Social Security Number (SSN) of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, date of birth, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

The State of Mississippi enrolls all FFS and managed care network providers and is responsible for capturing disclosures of ownership and control for all such providers. In CMS's earlier review, the State was not capturing address information, information about other disclosing entities owned or controlled by a person with an ownership or control interest in the disclosing entity, relationships among those with ownership or control, or fiscal agent disclosures. In the 2012 review, the team found that the Medicaid agency's enrollment forms are still not in compliance with these elements of the Federal regulation as well as some of the new 455.104 requirements that went into effect on March 25, 2011. Specifically, the forms do not solicit:

- enhanced address information for providers, persons with ownership or control interests or managing employees,
- disclosure of sub-contractors in which the disclosing entity has a 5 percent or more ownership interest,

- whether any persons with ownership or control interests in the disclosing entity or named subcontractors have a relationship as parent, child, sibling or spouse, and
- the name of other disclosing entities in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest.

The team further noted that fiscal agent disclosures are not captured and that MCE disclosures are captured in the procurement process but with significant gaps. For example, during the procurement process for MCEs whose contracts took effect in January 2011, the following required information was not solicited:

- whether the person (individual or corporation) with an ownership or control interest in the MCE is related to another person with ownership or control interest in the MCE as spouse, parent, child, or sibling,
- whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the MCE has a 5 percent or more interest is related to another person with ownership or control interest in the MCE as a spouse, parent, child, or sibling, and
- the name, address, date of birth, and SSN of any managing employee.

Further, at the time of the review, the State did not collect required ownership and control disclosures from the NEMT broker.

Recommendations: Develop and implement policies and procedures for the appropriate collection of disclosures from disclosing entities, fiscal agents, or MCEs regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities, fiscal agents, or MCEs. Modify disclosure forms as necessary to capture all disclosures required under the regulation. The MIG made the same recommendation specific to FFS providers and the fiscal agent in its 2009 report.

The State does not capture criminal conviction disclosures from providers or contractors. (Uncorrected Partial Repeat Finding)

The regulation at 42 CFR 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

In the 2009 review, the CMS team found that Mississippi's provider enrollment application only requested criminal history disclosures from providers. The State subsequently modified its application. The application now asks for criminal conviction disclosures with a comprehensive set of questions aimed at all required parties: persons with ownership and control interests, directors, officers, agents and managing employees. However, the wording of this section omits "since the inception" of the programs or "ever," and there is no space for disclosing the identity of agents or managing employees.

***Recommendations*:** Develop and implement policies and procedures for the appropriate collection of disclosures from providers regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers, who have been convicted of a criminal offense related to Medicare, Medicaid or Title XX since the inception of the programs. Modify disclosure forms to specify the listing of all criminal convictions that occurred since the inception of the Medicaid, Medicare, or Title XX programs and to provide room for listing such convictions on the part of agents and managing employees. The 2009 review team recommended that the State revamp its enrollment form much more extensively in order to comply with the regulation.

The State does not adequately address business transaction disclosure requirements in its provider agreements or contracts. (Uncorrected Repeat Finding)

The regulation at 42 CFR 455.105(b) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

Mississippi's Provider Agreement does not contain a provision that upon request providers are obligated to produce business transaction information as stated. This affects both FFS and managed care providers and was an issue in the 2009 review. In addition, the State's contracts with the MCEs and the NEMT broker do not include this provision.

***Recommendations*:** Revise the provider agreement and contract language to require disclosures, upon request, of business transaction information identified in 42 CFR 455.105(b). The same recommendation was made in 2009.

Vulnerabilities

The review team identified six areas of vulnerability in Mississippi's program integrity practices that put the Medicaid program at risk. One global vulnerability relates to insufficient program integrity activities and coordination across the State agency and MFCU. Other vulnerabilities involve reporting adverse actions taken against providers, direct verification of services with beneficiaries, capturing ownership and control disclosures from NEMT providers, conducting complete exclusion and debarment searches in the NEMT program, and addressing business transaction disclosures in NEMT network provider contracts.

Insufficient program integrity activity and coordination across the State Agency and MFCU.

Although the CMS team noted that the State is working to improve its fraud and abuse detection and prevention capacities, program integrity considerations are not yet fully integrated across DOM activities and functions. In addition, the CMS team questioned whether the State's current level of program integrity activity was commensurate with the size of Mississippi's Medicaid program. In Federal fiscal year (FFY) 2011, the four States closest to Mississippi in terms of annual Medicaid expenditures were Alabama, Oregon, Colorado, and Oklahoma. Alabama and Oregon were slightly larger programs, Colorado and Oklahoma slightly smaller. While Mississippi performed an average of 70 audits and 80 preliminary investigations in the 3 years

prior to the FFY 2012 program integrity review, none of the other four States averaged fewer than 114 audits or 96 preliminary investigations, respectively.

Other observations noted during the review which raised concerns included:

- **Limited BPI involvement in the managed care program.**
  The BPI has not been adequately involved in the development of the State's managed care contracting program. Although it undertakes some program integrity activities, the managed care program has had limited interaction with BPI. For example, State staff reported that regular meetings of managed care and BPI personnel are not held and joint trainings have not been conducted. While MCEs report suspected fraud immediately to BCC and send quarterly reports listing current investigations to this component, the quarterly reports are not shared routinely with BPI. Further, the State does not yet use MCE encounter data in a meaningful way for purposes of data mining.

- **Low number of referrals to the MFCU and limited collaboration**.
  According to Medicaid agency data, no cases were referred to the MFCU from March 2011 to February 2012. Agency officials explained that DOM and BPI have been in transition in the past 18-month period. In addition, both the MFCU director and program integrity director expressed the belief that the payment suspension rule deters rather than encourages MFCU referrals. However, a similar period of no referrals occurred from the second to fourth quarter of calendar year 2009. The MFCU director expressed interest in receiving more referrals, and the program integrity director stressed the need for hiring additional staff to increase the State's audit and review activity alongside the development of Mississippi's Recovery Audit Contractor program. The State wants to reach a higher level of surveillance and utilization review and investigative activity by increasing staffing levels in these areas, but the additional personnel are not yet in place.

  The 2009 CMS team also noted vulnerabilities in the State-MFCU relationship. Since that time the leadership of all units (MFCU, DOM, and BPI) has changed, and the State agency and MFCU have a new Memorandum of Understanding. The State has strengthened its case investigation techniques with respect to closure of cases (noted as a problem in 2009), data sharing and data mining strategies and has improved its communications with the MFCU through the recent introduction of monthly joint meetings. Nevertheless, both units must continue to build an effective working relationship. For example, while improving, communication between DOM and the MFCU has not been timely. The review team observed that communications from the MFCU on cases pending on or around March 25, 2011 were only received in April 2012. Additionally, while MFCU and BPI staff get together monthly, there has been limited cross training and little interaction with other units of the State agency or MCEs around issues of preventing and detecting fraud and abuse. The State provided only one training to the MFCU within the past 4 SFYs.

- **Problems in provider enrollment systems.**
  As reflected in this report, DOM has not fully developed its provider enrollment materials and equipped its systems with program integrity safeguards. The CMS review team identified several uncorrected repeat findings in the capturing of ownership and control disclosures, and the State has not yet updated its enrollment and contracting procedures to comply with the new Federal requirements that went into effect on March 25, 2011. The exclusion checking system has not functioned for a period of time and technical issues, which are thought to be well within the capacities of the State and the fiscal agent, a major national vendor in the provider enrollment area, had not been resolved at the time of the review.

Recommendations: Improve coordination and collaboration within the State agency to strengthen fraud and abuse prevention, detection, and oversight across all programs and in managed care. Continue to strengthen coordination and collaboration with the MFCU. Where appropriate, expand program integrity resources commensurate with the size of Mississippi's Medicaid program and establish cross training on program integrity issues by calling on the expertise of BPI, BCC, the State agency's policy and provider enrollment components, and the MFCU. Revise provider enrollment materials and implement effective methods of screening providers and affiliated parties for exclusions and debarments.

Not reporting all adverse actions taken against providers to HHS-OIG.
The regulation at 42 CFR 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The State does not have policies and procedures or contract requirements directing MCEs to report to it any program integrity-related adverse actions they take on a provider's participation in the network, e.g., denials of credentials, enrollment, or contracts, or terminations of credentials, enrollment, or contracts. Program integrity reasons include fraud, integrity, or quality.

Both MCEs stated they do not report adverse actions taken against provider participation to the State agency. As a result, DOM is not able to report these adverse actions to HHS-OIG.

Recommendations: Require contracted MCEs to notify the State when they take adverse action against a network provider for program integrity-related reasons. Develop and implement policies and procedures for reporting these actions to HHS-OIG.

Not verifying with managed care enrollees whether services billed were received and inclusion of confidential information in beneficiary verification notices.
The regulation at 42 CFR 455.20 requires the State Medicaid agency to have a method for verifying with beneficiaries whether services billed by providers were received. In addition, the regulation stipulates that States receiving Federal matching funds for a mechanized claims processing and information retrieval system under part 433, subpart C, must provide prompt

written notice as required by Sec. 433.116 (e) and (f). Specifically, 42 CFR 433.116(f)(2) requires that the written notice must not specify confidential services (as defined by the State) and must not be sent if the only service furnished was confidential.

The MCE contract does not require that plans verify receipt of services with managed care enrollees, and Mississippi's MCEs do little in this area. One of the MCEs sends explanations of medical benefits (EOMBs) to managed care enrollees only for services provided by out-of-network providers where the enrollee has incurred an out-of-pocket cost. The other MCE indicated it does not verify receipt of services.

In Mississippi's FFS program, the State verifies services by sending EOMBs each month to a random sample of beneficiaries. A review of the EOMBs mailed to beneficiaries in the past three SFYs indicated that, in addition to referencing other medical services, such notices occasionally provided information on confidential services, such as testing for the Human Immunodeficiency Virus and sexually transmitted diseases. The identification of specified confidential services is prohibited by the Federal regulation and constitutes a potential breach of State law provisions protecting the unauthorized release of confidential medical information.

Recommendations: Develop and implement policies and procedures to verify with MCE enrollees whether services billed by providers were received and ensure that EOMBs contain only information consistent with State privacy laws.

Not capturing full ownership and control disclosures from NEMT network providers.
Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date of birth, and SSN of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, date of birth, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

The NEMT broker's provider agreement and application has an ownership and disclosure form which follows 42 CFR 455.104. However, the form omits several elements of the regulation, such as date of birth, SSN, and the names of subcontractors in which the disclosing entity has a 5 percent or more interest. The form also does not indicate whether persons with ownership or

control interests in the disclosing entity and subcontractors are related as family members and does not solicit any of the required information on managing employees.

Recommendations: Modify the NEMT broker's contract to require, or ensure that provider enrollment forms require the disclosure of complete ownership, control, and relationship information from all NEMT network providers. Include contract language requiring the broker to notify the State of such disclosures on a timely basis.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

The regulations at 42 CFR 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the Medicaid Management Information System, then the State cannot conduct adequate searches of the LEIE or the MED.

The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the EPLS on a monthly basis.

As noted above, the NEMT broker does not solicit all required disclosure information on relevant subcontractors or any managing employees of contracted transportation providers. This means the broker cannot perform the required enrollment and debarment searches on all affiliated parties specified in the regulation. Regarding those persons and entities that are reviewed, the NEMT broker reported that it checks the LEIE and EPLS for contracted drivers, companies and their owners at the time of initial contracting. Annual checks are done by the broker's corporate office, but monthly checks are not performed against either database.

Recommendations: Amend the NEMT broker's contract to require the appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Require the contractor to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or recredentialing of network providers, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Not adequately addressing business transaction disclosures in NEMT network provider contracts.

The regulation at 42 CFR 455.105(b) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors.

The NEMT provider agreement does not include a provision requiring the broker's network of providers to supply business transaction information upon request.

Recommendation: Modify the NEMT broker's contract and provider agreements to require disclosure upon request of the information identified in 42 CFR 455.105(b).

CONCLUSION

The State of Mississippi applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of five areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, six areas of vulnerability were identified. The CMS is particularly concerned over the three uncorrected or partially uncorrected repeat findings. The CMS expects the State to correct them as soon as possible.

To that end, we will require Mississippi to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Mississippi will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter accompanying this report. If Mississippi has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Mississippi on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.