DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

DEC 13 2002

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

CIN: A-04-02-07010

Ms. Rica Lewis-Payton
Executive Director, Division of Medicaid
Office of the Governor
239 North Lamar Street. Suite 801
Jackson, Mississippi 39201-1399

Dear Ms. Lewis-Payton:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, *Audit of the Office of Inspector General Excluded Providers in Mississippi.*

We reviewed the Mississippi Division of Medicaid (MSDOM) internal controls that prevent payments to providers that have been excluded from participation in federal health care programs. Our audit period covered state fiscal years 1997 through 2002.

The HHS action official will make the final determination as to actions taken on all matters we have reported. We request that you respond to the HHS action official within 60 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 Code of Federal Regulations Part 5.) As such, within 10 business days after we issue the final report, we will post it on the World Wide Web at http://www.hhs.gov/progorg/oig.

We appreciate the cooperation your staff provided to us during this audit. They contributed greatly toward the successful completion of this audit.

To facilitate identification, please refer to the report number A-04-02-07010 in all correspondence relating to this report.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure

HHS ACTION OFFICIAL:

Rose Crum-Johnson, Regional Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

AUDIT OF THE OFFICE OF INSPECTOR GENERAL EXCLUDED PROVIDERS IN MISSISSIPPI

JANET REHNQUIST
Inspector General

December 2002
A-04-02-07010

Notices

OAS FINDINGS AND OPINIONS

The designation of financial management practices as questionable as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS operating divisions.

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DEC 13, 2002

CIN: A-04-02-07010

Ms. Rica Lewis-Payton, Executive Director
Division of Medicaid, Office of the Governor
239 North Lamar Street, Suite 801
Jackson, Mississippi 39201-1399

Dear Ms. Lewis-Payton:

This report provides you with the results of our ***Audit of the Office of Inspector General Excluded Providers in Mississippi***.

EXECUTIVE SUMMARY

OBJECTIVE

The objective of the audit was to determine whether the Mississippi Division of Medicaid (DOM) had adequate internal controls to prevent providers that had been excluded from participating in federal health care programs by the Office of Inspector General (OIG) from being enrolled in and paid by the Medicaid program.

FINDINGS

We found that the Mississippi DOM did not have adequate internal controls to prevent payments to providers that had been excluded from participation in federal health care programs. As a result, $358,761 (federal share $275,583) had been paid by the DOM to excluded providers during the state fiscal years (FY) 1997 through 2002. These improper Medicaid payments occurred because the DOM's Division of Provider Enrollment had not implemented adequate internal controls to prevent excluded providers from participating in the Medicaid program.

RECOMMENDATIONS

We recommend that the DOM recover the improper payments of $358,761 (federal share $275,583) from the providers that received the payments.

We also recommend that the DOM implement adequate internal controls to prevent excluded providers from participating in the Medicaid program. We further recommend that the DOM terminate payments to those excluded providers identified during our audit. Specifically, we recommend:

- Background checks should be run on all providers seeking enrollment in the Medicaid program.
- Medicaid providers should be required to reenroll every 2-3 years. This would ensure background checks are performed on all providers.
- Periodic site visits should be conducted to determine the validity of the provider and his billing number(s).

State Agency Comments

Medicaid officials generally agreed with our findings and recommendation. See Appendix A for their comments in its entirety.

To facilitate identification, please refer to the Common Identification Number (CIN) A-04-02-07010 in any correspondence related to this report. If you need additional information, please contact Andrew A. Funtal at (404) 562-7762.

Glossary of Abbreviations and Acronyms

BBA1997	Balanced Budget Act of 1997
CFR	Code of Federal Regulations
CIN	Common Identification Number
CMS	Centers for Medicare & Medicaid Services
DOM	Division of Medicaid
FY	Fiscal Year
HHS	Department of Health and Human Services
LEIE	List of Excluded Individuals and Entities
OIG	Office of Inspector General

BACKGROUND

Medicaid Program

Medicaid (Title XIX of the Social Security Act) is a jointly funded federal-state health program for eligible low-income and needy individuals. Nationwide, it covers approximately 41 million individuals, including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments. In FY 1999, the federal and state governments jointly expended $180.9 billion to provide for medical care to Medicaid beneficiaries. These expenditures are projected to increase to $285 billion by FY 2005. The Centers for Medicare & Medicaid Services (CMS - formerly the Health Care Financing Administration) provides federal oversight for the Medicaid program.

States are allowed, within federal laws, regulations, and program policies, to exercise discretion in the methods used to administer, operate, and reimburse services for their Medicaid programs. Nonetheless, the Federal Government retains an obligation to ensure that Medicaid beneficiaries receive services only from qualified providers and that excluded providers do not receive reimbursement from the Medicaid program.

The Mississippi Medicaid program was created by the Legislature in 1969 (Section 43-13-101, MS Code of 1972) in order to provide medical assistance to low-income people. The DOM also provides medically necessary services to children living below specified poverty levels. In addition, the DOM develops programs demonstrating innovative services or service delivery to increase the benefits of services and/or reduce their cost. Further, the DOM purchases insurance in lieu of providing services when cost-effective; and develops the capacity to gather and analyze information necessary for the development of a state health policy and the improvement of the health status for all Mississippi citizens.

According to MS DOM officials, during the state FYs 1997 through 2002, more than 18,000 providers submitted over $6 billion dollars in claims.

The OIG Excluded Provider List

The Secretary of the Department of Health and Human Services (HHS) has delegated to the OIG the authority, under Sections 1128 and 1156 of the Social Security Act, to exclude certain health care providers from most federal health care programs. Under the law, the OIG, which acts through its Office of Investigations, must exclude, nationwide, providers that have been convicted of a criminal offense related to Medicare or any state health care program, a criminal offense related to patient abuse or neglect, or a felony related to other health care fraud or controlled substances.

The OIG exclusions apply to Medicare (Title XVIII of the Social Security Act) and state health care programs defined as Medicaid (Title XIX), Maternal and Child Health Services Block grant (Title V), and block Grants to States for Social Services (Title XX).

When an individual or entity is excluded, notification is sent to the appropriate licensing boards and the exclusion is posted on the OIG's web site. The Publication 69, a monthly Medicare and Medicaid report on exclusions and reinstatement actions in Medicare, Medicaid and other federal health care programs that have occurred the month prior to the release of the report, will no longer be published effective September 2001. The information contained in Publication 69 absent the social security numbers, is available on the List of Excluded Individuals and Entities (LEIE) at the OIG website (www.dhhs.gov/oig/cumsan/index.htm). The LEIE is available in two formats, a downloadable database file and an online searchable database. The online searchable database allows users to enter a social security number and verify if the provider in question is currently excluded. The user will receive either a positive or a negative response as to whether the entered social security number matches a social security number on the exclusion list.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of the audit was to determine whether the Mississippi DOM had adequate internal controls to prevent providers that had been excluded from participating in federal health care programs by the OIG from being enrolled in and paid by the Medicaid program.

Scope

As part of our review, we obtained an understanding of the internal control structure relating to the enrollment of providers in the Medicaid program in Mississippi, and we did perform an assessment of these controls. We conducted our audit in accordance with generally accepted government auditing standards. Fieldwork was performed at the offices of the Mississippi Division of Medicaid, Jackson, Mississippi, and the HHS/OIG/Office of Audit Services office in Birmingham, Alabama from October 2001 through February 2002. Our findings covered state FYs 1997 through 2002.

Methodology

To accomplish the objective of this audit, we:

- Obtained an understanding of the process of enrollment, internal controls, as well as the history and background of the State of Mississippi's Medicaid program through interviews and publications provided by the DOM.

- Obtained the OIG Excluded Provider database and compared it to a database of current Mississippi Medicaid providers used by the State of Mississippi, DOM. The match was performed based on the social security number and the provider name in the OIG Database and the DOM Database. This match was further refined through software and manual sorts.

- The list of provider matches was given to the DOM. The provider list was then compared to the individual exclusion date(s) of each of the associated providers. Those payments made during a

provider's exclusion period were counted as errors and calculated. Those payments made outside a provider's exclusion period were considered a non-error. A list of four provider identification numbers and their associated error amounts was compiled.

- The error list was reviewed to determine if any of the excluded providers had been granted waivers of their exclusion. Because one provider had been excluded and reinstated on the same day, this lowered our total of excluded providers to three.

RESULTS OF REVIEW

Our review indicated that the Mississippi DOM made $358,761 (federal share $275,583) in payments to providers that had been excluded by the OIG during their exclusion period.

The Code of Federal Regulations (CFR), Title 42, Section 1001.2, defines exclusion as:

> *"Items and services furnished, ordered or prescribed by a specified individual or entity will not be reimbursed under Medicare, Medicaid and all other Federal health care programs until the individual or entity is reinstated by the OIG. A federal health care program is any plan or program providing health care benefits, whether directly through insurance or otherwise, that is funded directly, in whole or part, by the United States Government (other than the Federal Employees Health Benefits Program), or any State health care program."*

With respect to these reimbursements, or payments, CFR, Title 42, Section 1002.211 states:

> *"No payment may be made by the State agency for any item or service furnished on or after the effective date specified in the notice by an excluded individual or entity, or at the medical direction or on the prescription of a physician who is excluded when a person furnishing such item or service knew, or had reason to know, of the exclusion."*

Clarification of this issue is also provided by the Balanced Budget Act of 1997 (BBA1997) which emphasizes that "no agency which funds a Federal health care program may reimburse excluded individuals for items or services they provide, nor may any such agency pay the salaries or expenses of such persons using Federal dollars." The exclusion applies to any individual or entity that provides or supplies items or services, directly or indirectly.

We determined that the DOM made improper payments to two providers that had been previously excluded by the OIG. Of these four providers identified, one (Provider C) had been excluded and reinstated on the same day, and another (Provider D) received no Medicaid payments. The remaining two providers accounted for $358,761.38 (federal share $275,583) in erroneous payments.

Provider Number	Summary of Total Amount Paid	State FYs	*Federal Portion*	*Amount of Error*
A	354,566.46	1997 to 2002	$272,365.57	$354,566.46
B	4,194.92	2001 to 2002	$3,217.55	$4,194.92
C	1,321.29	2002	0	0
D	0	2000 to 2002	0	0
	TOTAL ERROR:		**$275,583.12**	**$358,761.38**

Of the above four providers, all but one (Provider C), were on the OIG excluded provider list before they were enrolled in the Mississippi Medicaid program.

The overpayments occurred because the DOM Provider Enrollment Division had not implemented adequate internal controls to prevent excluded providers from participating in the Medicaid program.

RECOMMENDATIONS

We recommend that the DOM recover the improper payments of $358,761 (federal share $275,583) from the providers that receive the payments.

We also recommend that the DOM take additional steps to prevent excluded providers from enrolling in the Mississippi Medicaid program and terminate payments to those providers who are already enrolled and who are excluded in the future by the OIG. Specifically,

- background checks should be run on all providers seeking enrollment in the Medicaid program.
- Medicaid providers should be required to reenroll every 2-3 years. This would ensure background checks are performed on all providers.
- periodic site visits should be conducted to determine the validity of the provider and his billing number(s).
- providers identified during our audit should be excluded from receiving further payments from any federally funded healthcare program.

State Agency Comments

Medicaid officials generally agreed with our findings and recommendation. See Appendix A for their comments in its entirety.

To facilitate identification, please refer to the Common Identification Number (CIN) A-04-02-07010 in any correspondence related to this report. If you need additional information, please contact Andrew A. Funtal at (404) 562-7762.

Sincerely,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
RICA LEWIS-PAYTON
EXECUTIVE DIRECTOR

October 9, 2002

Charles J. Curtis
Regional Inspector General
for Audit Services
Region IV
Room 3T41
61 Forsyth Street, SW
Atlanta, GA 30303-6909

RE: CIN A-04-02-07010

Dear Mr. Curtis:

This is in response to your letter of September 12, 2002, regarding the draft report entitled *Audit of the Office of the Inspector General Excluded Providers in Mississippi*. We offer the following comments regarding the recommendations:

Once the Division of Medicaid staff was aware of the four (4) excluded providers being enrolled in the Medicaid program, immediate action was taken to close those providers and recover the improper payments from the two (2) providers that had received payments.

To prevent excluded providers from participating in the Medicaid program, each provider requesting enrollment as a Medicaid provider is checked against the Medicare exclusion report. This has recently changed and is now done online checking against the files of the Medicare Exclusion Database. There is one problem which may prevent the identification of possibly excluded providers. A match with Social Security Numbers cannot be done unless there is a match of the name on the Medicaid application. Thus, someone who has changed last names may not be identified as an excluded provider as was the case with one of the four providers identified by the audit. A Computer System Request (CSR) has been submitted so that on a monthly basis the Mississippi Medicaid provider file can be run against the exclusion database to identify those providers whose numbers should be closed due to an exclusion.

We would like to do background checks on providers and tried to use an online subscription program for this purpose but did not find it satisfactory. We would be interested in information about how other states handle this.

All Mississippi Medicaid providers will be required to reenroll in early to mid-2003 for HIPAA compliance purposes. Following that reenrollment, a plan for routine reenrollment every three (3) years will be implemented. Due to the need to stagger the reenrollment process, it may take five (5) years to get this fully implemented.

Periodic site visits are made to in-state providers to determine the validity of the provider and the provider numbers. This is done by staff from the Program Integrity Bureau who selects a number of new providers for inspection after reviewing a list of new Medicaid providers for each month. Investigators go on site to ensure that an actual place of business exist and no potential fraud or abuse exists. Prior to traveling to the provider's place of business, the investigator reviews MMIS data. A number of claims is selected for review. Any discrepancies in billing are noted, and based on the nature and degree of billing discrepancies, the provider may be scheduled for a full provider investigation. Staff from the Provider Relations Division makes on-site visits to assist providers with billing issues. When staff makes these visits, they verify the servicing and billing addresses as well as the provider number and any numbers of providers linked to the primary Medicaid provider number.

The provider numbers have been closed for those providers identified in the audit. This makes them ineligible to receive further Medicaid payments.

We appreciate the recommendations made as a result of your audit and are making plans to implement them. While we are not pleased that any providers were identified as excluded, we believe that we have adequate procedures in place to identify excluded providers. We think that only four (4) providers out of more than 18,000 providers is a low percentage. The dollar amount paid to these providers is also a low percentage. A total of $358,761.38 was paid in error over a five (5) year period when total payments to providers during this time was over $6 billion.

If additional information is needed to finalize your report, please contact Melzana Fuller or Sheila Meadows in the Provider/Beneficiary Relations Bureau at 601-359-6133.

Sincerely,

Rica Lewis-Payton

RLP/mmf