#431

Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER)

Report to
the Mississippi Legislature

A Review of Administrative Expenditures and Selected Administrative Functions of Mississippi's Division of Medicaid

Mississippi's Medicaid program, as administered by the Office of the Governor Division of Medicaid (DOM), provides a broad range of health related services to low-income individuals who fall into certain categories (primarily elderly, blind, disabled, pregnant women, and children). In FY 2001, 650,000 Mississippians were enrolled in the state's Medicaid program at a general fund cost of $221 million (6% of the state's total general fund expenditures of $3.5 billion).

In FY 2002, Mississippi's Medicaid program began experiencing budget problems, affected by increases in both health care costs and enrollment. DOM projects an unprecedented growth rate in expenditures of 25% in FY 2002. The Division also projects a FY 2003 general fund shortfall of $120 million, even after DOM implements legislatively mandated cost saving measures enacted earlier this year that DOM asserts will save $54.8 million in general funds.

PEER's review of DOM administrative expenditures and selected administrative functions identified an additional $86.7 million in potential general fund savings which could further reduce DOM's projected FY 2003 general fund shortfall. The largest component of the potential cost savings, $73 million, results from using DOM's statistically projected FY 2003 expenditure growth rate of 9.7% rather than the Division's revised and inflated FY 2003 growth rate of 22.5%.

The second largest component of the potential cost savings, $7.7 million, results from savings related to contractual services. PEER determined that DOM does not consistently follow the elements of effective contracting, resulting in higher than necessary costs for services and possible compromises to service quality. These deficiencies resulted in DOM contracting for services that can be performed more efficiently in-house; paying significantly more than other states for the same services; and contracting for a service that was already being performed by other entities.

PEER also determined that the Medicaid eligibility determination process followed by DOM and the Department of Human Services is inadequate. PEER staff estimates that DOM could save $6 million in general funds for every 1% reduction in the number of ineligible Medicaid recipients on the rolls.

June 24, 2002

PEER: The Mississippi Legislature's Oversight Agency

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A standing joint committee, the PEER Committee is composed of five members of the House of Representatives appointed by the Speaker and five members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms with one Senator and one Representative appointed from each of the U. S. Congressional Districts. Committee officers are elected by the membership with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of three Representatives and three Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues that may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, special investigations, briefings to individual legislators, testimony, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, and the agency examined.

The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

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June 24, 2002

Honorable Ronnie Musgrove, Governor
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Members of the Mississippi State Legislature

On June 24, 2002, the PEER Committee authorized release of the report entitled **A Review of Administrative Expenditures and Selected Administrative Functions of Mississippi's Division of Medicaid.**

Senator William Canon, Chairman

This report does not recommend increased funding or additional staff.

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A Review of Administrative Expenditures and Selected Administrative Functions of Mississippi's Division of Medicaid

Executive Summary

Background

Congress enacted Title XIX of the Social Security Act in 1965 to provide medical assistance to the poor. The Mississippi Legislature enacted enabling legislation for Mississippi's Medicaid program during a special session in 1969. MISS. CODE ANN. Section 43-13-107 (1) (1972) places responsibility for administration of Mississippi's Medicaid program with the Division of Medicaid (DOM), under the Office of the Governor.

In fiscal year 2001 (FY 2001), 650,000 Mississippians were enrolled in the state's Medicaid program. In general, eligibility is limited to low-income individuals who fall into certain categories (primarily low-income elderly, blind, disabled, pregnant women, and children).

In Mississippi, as in all states, the vast majority of Medicaid program expenditures are for a broad range of health related services provided to Medicaid recipients. In FY 2001, Mississippi's Medicaid federal/state funding match rate was 76%/24%, one of the highest match rates in the country. Mississippi's total FY 2001 Medicaid expenditures of $2.38 billion comprised 27% of the state's total expenditures of $8.8 billion. DOM's FY 2001 general fund expenditures comprised 6% of the state's total FY 2001 general fund expenditures of $3.5 billion.

In FY 2002, Mississippi's Medicaid program experienced a funding shortfall, resulting from an unprecedented projected 25% increase in expenditures. While other states are also experiencing growth in their Medicaid expenditures due to factors such as the rapid increase in the cost of prescription drugs, Mississippi's projected 25% FY 2002 growth rate is higher than those of its neighboring states and significantly higher than the federal FY 2002 growth rate of 12% as reported by the Congressional Budget Office.

The Division of Medicaid projects a continued rapid growth rate of 22.5% in the upcoming fiscal year, resulting in a projected FY 2003 general fund shortfall of $120 million (after netting out DOM's projected FY 2003 general fund savings of $54.8 million from implementation of Medicaid cost saving measures included in laws passed by the Mississippi Legislature during its 2002 Regular Session).

PEER contends that more realistic DOM budget projections combined with the administrative cost saving measures identified in this report can reduce DOM's projected FY 2003 shortfall by at least $86.7 million, to $33 million (see Table 1, below). It is even feasible that DOM could eliminate its projected FY 2003 funding shortfall, depending on how aggressively the division pursues measures such as eliminating ineligible beneficiaries from the Medicaid rolls and implementing the cost saving measures adopted by the Legislature during its 2002 Regular Session (e.g., management of pharmacy benefits, including adoption of a restricted drug formulary; increasing provider fees; implementing co-pays).

Table 1

Summary of Potential FY 2003 DOM General Fund Cost Savings

Measure	Savings
Adopt PEER's contractual services recommendations	$7.7 million
Reduce the number of ineligible Medicaid recipients on the rolls	$6 million for each 1% reduction
Eliminate inflated portion of DOM's FY 2003 budget estimate	$73 million
TOTAL	At least **$86.7 million**

Analysis of Division of Medicaid Administrative Expenditures

In FY 2001, Mississippi's Division of Medicaid expended $69.2 million on administration of the state's Medicaid program, or 2.9% of total Medicaid expenditures. DOM spends more on contractual services for program administration ($46.8 million, or 68% of total administrative expenditures) than on in-house personnel ($19.3 million, or 28% of the total). The combined

categories of equipment, commodities, and travel only represented 4% ($3.1 million) of DOM's FY 2001 administrative expenditures.

Potential $7.7 million in general fund savings in FY 2003 Contractual Services Expenditures

PEER determined that DOM does not consistently follow the elements of effective contracting, resulting in higher than necessary costs for services and possible compromises to service quality. DOM's most serious deficiencies were failure to: adequately assess the need for the contracts, evaluate contract bids using consistent point values for selection criteria, and monitor the contracts.

These deficiencies resulted in DOM contracting for services that could have been performed more efficiently in-house; paying significantly higher contractual costs for services than contractual costs paid by other states for the same services; and contracting for a service that was already being performed by other entities. In the most egregious case, DOM pays $5 million to the Mississippi Hospital Association annually for a service (administrative support of the state's Disproportionate Share Hospital and Medicare Upper Payment Limits programs) that neighboring states perform in-house for less than $100,000. Also, DOM pays at least twice the amount ($17 million total in FY 2001) that neighboring states are paying to provide non-emergency transportation services for Medicaid recipients.

Table 2, page x shows the potential $7.7 million in FY 2003 contractual services general fund savings identified by PEER, by contractual area.

Table 2

Potential FY 2003 DOM General Fund Net Savings Identified through PEER's Review of DOM Contracts

Type of Contract	Net General Fund Savings
Non-emergency transportation	$5 million
Peer review (prior approval and oversight of in-patient hospital costs)	$1.4 million
Pharmacy benefits management/drug utilization review	$0.74 million
Assistance in reviewing provider cost reports	$0.32 million
Providing information on long term care alternatives	$0.2 million
Other miscellaneous (e.g., human resource consultant, CPA consultant, CHIP outreach assessment)	$71,796
Administrative support for Disproportionate Share Hospital and Medicare Upper Payment Limits programs	($61,875)
TOTAL	**$7.7 million**

From FY 1993 through FY 2001, DOM expenditures on salaries, wages, and fringe benefits increased by 128%, adjusted for inflation, and staff increased by 126%, from 264 employees to 596 employees.

In FY 2001, DOM eligibility staff comprised the largest percentage of total DOM staff (42%), followed by program oversight staff (11%), and non-emergency transportation staff (10%). In terms of increases in the number of staff over the period of FY 1993 through FY 2001, by functional area, the largest increases were the addition of 100 eligibility staff, 57 non-emergency transportation staff and 48 program oversight staff.

DOM significantly reduced travel expenditures in FY 2002.

Although DOM travel expenditures grew by 219% (adjusted for inflation) from FY 1993 through FY 2001, DOM travel expenditures represent only 1% of DOM total administrative expenditures. In FY 2002, DOM reduced its travel expenditures significantly (by 41%, as of May 29, 2002) as a result of restrictions on travel. PEER conducted an in-depth review of the fourteen DOM employees who expended $6,000 or more in travel in FY 2001 and determined that travel costs for these individuals were not unreasonable. The majority of the fourteen cases reviewed by PEER perform program oversight and/or delivery functions that require travel to clients and service delivery sites around the state.

Review of Selected DOM Administrative Processes

Eligibility determination process is inadequate.

Three agencies share responsibility for making Medicaid eligibility determinations for specific categories of Medicaid applicants: DOM (primarily the aged), the Mississippi Department of Human Services (primarily pregnant women and children), and the Social Security Administration (primarily the blind and disabled).

PEER's review of the eligibility determination process at both DOM and the Department of Human Services revealed that eligibility workers do not adequately verify an applicant's resources prior to determining an applicant eligible to receive Medicaid benefits. In general, the eligibility workers rely on an applicant's truthfulness in completing the application form and do not independently verify resources (other than in those cases where the applicant is qualifying through another program such as Temporary Assistance to Needy Families [TANF]). In fact, eligibility workers at the Department of Human Services told PEER staff that management in the Jackson office told them to enroll as many people in the Medicaid program as possible.

DOM's Medicaid Eligibility Quality Control unit determined that from October 1992 to September 2000, an average of 7.34% of those Medicaid recipients determined eligible by either DOM or the Department of Human Services were actually ineligible to receive benefits, based on a more in-depth review of applicant resources.

Based on FY 2003 budget projections, every 1% increase in Medicaid enrollment results in an annual increase of $6 million in general fund expenditures. Therefore, the general fund cost of the 7.34% average error rate identified

by DOM's quality control unit is approximately $42 million.

Budgetary Process Yields Inflated Estimate

PEER determined that DOM's FY 2003 budget request is based on an inflated growth rate of 22.5%, rather than the Division's statistically projected growth rate of 9.7% (based on historical expenditure data, adjusted for program changes). Using the 22.5% growth rate increased DOM's FY 2003 estimated total funding needs by $307 million.

As shown in Table 3, below PEER determined that the additional $307 million that DOM included in its FY 2003 budget request was comprised of four categories: Net New Eligibles, Prescription Drugs, Physician Services, and Hospital Services.

Table 3

Components of the $307 Million in Requested Funding that Exceeded Statistical Projections Spring of 2002

Net New Eligibles	$213,060,000
Prescription Drugs	$20,000,000
Physician Services	$25,000,000
Hospital Services	$49,102,557
Total	$307,162,557

SOURCE: DOM projections for FY 2003 and PEER analysis.

Because DOM's statistically projected growth rate of 9.7% includes expenses associated with projected growth in the number of net new eligibles in FY 2003, DOM's funding request for an additional $213 million for net new eligibles is a double counting of expenditures. Similarly, DOM's FY 2003 statistical projections included the following growth rates for the remaining three categories shown in Table 3: 20% for prescription drugs, 8.8% for physician services, and 8.1% for hospital services. To arrive at its 22.5% projected growth rate, DOM added additional "funding needs" for these three categories, based on FY 2002 shortfalls alone. DOM provided no documentation to support the need for consideration of additional funding for these categories beyond their contribution to the FY 2003 projection of 9.7% growth. Funding DOM based on the division's statistically projected growth rate of 9.7% rather than its inflated estimate of 22.5% growth reduces

FY 2003 funding needs by a total of $307 million ($73 million in state general funds).

Recommendations

Contractual Services

1. To ensure the procurement of quality services at a cost effective rate, the Division of Medicaid should adopt internal procurement guidelines based on generally recognized elements of effective contracting (refer to page 15). DOM should pay particular attention to the development of guidelines addressing needs assessments, systematic review of proposals, and contract monitoring.

2. The Division of Medicaid should consider two options concerning its contract with the Mississippi Hospital Association:

   - Consider asking the Legislature to amend MISS. CODE ANN. Section 43-13-117 (1972) to remove the requirement that the Division of Medicaid contract with the Mississippi Hospital Association for the administrative support of the Medicare Upper Payment Limits program and Disproportionate Share Hospital program so that DOM could perform the task in-house. This would include the reclassification of several vacant positions in order to meet staffing needs.

   - The Division of Medicaid should reduce the contract price to include only those costs associated with the tasks required by state and federal law and regulations. The Division of Medicaid should complete a cost analysis for these services to ensure a fair and competitive contract price.

   If the division wants to pursue other special projects that could benefit the Medicaid program and its beneficiaries, they should define the tasks that they want to accomplish and issue a Request for Proposals to obtain the desired services in a competitive environment.

3. The Division of Medicaid should consider more cost effective ways of providing information on long term care alternatives to Medicaid beneficiaries. In

considering whether to terminate its ten contracts with the Area Agencies on Aging, DOM should review the efforts of the entities that already provide these services, such as eligibility workers and hospital and nursing home discharge planners and social workers. The Division of Medicaid should also consider requiring medical providers to share this information with Medicaid beneficiaries.

4. The Bureau of Compliance and Financial Review should seek more cost effective methods of eliminating the backlog of cost report reviews, including the possibility of discontinuing its use of multiple CPA firms and seeking individual contractors or a single CPA firm to perform these services.

5. The Division of Medicaid should consider a more cost effective method for providing peer review organization services including, but not limited to, the termination of its current contract with Healthsystems of Mississippi and performance of these required services in-house. If DOM chooses to continue the use of the current contractor, it should consider establishing a new method of payment other than a per member per month fee in order to control costs.

6. The Division of Medicaid should consider a more cost effective method of providing prior approval and drug utilization services, including discontinuing the contract with Health Information Designs. DOM could perform prior authorization services in-house by using current vacancies to allocate additional staff to the Bureau of Pharmacy. DOM's Bureau of Pharmacy could perform the drug utilization function by using data and reports generated by the Division's Surveillance and Utilization Review Subsystem and Medicaid Management Information Retrieval System and any additional reports that can be generated by the fiscal agent.

7. The Division of Medicaid should identify methods of controlling expenditures for the non-emergency transportation (NET) program, including, but not limited to:

   a. Elimination of staff

      Other states operate their NET programs with limited staff. For example, Louisiana's dispatch contractor operates the NET program with a staff of thirty-six including twenty to twenty-five call center unit staff. Louisiana utilizes three state staff to monitor the

contract and assist with audit functions. Alabama operates their program with a staff of twenty employees including ten regional coordinators, one call center supervisor, one call center secretary, three call center operators, two directors, one clerical employee, and two inmates for office support. DOM should consider reducing the number of NET staff by reducing the number of NET regions to six regions with eighteen NET Coordinators. This could result in additional general funds savings of $464,062.

b. Implementation of retrospective reviews of claims

   DOM should implement a retrospective review of claims to ensure that the beneficiary actually attended his/her scheduled medical appointment. Alabama conducts a retrospective review from a sample selected each month.

c. Establishment of monthly reporting requirements

   DOM should establish monthly reporting requirements to identify process improvement.

d. Building of relationships with other transportation entities

   DOM's Bureau of Compliance and Financial Review should work with public transportation companies to provide transportation services to medical appointments for those beneficiaries who are physically able to use these services. The division should also work with various community transportation resources who could potentially transport beneficiaries for reduced rates or rates that are lower than those of current group providers.

e. Identification of new methods of provider reimbursement

   Current group provider rates are not cost efficient. DOM should identify a new method of reimbursement for transportation services. States such as Louisiana have capped rates based on the miles traveled, whereas Alabama uses a voucher system and reimburses for miles traveled.

f. Enhancement of NET system capabilities

   DOM's Bureau of Compliance and Financial Review should work with the Division's Information Technology staff to enhance the capabilities of the NET computer system. The system should be capable of tracking information that would assist the division in controlling costs and formulating policy. The

Bureau of Compliance and Financial Review should be able to generate these reports on request.

g. Amendment of NET policy to eliminate the ability of providers to file claims over a twelve month time period

The Division of Medicaid should amend the requirement that allows the provider twelve months to file claims. The provider should be given a shorter time frame in which to file claims. All group providers are required to file claims electronically, so this should not be an imposition to the provider. The state of Texas requires providers to file claims within ninety-five days of appointment confirmation. Texas' group providers' contracts state that a provider waives his right to file the claim after the ninety-five days have passed. This will provide the agency with a more accurate accounting of program costs.

Eligibility Determination Process

8. DOM should develop cost effective options and procedures for receiving information from the IRS for verification of eligibles' income. DOM should report these options and the associated cost of each option to the Legislature by the beginning of the 2003 Regular Session.

9. DOM eligibility workers or Medicaid Eligibility Quality Control unit investigators should conduct random samples to verify the declared assets and search for undeclared property of Medicaid applicants at the time of application.

10. The Medicaid Eligibility Quality Control unit should investigate the use of pilot programs for identifying ineligible recipients, such as those programs implemented in Arizona and Florida. These programs sample target populations in high cost areas, such as long term care.

11. The Medicaid Eligibility Quality Control unit should establish a procedure for follow-up on cases they determine to be ineligible in order to ensure that local offices take appropriate action to terminate benefits. A case review should be completed within ninety days of referral to the local office.

Medical Services Expenditures

12. The Legislature should require the Division of Medicaid to provide documentation to support the agency's claimed need for funding to support a 22.5% growth rate in FY 2003. In the event that the Division cannot provide documentation detailing the specific external factors driving a 22.5% growth rate, the Legislature should fund program growth in line with the 9.7% projection derived from the Division of Medicaid's own statistical model.

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A Review of Administrative Expenditures and Selected Administrative Functions of Mississippi's Division of Medicaid

Introduction

Authority

The PEER Committee authorized a review of the Division of Medicaid (DOM), focusing on administration of the state's Medicaid program. PEER conducted the review pursuant to the authority granted by MISS. CODE ANN. Section 5-3-57 et seq. (1972).

Scope and Purpose

The primary purpose of this review is to identify ways of reducing costs of administering the state's Medicaid program and to examine selected administrative functions with high impact on Medicaid program costs.

While this report describes all areas of DOM administrative costs over the past decade, PEER focused its cost reduction efforts on the high cost area of contractual services. PEER examined two DOM administrative functions with high cost impact: the eligibility determination process and the budgetary process, particularly on DOM's FY 2003 budget estimate.

Method

In conducting this review, PEER:

- reviewed state law and regulations governing the Medicaid program;
- reviewed federal law and regulations governing the Medicaid program;

- reviewed randomly selected completed applications for Medicaid benefits from the DOM and the Mississippi Department of Human Services to determine if eligibility workers were verifying information supplied by Medicaid applicants;

- reviewed personal service contracts, personnel costs, and administrative costs of DOM;

- contacted the following states regarding selected aspects of their Medicaid programs: Alabama, Arizona, Arkansas, Florida, Louisiana, North Carolina, and Oklahoma;

- interviewed staff of DOM; and,

- interviewed staff of the Centers for Medicare and Medicaid Services (CMS) (formerly known as Health Care Financing Administration [HCFA]), the federal agency that is responsible for states' administration of Medicaid.

Background

Mississippi's Medicaid Program

Congress enacted Title XIX of the Social Security Act in 1965 to provide medical assistance to the poor. The Mississippi Legislature enacted enabling legislation for Mississippi's Medicaid program during a special session in 1969.

In FY 2001, 650,000 Mississippians were enrolled in the state's Medicaid program. In general, eligibility is limited to low-income individuals who fall into certain categories (primarily low-income elderly, blind, disabled, pregnant women, and children).

In order to receive federal funding, states must provide certain mandatory services to those who are eligible for Medicaid. States may also receive federal matching funds for certain optional services and can apply to the federal government for permission to operate waiver programs. Mississippi operates five waiver programs, which provide individuals with alternatives to hospitalization and nursing facility placement. Exhibit 1 on page 4 lists the mandatory, optional, and waiver services that comprise Mississippi's Medicaid program.

In FY 2001, Mississippi's Medicaid match rate was 76% federal funds and 24% state funds, one of the highest match rates in the country. Mississippi's total FY 2001 Medicaid expenditures comprised 27% of the state's total expenditures of $8.8 billion. DOM's general fund portion of FY 2001 expenditures ($221 million) comprised 6% of the state's total FY 2001 general fund expenditures of $3.5 billion.

As in all states, the vast majority of Mississippi Medicaid program expenditures are for a broad range of health related services provided to Medicaid recipients (refer to page 51 for a discussion of growth in DOM expenditures on medical services from FY 1993 through FY 2003, projected). In FY 2001, expenditures on medical services ($2.09 billion) comprised 88% of DOM total expenditures of $2.38 billion.

Exhibit 1

List of Mandatory, Optional, and Waiver Services Included in the Division of Medicaid Programs

Federally-mandated Services	Optional Services	DOM-operated Waiver Programs
· certified nurse practitioner	· disease management	· assisted living
· outpatient hospital	· targeted case management services for children with special needs	· home and community-based services for the elderly and disabled
· federally qualified health clinic	· clinic services (ambulatory surgical, birthing, and freestanding dialysis centers)	· home and community-based services for the neurologically or orthopedically impaired
· early and periodic screening, diagnostic and treatment (EPSDT) for children under 21	· intermediate care facilities for the mentally retarded (ICF/MRs)	· home and community-based services for the mentally retarded/developmentally disabled
· non-emergency transportation	· ambulatory surgical center services	· traumatic brain injury/spinal cord injury
· inpatient hospital	· hospice	
· rural health clinic	· podiatrist	
· laboratory and X-ray	· physician assistants	
· family planning	· durable medical equipment	
· nursing facility	· Christian science sanatoria	
· nurse midwife	· home health	
· physician	· emergency ambulance	
	· therapy services	
	· perinatal risk management	
	· chiropractic services	
	· inpatient psychiatric services	
	· psychiatric residential treatment facilities	
	· mental health	
	· eyeglasses	
	· dental services	
	· prescription drugs	
	· pediatric skilled nursing	

SOURCE: Division of Medicaid

Administration of Mississippi's Medicaid Program

Title 42 of the Code of Federal Regulations Section 431.10 requires each state to designate a single state agency to supervise the administration of its Medicaid program. MISS. CODE ANN. Section 43-13-107 (1) (1972) places responsibility for administration of Mississippi's Medicaid Program with the Division of Medicaid under the Office of the Governor.

The primary responsibilities of Mississippi's Division of Medicaid are to:

- set regulations and standards for the administration of the Medicaid program;
- submit a state plan to the federal government that is in accordance with federal regulation;
- receive and expend funds for Medicaid;
- investigate alleged or suspected violations or abuses of the Medicaid program;
- cooperate and contract with other state agencies for the purpose of conducting the Medicaid program; and,
- make Medicaid eligibility determinations for certain aged, blind, and disabled individuals who are not eligible for or receiving Supplemental Security Income.

While the overall administration of the state's Medicaid program is the responsibility of the Division of Medicaid, the provision of state law addressing eligibility determination, MISS. CODE ANN. Section 43-13-115 (1972), requires that field-level eligibility determinations for certain categories of individuals be made by the Mississippi Department of Human Services and the federal Social Security Administration, and certified to the Division of Medicaid. (Refer to the discussion beginning on page 38 and to Appendix A on page 63 for a listing of categories of Medicaid applicants, by agency responsible for making the eligibility determination.)

Resources Allocated to Administration of Mississippi's Medicaid Program

Financial Resources Allocated to DOM Administration

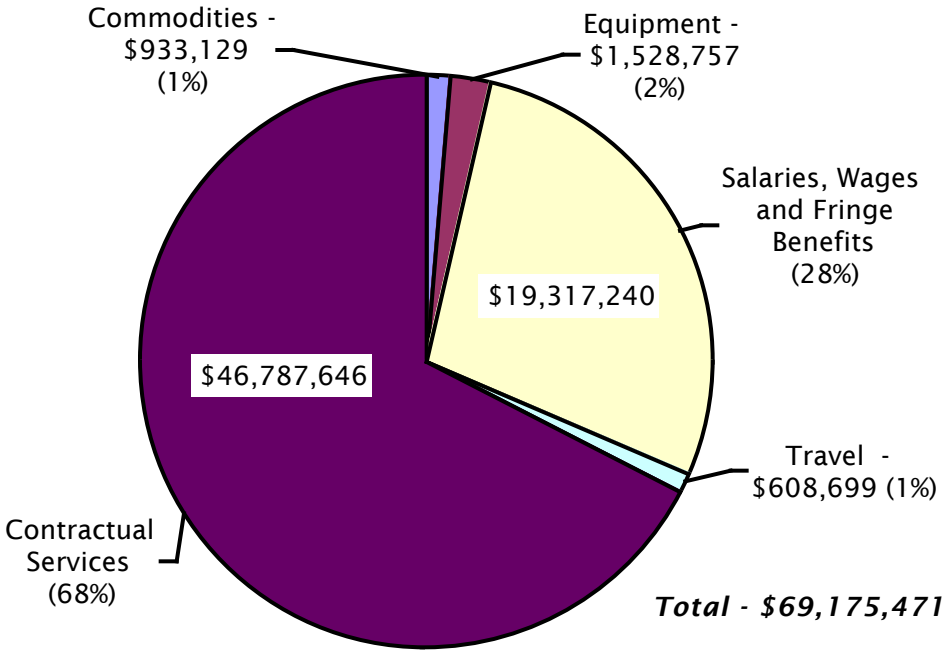
In FY 2001, DOM expended $69.2 million on administration of Mississippi's Medicaid program, 2.9% of the state's total Medicaid budget of $2.38 billion. As shown in Appendix B on page 66, in FY 2000 Mississippi ranked fiftieth among the states in the amount of Medicaid dollars spent on administration of the program, on a per recipient basis.

Exhibit 2 on page 6 shows a breakdown of DOM's FY 2001 administrative expenditures, by major category. As shown in the exhibit, DOM spent more on contracts for administrative services in FY 2001 ($46.8 million, or 68% of total administrative expenditures) than it spent on administrative services provided in-house. The largest category of "in-house" DOM administrative expenditures was for salaried employees ($19.3 million, or 28% of total

administrative expenditures). The Division spent the remaining $3.1 million in administrative expenditures (4% of total) on all other categories of administrative expenditures combined (i.e., equipment, commodities, and travel).

Exhibit 2

Administrative* Expenditures for the Division of Medicaid by Major Object of Expenditure for FY 2001



* Administrative expenditures consist of the budget categories of contractual services; salaries, wages, and fringe benefits; travel; commodities; and equipment.

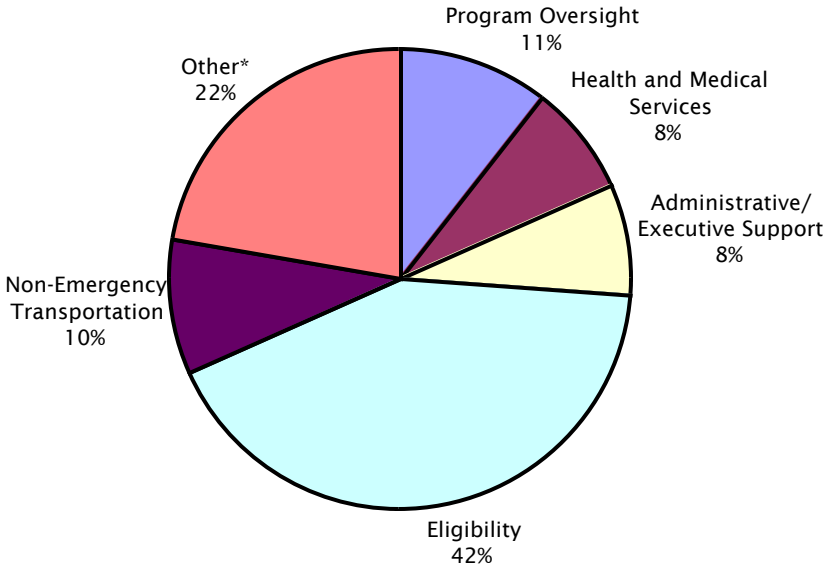
SOURCE: Mississippi Statewide Automated Accounting System

Staffing Resources Allocated to DOM Administration

As of June 30, 2001, DOM had 596 full-time employees. Exhibit 3, below shows a breakdown of employees, by functional area. As shown in Exhibit 3, DOM eligibility staff comprise the largest portion of DOM total staff (42%), followed by program oversight staff (11%), and non-emergency transportation staff (10%).

Exhibit 3

Division of Medicaid Staff by Major Category, FY 2001



NOTE: Percentages in the chart add to 101% due to rounding errors.
* The Other category includes six sub-categories which each equal less than 6% of the total staff.
SOURCE: PEER analysis of Division of Medicaid data

Analysis of DOM Administrative Expenditures

PEER focused its review of administrative expenditures on the categories of contractual services; salaries, wages and fringe benefits; and travel. PEER identified significant potential cost savings in the area of contractual services (at least $7.7 million in potential general fund savings in FY 2003). PEER also identified areas of staffing growth that merit further internal review by DOM for possible cost savings. PEER found no additional cost savings in the area of travel, as DOM significantly curtailed its travel expenditures prior to PEER's review.

This chapter begins with an overview of growth in DOM administrative expenditures during the period of FY 1993 through FY 2001, followed by a detailed analysis of DOM expenditures in each of the three categories reviewed by PEER.

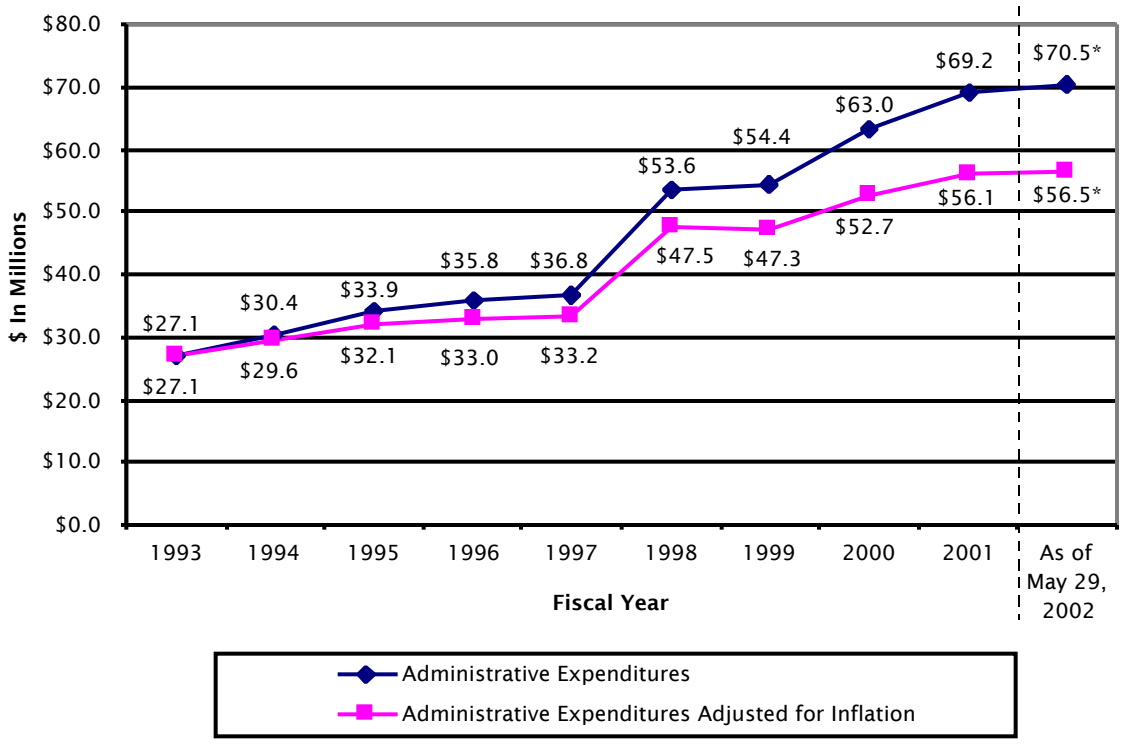
DOM Administrative Expenditures from FY 1993 through FY 2001

DOM administrative expenditures more than doubled from FY 1993 through FY 2001, from $27.1 million to $69.2 million ($56.1 million in inflation adjusted dollars).

As shown in Exhibit 4 on page 9, from FY 1993 through FY 2001, DOM administrative expenditures increased from $27.1 million to $69.2 million. Adjusted for inflation, DOM administrative expenditures more than doubled during this period, from $27.1 million to $56.1 million (i.e., FY 2001 actual expenditures of $69.2 million are equivalent to $56.1 million in FY 1993 dollars). For the interim period ended May 29, 2002, expenditures had increased to $70.5 million, or $56.5 million adjusted for inflation.

Exhibit 4

Administrative Expenditures of the Division of Medicaid for State Fiscal Years 1993 through 2001 and through May 29 of FY 2002



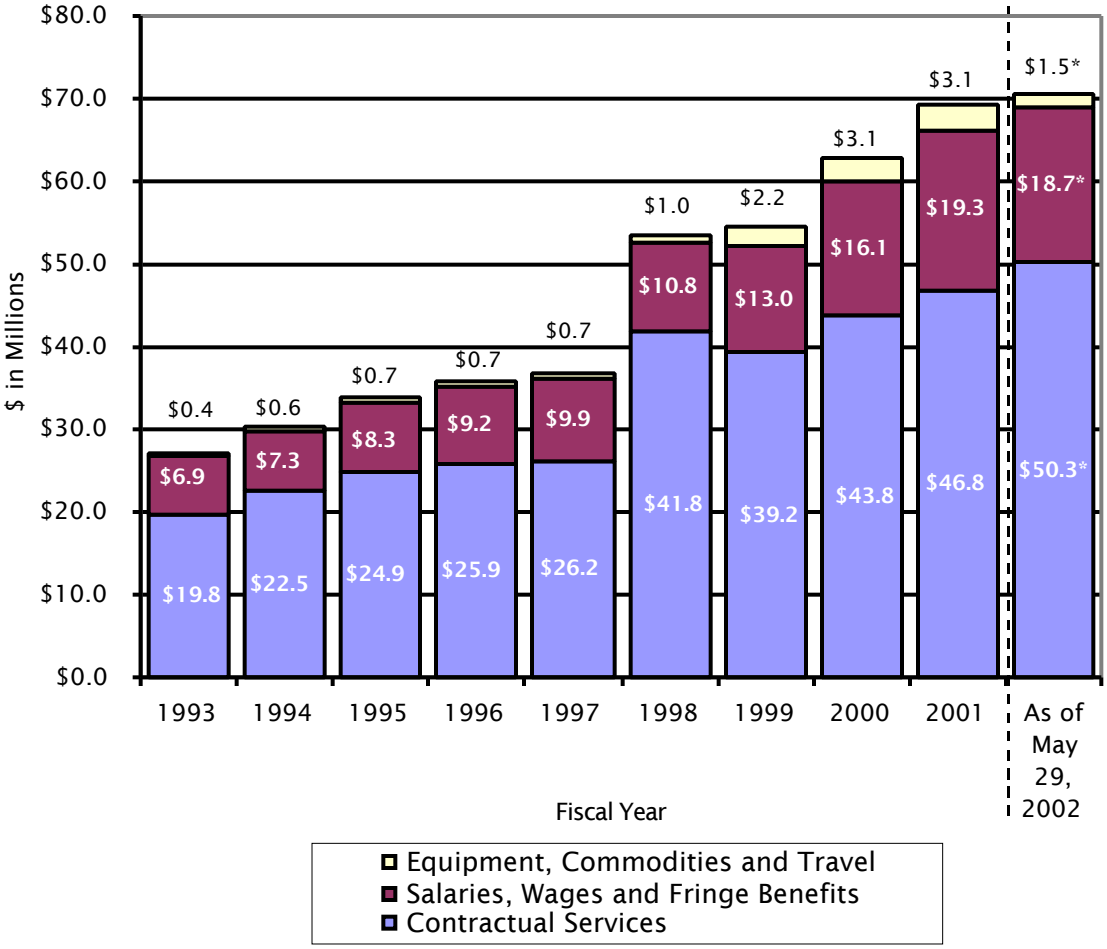
*Consists of interim period numbers as of May 29, 2002. The state fiscal year ends on June 30. In addition, funds obligated through June 30 but paid through August 31, 2002, will be accounted for as expenditures in FY 2002.
** Administrative expenditures consist of the budget categories of contractual services; salaries, wages, and fringe benefits; travel; commodities; and equipment.

SOURCE: Mississippi Statewide Automated Accounting System, U. S. Department of Labor Bureau of Labor Statistics CPI data

Exhibit 5 on page 10 shows actual growth in DOM administrative expenditures by major category for the period of FY 1993 through FY 2001 and for the interim period ended May 29, 2002. As the exhibit shows, contractual services represented the largest portion of administrative expenditures for the entire period reviewed. The second largest category of expenditures consisted of salaries, wages, and fringe benefits. The smallest category of expenditures included equipment, commodities and travel.

Exhibit 5

DOM Administrative Expenditures by Major Category for State Fiscal Years 1993 through 2001 and through May 29 of FY 2002**



* Consists of interim period numbers as of May 29, 2002. The state fiscal year ends on June 30. In addition, funds obligated through June 30 but paid through August 31, 2002, will be accounted for as expenditures in FY 2002.
** Administrative expenditures consist of the budget categories of contractual services; salaries, wages, and fringe benefits; travel; commodities; and equipment.

SOURCE: Mississippi Statewide Automated Accounting System, U. S. Department of Labor Bureau of Labor Statistics CPI data

Analysis of DOM Contractual Services Expenditures

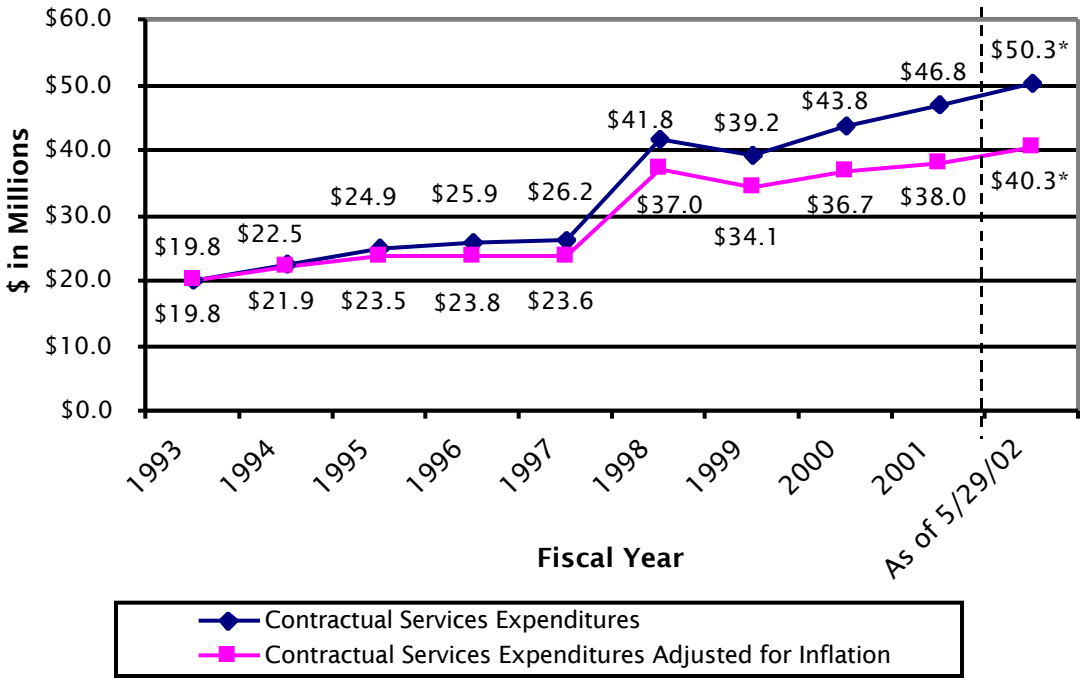
DOM does not consistently follow the elements of effective contracting, resulting in higher than necessary costs for services and possible compromises to service quality. PEER identified $7.7 million in potential FY 2003 general fund savings in the area of contractual services.

Contractual services expenditures are the largest category of DOM administrative expenditures. As previously noted, the Division of Medicaid spends more on its contracts for administrative services than it expends on administrative services provided in-house (refer to page 5). In FY 2001, DOM expended $46.8 million on administrative service contracts.

As shown in Exhibit 6 on page 12, from FY 1993 through FY 2001, DOM contractual services expenditures grew from $19.8 million to $50.3 million in actual dollars, and from $19.8 million to $40.3 million adjusted for inflation, a 91% adjusted growth rate.

Exhibit 6

Contractual Services Expenditures of the Division of Medicaid for State Fiscal Years 1993 through 2001 and through May 29 of FY 2002



* Consists of interim period numbers as of May 29, 2002. The state fiscal year ends on June 30. In addition, funds obligated through June 30 but paid through August 31, 2002, will be accounted for as expenditures in FY 2002.
SOURCE: Mississippi Statewide Automated Accounting System, U. S. Department of Labor Bureau of Labor Statistics CPI data

PEER's Method for Selecting DOM Contracts for Review

Due to the large volume of DOM administrative service contracts, PEER excluded from its review contracts with governmental units and individual service providers (e.g.; physicians, dentists, temporary staff hired by DOM).

PEER reviewed fifty-two of DOM's 133 contracts for compliance with the elements of effective contracting. These contracts totaled $32.7 million. PEER also reviewed DOM's $24.1 million fiscal agent contract for compliance with the element of contract monitoring.[1] Of those

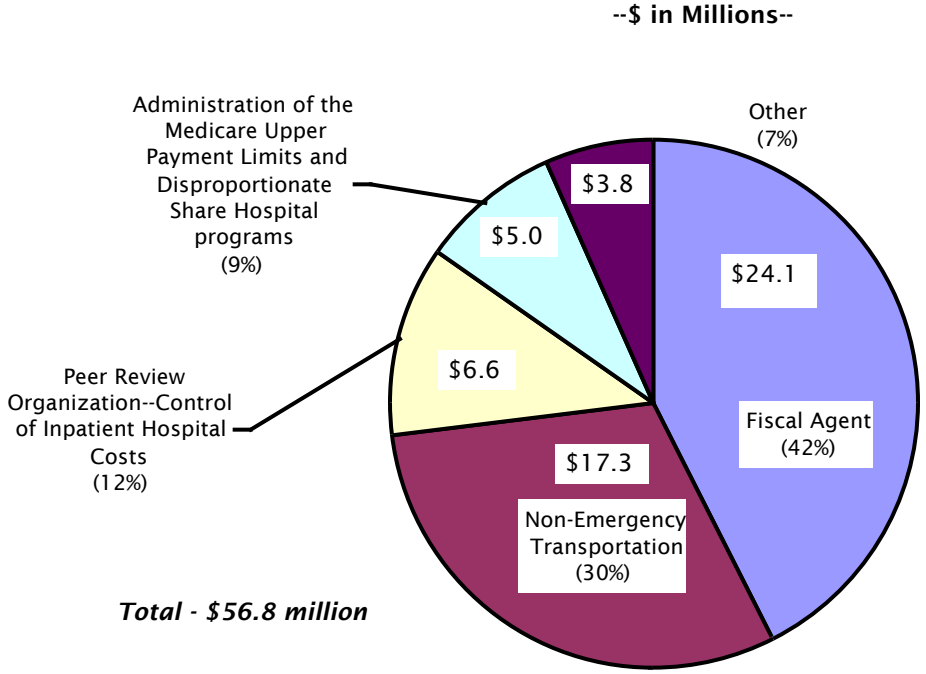
[1] Ongoing litigation concerning DOM's selection of its fiscal agent (the largest of DOM's contracts) forced PEER to significantly limit its review of this contract. Rather than reviewing this contract according to all of the elements of effective contracting discussed on page _, PEER limited its review of the fiscal agent contract to only one element – DOM's effectiveness in overseeing the contract (i.e., contract monitoring).

contracts reviewed by PEER, there were certain cases where DOM entered into multiple contracts for the same service. Specifically, DOM entered into twenty-two contracts for the provision of non-emergency transportation services, ten contracts for the provision of information related to long term care alternatives, and twelve contracts for cost report reviews.

Appendix C on page 67 contains a brief description of each contract type reviewed by PEER. Exhibit 7 on page 14 shows a percentage breakdown of the amounts spent on DOM contracts, by type. As shown in the exhibit, the largest contract of $24.1 million, representing 42% of the total, was for the fiscal agent, followed by the twenty-two contracts for non-emergency transportation (NET) totaling $17.3 million, or 30% of the total, the contract for Peer Review Organization (the entity responsible for determining if services are medically necessary) in the amount of $6.6 million, or 12% of the total, the contract for administration of the state's Disproportionate Share Hospital and Medicare Upper Payment Limits programs ($5 million, or 9%), and miscellaneous other contracts totaling 7%, or $3.8 million.

Exhibit 7

Division of Medicaid Estimated Annual* Contract Expenditures for the Contract Types Reviewed by PEER



* Based on FY 2001 actual contract expenditures when available. Otherwise, the amounts were obtained from FY 2002 contract documents.
SOURCE: Analysis of Division of Medicaid contract documents and FY 2001 and 2002 financial reports from the Statewide Automated Accounting System.

Elements of Effective Contracting

Exhibit 8 on page 15 summarizes the seven elements of effective contracting. These elements are designed to ensure that an agency:

- only contracts for needed services that it cannot perform more efficiently and effectively in-house; and,
- obtains quality services at the lowest possible cost.

Exhibit 8

Elements of Effective Contracting

ELEMENT	DESCRIPTION
ELEMENT 1: **Needs Assessment** **a. Staffing Analysis** b. **Cost Analysis**	A needs assessment determines what tasks and services are needed, whether current staff can perform these tasks and provide these services, and the estimated cost of these tasks and services.
ELEMENT 2: **Request for Proposals or Qualifications**	A request for proposals describes in sufficient detail the agency's service needs, expectations (i.e., performance level), and selection criteria.
ELEMENT 3: **Notice of Intent**	The notice of intent to secure a service provider notifies interested parties of the agency's request for proposals. Generally, opening the process to the marketplace ensures quality services at competitive prices.
ELEMENT 4: **Systematic Review of Proposals**	The agency's selection of a contractor must be made without bias, based on the contractor's documentation of its ability to meet the agency's expectations, needs, and other criteria specified in the request for proposals.
ELEMENT 5: **Written Contract**	A written contract specifies the responsibilities of both the agency and contractor, including the services contracted, level of performance required, compensation, and the performance period.
ELEMENT 6: **Contract Monitoring**	Contract monitoring provides opportunity for the agency to measure the contractor's performance level and adherence to contract terms.
ELEMENT 7: **Contract Evaluation**	A final evaluation assesses the contractor's performance in meeting the agency's expectations and contractual terms. An evaluation is important for both future selection and termination of a contractor.

SOURCE: PEER analysis of MISSISSIPPI CODE ANNOTATED (1972), other states' statutes, and American Bar Association's *Model Procurement Code for State and Local Governments*.

Appendix D on page 73 lists the Mississippi State Personnel Board's Personal Services Contract Review Board regulations, by element of effective contracting. The Contract Review Board regulations do not require state agencies to adhere to every element of effective contracting noted in Exhibit 8, for every contract. While the Review Board's strictest regulations apply to contracts greater than $100,000, the regulations encourage agencies to seek competition to the fullest extent possible on all contracts. PEER contends that in most cases, regardless of the cost of the contract, state agencies should adhere to the elements of effective contracting for the reasons previously stated.

DOM Compliance with Elements of Effective Contracting

Exhibit 9 on page 17 shows a breakdown of DOM compliance with the first six elements of effective contracting, by contract type. PEER omitted the seventh element, contract evaluation, from its analysis because none of the contracts reviewed had concluded at the time of PEER's review.

Exhibit 9

Report Card - Review of the Division of Medicaid's Performance in Executing the Standard Elements of Effective Contracting, by Type of Contract

Key:	√ = Met the criteria	P = Partially met the criteria
	X = Did not meet the criteria	N/A = Did not review the element

Element:		1	2	3	4	5	6	7
Type of Contract	No. of Contracts Reviewed	Needs Assessment	Request for Proposals or Qualifications	Notice of Intent	Systematic Review of Proposals	Written Contract	Contract Monitoring	Contract Evaluation
Peer Review Organization	1	x	√	√	**P**	√	**P**	N/A
Pharmacy Benefits Management /Drug Utilization Review	1	x	√	√	**P**	√	x	N/A
Long Term Care Alternatives	10	x	N/A	N/A	N/A	√	**P**	N/A
Administrative Support for the Medicare Upper Payment Limits Program and the Disproportionate Share Hospital Program	1	x	N/A	N/A	N/A	x	x	N/A
Non-Emergency Transportation	22	x	√	√	**P**	√	**P**	N/A
Cost Report Review	12	x	√	√	√	√	x	N/A
CPA Consultant	1	x	x	x	N/A	√	x	N/A
Reorganization /Human Resource Consultant	1	x	x	x	N/A	√	x	N/A
Medical Coding	1	x	x	x	N/A	√	x	N/A
CHIP Outreach Assessment	1	x	x	x	N/A	√	x	N/A
Fiscal Agent	1	N/A	N/A	N/A	N/A	N/A	**P**	N/A
Total Reviewed	52							

* PEER only reviewed the contract monitoring element for the fiscal agent contract due to ongoing litigation.

SOURCE: PEER review of Division of Medicaid records

As shown in Exhibit 9, above, DOM did not fully comply with the first six elements of effective contracting with respect to any of the eleven contractual services reviewed by PEER. The worst deficiencies were in the areas of needs assessment (none were performed), systematic review of proposals (DOM only complied on one contract), and contract monitoring (only partial compliance). A more

detailed discussion of the deficiencies in these areas follows.

Needs Assessment

In conducting a formal needs assessment, an agency must document:

- clear definition of the problem (need) to be addressed;
- estimated resources needed to address the problem (including staff, expertise, and dollars - i.e., cost); and,
- deficiencies in its own resources relative to addressing the problem (e.g., deficiencies in available time, expertise).

There is no documentation contained in the eleven contract files reviewed by PEER to indicate that DOM performed formal needs assessment prior to entering into the contracts. For two of the eight DOM contracts requiring approval from the state's Personal Services Contract Review Board, DOM did state in writing that it did not have the staff or expertise to perform the services in-house. For twenty-six contracts agency staff stated they did not have the agency staff or expertise to perform the services in-house. However, DOM has no documentation in its contract files to support this claim. While in one case (the Upper Payment Limits/Disproportionate Share Hospital contract), state law required DOM to contract for performance of the service (rather than perform it in-house), DOM should have still performed a needs assessment in order to determine a reasonable cost for the service (see discussion of this contract on page 25).

Systematic Review of Proposals

In order to ensure selection of the lowest and best bidder for a contract, the agency must clearly establish the criteria on which the bidders will be judged, assign possible point values to each criteria, and train the proposal evaluators as to how to objectively assign points based on documentation provided by the bidder in the proposal.

While DOM used evaluation instruments for thirty-six of fifty-one contracts reviewed by PEER on this element, only one evaluation instrument (for DOM's Cost Report Review contract) contained specific information on how the evaluator was to complete the instrument and what possible point values were assigned to each criteria. The evaluator's instructions were clear and concise and provided each bidder the opportunity to be fairly and accurately evaluated.

An example of poor utilization of an evaluation instrument involved DOM's selection of a Pharmacy

Benefits Manager/Drug Utilization Review contract provider. In reviewing the evaluation instrument for this contract, PEER found that while DOM assigned total possible values to sections of the instrument, no value ranges were assigned to individual items within the sections. As a result, the value of individual items was left up to the evaluator. For example, in a section worth 80 points and containing 9 questions, one evaluator assigned a value of 8.8 to each question while another evaluator scored questions in this section using values of 5, 10 and 15.

The proposal evaluators did not use the same values for scoring individual questions and were not required to justify their scores.

PEER also found that evaluators were not required to explain their scores in writing, making it difficult to resolve any major score discrepancies between evaluators.

PEER used a statistical measure, Cronbach's Alpha, in order to measure inter-rater reliability (i.e., the degree to which evaluators gave similar scores, based on the same documentation). PEER's analysis revealed that two of the nine evaluators did not score the proposals consistently with the other evaluators, resulting in poor inter-rater reliability. The level of reliability is important because any failure on the part of the agency to apply evaluation criteria consistently could result in the elimination of a qualified firm or certification of an unqualified firm.

Contract Monitoring

DOM did not perform any oversight of contractor performance on nineteen of the contracts reviewed by PEER. For example, DOM staff does not know who at DOM is responsible for auditing the contract with the Mississippi Hospital Association for administering the state's Upper Payment Limits/Disproportionate Share Hospital programs. DOM's Director of the Bureau of Reimbursement, who serves as the Contract Administrator, stated that DOM's Bureau of Compliance and Financial Review was responsible for monitoring this contract, but DOM's Bureau of Compliance and Financial Review stated they were not responsible for auditing the contract. While the contract administrator told PEER that she knows if the Mississippi Hospital Association is doing its job because providers will contact her if they do not get paid, adequate contract monitoring would require DOM to at least review a random sample of UPL and DSH calculations for accuracy. Also, active contract monitoring would have alerted DOM to the Mississippi Hospital Association's use of contract proceeds for activities which fall outside of the scope of work described in the contract (see discussion on page 25).

Although DOM completed audits on thirty-three of the fifty-two contracts reviewed by PEER (the Peer Review

Organization contract, the ten long term care alternatives contracts administered by the Area Agency on Aging, and the twenty-two non-emergency transportation contracts), these audits focused primarily on administrative aspects of the contract and did not measure contractor performance.

For example, PEER determined that DOM is not adequately auditing its fiscal agent contract. The contract requires DOM to evaluate the contractor's compliance with responsibilities outlined in the Request for Proposals and to notify the contractor on a monthly basis of all deficiencies. Although DOM employs two staff members who monitor the fiscal agent, DOM has not modified the format of its evaluation instrument to meet the criteria of its current contract, is not enforcing the requirements of the contract, and has taken no action against the contractor for non-performance, other than requesting thirty-seven corrective action plans for performance deficiencies.

Also, PEER found deficiencies in DOM's monitoring of its non-emergency transportation contracts. While DOM's Bureau of Compliance and Financial Review conducts an annual audit of non-emergency transportation group providers, the review provides insufficient ongoing program oversight. Annually, the Bureau selects a random sample of NET provider claims to ensure that a Medicaid NET Documentation form exists for each claim in the sample, that the medical provider stamped or signed the document, and that the Medicaid NET Documentation form supports the number of units that the provider charged on the claim. Also, in its annual audit DOM verifies whether the provider has a disaster recovery plan (i.e., what the provider will do in case of a vehicle breakdown), maintains a complaint log, and renewed their insurance within fifteen days of expiration.

The Bureau of Compliance and Financial Review completes no retrospective review of claims paid to ensure that a beneficiary actually attended the scheduled medical appointment for which the claim was filed. DOM's NET Coordinators told PEER that many times the medical provider informs the NET Coordinator that the beneficiary cancelled an appointment. Without this notification, the NET Coordinator would not have known the beneficiary did not attend the appointment and the provider could have charged for a trip that did not occur.

Also, the Bureau of Compliance and Financial Review does not require NET Coordinators to submit monthly reports to the Bureau of Compliance and Financial Review for review. Monthly reporting is necessary to identify best practices and roadblocks in completing objectives and to

monitor overall program operations and efficiency. PEER identified numerous problems in the NET program (which should have been identified by DOM staff through contract oversight) by interviewing field staff and reviewing NET system data and claims data. Appendix E on page 74 contains a detailed discussion of the problems identified by PEER.

Areas of Potential FY 2003 General Fund Savings in DOM Contractual Services Expenditures

PEER identified $7.7 million in potential FY 2003 general fund savings in the DOM expenditure category of contractual services.

PEER identified the following inefficiencies in DOM contractual services expenditures:

- contracting for services that DOM could have performed more efficiently in-house (Management/Training Consultant, Peer Review Organization, Pharmacy Benefits Management and Drug Utilization Review, and the Children's Health Insurance Program Outreach Assessment);
- paying significantly higher contractual costs for services than contractual costs paid by other states for the same services (non-emergency transportation contract, CPA consultant, and reviewers of cost reports and medical codes); and,
- contracting for a service that was already being performed by other entities (long term care alternatives contract).

Exhibit 10 on page 22 shows a breakdown of PEER's estimated $7.7 million in potential FY 2003 general fund savings in the DOM expenditure category of contractual services, by contract type. A discussion of each category of inefficient contractual services expenditures follows. (See Appendix F, page 78 for a detailed explanation of potential general fund savings.)

Exhibit 10

FY 2003 Potential General Fund Net Savings Identified through PEER's Review of DOM Contracts

Type of Contract	No. of Contracts Reviewed	Annual* Contract Expenditures	Annual* General Fund Portion of Contract Expenditures	Matching Rate (State/ Federal)	FY 2003 Potential General Fund Net Savings
Non-Emergency Transportation	22	$17,298,414	$8,649,207	50/50	$5,000,000
Peer Review Organization	1	$6,613,528	$1,581,295	.2391 /.7609	$1,358,931
Pharmacy Benefits Management and Drug Utilization Review	1	**$1,691,667	$845,833	50/50	$735,696
Cost Report Review	12	****$908,977	$454,489	50/50	$324,551
Long Term Care Alternatives	10	***$943,720	$225,643	.2391 /.7609	$225,643
CPA Consultant	1	$75,000	$37,500	50/50	$29,765
CHIP Outreach Assessment	1	$50,000	$25,000	50/50	$25,000
Medical Coding	1	***$50,000	$25,000	50/50	$9,531
Management/ Training Consultant	1	***$15,000	$7,500	50/50	$7,500
Administrative Support for the Medicare Upper Payment Limits and Disproportionate Share Hospital programs	1	$5,000,000	0	50/50	($61,875)
TOTALS	**51**	**$32,646,306**	**$11,851,467**		**$7,654,742**

* Based on FY 2001 actual contract expenditures unless noted below.

** Data on a full year of expenditures was not available as the contract was not effective until July 1, 2001. Figure is based on average yearly expenditure for the $5,075,000 three-year contract.

*** Figure is based on FY 2002 contract amounts.

**** Figure is based on FY 2002 contracts and those contracts including FY 2001 start dates and FY 2002 end dates.

SOURCE: Analysis of Division of Medicaid contract documents and FY 2001 and 2002 financial reports from the Statewide Automated Accounting System.

Services that DOM could perform more efficiently in-house

DOM could perform five of its contractual services more efficiently in-house, resulting in potential FY 2003 general fund savings of $5 million.

Peer Review Organization Contract

Possible FY 2003 General Fund savings: $1,358,931 million

DOM's contractor administers this contract with a total of sixty-three employees including nurses, contract physicians and support staff. FY 2001 expenditures were $6,613,528, or $1,581,295 in general funds.

By using current vacant positions and reclassifying other vacant positions, DOM could perform this service in-house with physicians, nurses, medical records staff and clerical office support staff. The duties of this contract are based on a standard set of criteria that is compared to requests for medical services to determine if services are medically necessary. By performing this service in-house, the Division of Medicaid could potentially save $1,358,931 in general funds annually.

However, if DOM elects to continue to contract for this service, it should negotiate for a better price. The Division of Medicaid requested a per member per month fee plus implementation costs for the PEER Review Organization contract. The Division of Medicaid pays the contractor a flat fee each month for each eligible beneficiary regardless of whether they received services or not. Productivity reports reveal that the contractor completed 159,508 reviews in FY 2001 for an average of 13,292 per month.

Pharmacy Benefits Management and Drug Utilization Review Contract

Possible FY 2003 General Fund savings: $735,696

DOM stated that they contracted for these services because they did not have the staff or scientific resources necessary to provide the services in-house. The contractor plans to employ fifteen to twenty people, including a pharmacist, registered nurse, licensed practical nurse, and pharmacy technicians. The contractor plans to find pharmacy technicians by using an employment agency to hire individuals who will obtain the necessary certification from the Board of Pharmacy. According to Article XL of the Mississippi Board of Pharmacy Regulations, a Pharmacy Technician applicant must submit an application, be of good moral character and pay a registration fee. There are no education or work requirements. Performing these services in-house could save $735,696 in general funds.

The drug utilization review program is run through the contractor's corporate office computer. By using data from the fiscal agent, the computer runs queries to identify spikes in prescribing patterns and generates reports for review by the Division of Medicaid's Drug Utilization Board. The division currently has two systems, the Medicaid Management Information Retrieval System and the Surveillance and Utilization Review Subsystem, which can track this information in addition to the fiscal agent who has the capability to generate reports based on claims data.

CHIP Outreach Assessment Contract

Possible FY 2003 General Fund savings: $25,000

DOM's Contract Administrator for the CHIP outreach assessment contract stated that DOM contracted for these services because no staff was available to perform them in-house. PEER determined that the contractor used DOM CHIP outreach program data to determine which method of outreach (e.g., radio, television, print media, hotline, public schools initiative, on-site campaigns at businesses and malls) reached the most individuals. DOM could have saved the cost of this contract by asking eligibles how they learned about the CHIP program.

Management/Training Consultant Contract

Possible FY 2003 General Fund savings: $7,500

DOM is paying a contractor $15,000 to facilitate meetings and planning sessions related to possible Medicaid reorganization efforts, develop and facilitate an implementation plan to achieve agency goals, provide supportive development activities for Medicaid staff, provide consultation on management issues, and perform other related professional services as directed by the Executive Director.

DOM contract documentation indicates that the only work activity that the management/training consultant performed under the contract was assistance on three DOM staff retreats. PEER determined that DOM could have used internal resources to assist with the facilitation of Medicaid retreats rather than contracting with an external organization. The Bureau of Human Resources has staff designated for training and should have been asked to oversee the retreats. The staff could have facilitated the meetings and reported the results of the meetings to the Executive Director.

Contract for Administrative Support of the Disproportionate Share Hospital Program and the Medicare Upper Payment Limits Program

Possible FY 2003 General Fund Cost: $61,875

The consideration DOM pays to the Mississippi Hospital Association for contract services related to administrative support of the Disproportionate Share Hospital and Medicare Upper Payment Limits programs is excessive in light of the costs of performing this function and may not comply with federal laws and regulations governing reimbursable administrative costs to states.

Senate Bill 2424 of the 2001 regular session of the Mississippi Legislature amended MISS. CODE ANN. Section 43-13-117 (1972) and added section 18 (c) requiring the Division of Medicaid to:

"contract with the Mississippi Hospital Association to provide administrative support for the operation of the disproportionate share hospital program and the Medicare Upper Payment Limits Program."

The legislation, however, did not specify a contract amount, only that any program established meet definitions in "the federal Social Security Act and any applicable federal regulations."

DOM's Executive Director agreed to a four-year $20 million contract ($5 million annually), without conducting a needs assessment to determine a reasonable cost for the service. PEER determined that Alabama and Louisiana each provide administrative support for their DSH/UPL programs for an estimated annual cost of less than $100,000. Louisiana uses an accountant and readily available software to calculate the Disproportionate Share Hospital payments to hospitals, and they use a contractor to calculate Upper Payment Limits for their long term care facilities. Alabama uses one staff member and readily available software to operate its DSH/UPL program.

PEER determined that the Mississippi Hospital Association plans to expend the $5 million that it received in FY 2002 contractual payments from DOM, as shown in Exhibit 11 on page 26.

Exhibit 11
Breakdown of FY 2002 Mississippi Hospital Association Actual and Planned Expenditures for Its Contract with DOM

Amount	Stated Purpose
$562,000	Professional and consulting fees, including $15,000 per month for 75 hours of work each month paid to Health Management Associates of Tallahassee, Florida, the company that makes Mississippi's Upper Payment Limits and provider assessment calculations
$510,000	Salary supplements for 13 Mississippi Hospital Association employees and full-time salary for 1 employee
$800,000	Endowment for nursing shortage scholarships (1)
$300,000	Fall 2002 issuance of nursing shortage scholarships (1)
$410,000	Health Careers Center (2)
$150,000	Rural hospital technical assistance (3)
$2,068,000	Future projects (4) and profit
$85,000	Other operating expenses (5)
$15,000	Travel
$5,000,000	**TOTAL**

(1) MHA has not decided who will administer the program.

(2) MHA is designing a Health Careers Center to increase student enrollment in health education programs and to improve retention of health professionals. Plans for the center include on-campus education and recruitment meetings, marketing of health careers as a profession and training of hospital personnel in management and retention issues.

(3) Several members of Mississippi Hospital Association staff act as full-time consultants who assist rural hospitals with modifying clinical and business office practices in order to operate more efficiently and provide a higher quality of care.

(4) Stated options include funding of a diagnostic medical sonography faculty position at Hinds Community College and a nurse anesthetist position at the University of Mississippi Medical Center and plans to assist rural hospitals in building and improving their communications infrastructure.

(5) Includes $35,000 for insurance, as required in the contract, and $50,000 for overhead.

SOURCE: PEER analysis of Mississippi Hospital Association documents

As Exhibit 11 on page 26 shows, the Mississippi Hospital Association is expending at least $3,728,000 of the $5 million contract total on items clearly unrelated to the legislated purpose of the contract and clearly outside the scope of work set forth in Section 1 of the contract. (MHA was unable to provide PEER with documentation of the percentage of time that staff paid with contractual monies are spending on administration of the state's UPL/DSH programs.)

Further, these expenditures that are unrelated to administration of the state's UPL/DSH programs may not comply with federal laws and regulations governing reimbursable administrative costs to states. Section 42 U.S.C. 1396b (2001) requires that services for which federal administrative match is claimed must also be "found necessary by the Secretary [of the U.S. Department of Health and Human Services] for the proper and efficient administration of the State plan." Such expenses as a health careers center and salary supplements to personnel of the private Mississippi Hospital Association do not appear necessary to proper and efficient administration of the state's Medicaid plan. Officials with the Centers for Medicare and Medicaid Services or the Office of the Inspector General within the U.S. Department of Health and Human Services could question such expenses under the current contract.

If the Centers for Medicare and Medicaid Services find that these administrative costs fail to comply with applicable federal statutes and regulations, the Centers for Medicare and Medicaid Services could take exception to these practices. Consequently, DOM could be forced to repay the federal government for claimed expenditures that are not deemed in compliance with federal law and regulations.

The contract with the Mississippi Hospital Association also fails to specifically provide for indemnity to the state if the Centers for Medicare and Medicaid Services require repayment of administrative costs attributable to the MHA contract.

Services that DOM could contract for at a lower cost

DOM could save approximately $5 million in state general funds by negotiating lower cost contracts with the following service providers: non-emergency transportation, CPA consultant, and reviewers of cost reports and medical codes.

Non-emergency transportation

Possible FY 2003 General Fund savings: $5 million

The Division of Medicaid expended $17,298,414, or $8,649,207 in general funds, in FY 2001 for non-emergency transportation services. As of April 30, 2002, DOM has expended $21,184,844 for these services. Twenty-two vendors have contracts with the Division of Medicaid to provide non-emergency transportation services for Medicaid beneficiaries. Group provider one-way rates range from $19 to $50, regardless of the miles traveled. For example, Medicaid pays the group provider the same rate for a trip from Greenville to Jackson that it would pay for a beneficiary to be transported from his home to the doctor's office five miles away.

States such as Louisiana and Alabama are expending between $5 million and $8 million annually to operate their non-emergency transportation programs. Louisiana operates its program as an optional medical expense (see Appendix G on page 85) and capped their rates based on miles traveled. They also capped their rates for repetitive trips such as dialysis, chemotherapy, and therapy, in order to control costs.

Alabama operates its non-emergency transportation program as an administrative option (see Appendix G on page 85) and uses a voucher system. The beneficiary receives a voucher and uses this voucher to pay a family member or friend to transport him or her, or uses it for public transportation, or uses it to pay a provider enrolled for the beneficiary's service area. By implementing a model similar to the Alabama model or the Louisiana model, the state could save approximately $10 million, or $5 million in general fund expenditures.

Cost Report Reviews

Possible FY 2003 General Fund savings: $324,551

DOM initiated the twelve Cost Report Review contracts that received payment in FY 2002 due to a reported backlog created when the Bureau of Compliance and Financial Review inherited cost report review responsibilities from another bureau. According to the

Director of the Bureau of Compliance and Financial Review, there was not enough staff available to eliminate the backlog. There are currently seven Accountant III positions that perform these duties. Bureau staff stated that the responsibilities they have to assist the contractors with duties such as training, fieldwork assistance, information gathering, and the contract process prevent them from completing audits in-house. This can only lead to a larger backlog of audits. The number of audits the contractors are required to complete increased 300% from FY 2000 to FY 2002. The Director of the Bureau of Compliance and Financial Review stated that the current staff could perform the duties once the backlog was eliminated. If DOM contracted with seven individual accountants and paid them the base salary for this classification, the division could have saved $324,551 in general funds.

CPA Consultant

Possible FY 2003 General Fund savings: $29,765

The Director of the Bureau of Reimbursement stated that she hired a CPA firm to assist with desk reviews of nursing home cost reports because the bureau needed assistance and did not have adequate staff to perform the duties in-house. The Bureau of Reimbursement completed no cost analysis in order to determine the actual costs associated with these duties. DOM expended $37,500 in general funds for this five-month contract. If the division had contracted out these services for an individual accountant and paid the base rate for an Accountant III for five months of service, DOM could have saved $29,765 in general funds.

Medical Coding

Possible FY 2003 General Fund savings: $9,531

The Contract Administrator hired a company to check medical coding by providers for accuracy and to provide assistance in training personnel on proper medical coding. This contract is valued at $50,000, or $25,000 in general funds. DOM completed no cost analysis to identify the costs of providing these services. The agency hired an organization to provide these services because they have no medical coding staff position, but could have saved money had they hired a single subject matter expert. In Mississippi, the average salary for a medical coding expert is $25,000. Use of a subject matter expert could have resulted in savings of $19,062, or $9,531 in general funds.

Duplicative Services

DOM's ten contracts with Area Agencies on Aging for providing information on long term care alternatives (totaling $225,643 in general fund expenditures) duplicate services already being performed by other entities.

Long Term Care Alternatives

Possible FY 2003 General Fund savings: $225,643

MISS. CODE ANN. Section 43-13-117 (f) (iii) states that DOM may provide long term care alternatives services directly or through contract with the case managers from the local Area Agencies on Aging. State law further states that DOM shall coordinate long term care alternatives to avoid duplication with hospital discharge planning procedures.

In July of 2000, DOM contracted with Mississippi's ten Area Agencies on Aging to provide long term care alternatives information to Medicaid beneficiaries. FY 2002 contracts total $943,720 ($225,643 in general funds).

Medicaid eligibility workers, hospital discharge planners and hospital and nursing home social workers provide information to Medicaid beneficiaries on long term care alternatives.

Many entities, including DOM, hospitals, and nursing homes already provide long term care alternative information to Medicaid beneficiaries. For example, DOM eligibility workers inform applicants about the Home and Community Based Services Waiver program either verbally or with pre-printed materials describing the services and providing a contact number. DOM eligibility determination letters also include a contact phone number and information concerning the waiver programs. Urban and rural hospitals employ discharge planners and social workers who also provide information to patients about long term care alternatives.

Review of DOM Salaries, Wages, and Fringe Benefits Expenditures

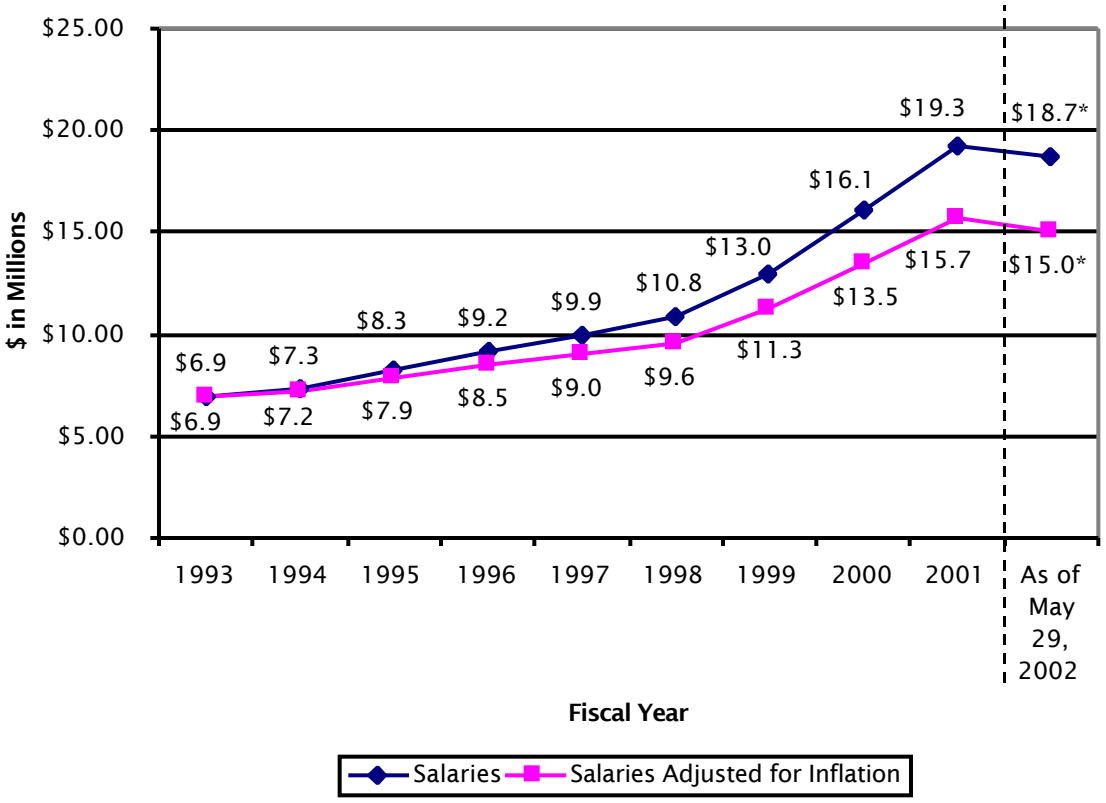
From FY 1993 through FY 2001, DOM salaries, wages and fringe benefits expenditures increased by 128% adjusted for inflation (from $6.9 million to $19.3 million in actual dollars, or $15.7 million adjusted for inflation), and staff increased by 126%, from 264 employees to 596 employees.

Growth in DOM Staffing

As shown in Exhibit 12 on page 31, from FY 1993 through FY 2001, DOM expenditures on salaries, wages and fringe benefits grew from $6.9 million to $19.3 million in actual dollars, and from $6.9 million to $15.7 million adjusted for inflation, a 128% adjusted growth rate.

Exhibit 12

Salaries, Wages and Fringe Benefits Expenditures of the Division of Medicaid for State Fiscal Years 1993 through 2001 and through May 29 of FY 2002

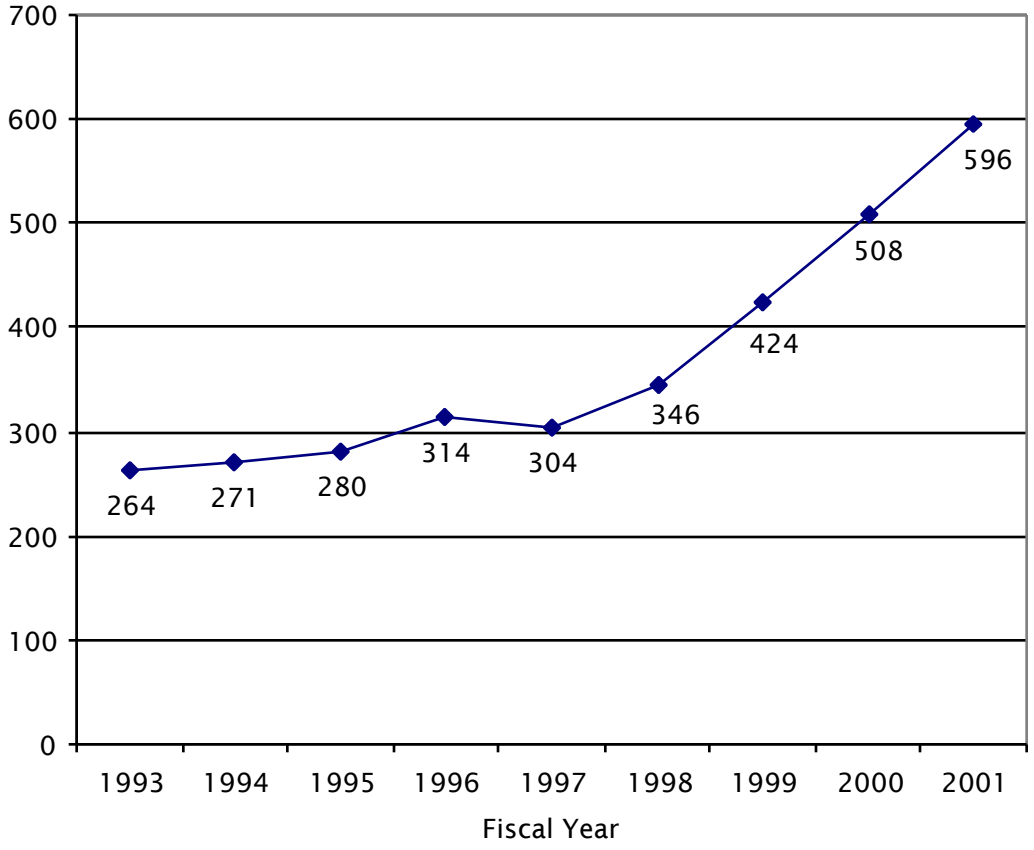


* Consists of interim period numbers as of May 29, 2002. The state fiscal year ends on June 30. In addition, funds obligated through June 30 but paid through August 31, 2002, will be accounted for as expenditures in FY 2002.
SOURCE: Mississippi Statewide Automated Accounting System, U. S. Department of Labor Bureau of Labor Statistics CPI data

In terms of number of employees, as shown in Exhibit 13 on page 32, DOM staff grew from 264 positions in FY 1993 to 596 positions in FY 2001, an increase of 126%.

Exhibit 13

Numbers of Medicaid Employees from FY 1993 to FY 2001



SOURCE: Division of Medicaid

Exhibit 14 on page 33 shows number of DOM positions, by functional area and by fiscal year for the period FY 1993 through FY 2001. As the exhibit shows, the largest increases were the addition of 100 eligibility staff, 57 non-emergency transportation staff and 48 program oversight staff. (Refer to page 59 for a discussion of PEER's recommendation to reduce the number of DOM non-emergency transportation staff.)

Exhibit 14

Increases in DOM Staff from FY 1992 to FY 2001, by Function

Functional Area	Fiscal Year									Increase in Positions 1993-2001
	1993	1994	1995	1996	1997	1998	1999	2000	2001	
Eligibility	151	150	146	158	153	169	173	210	251	100
Non-Emergency Transportation	0	0	0	0	0	0	37	55	57	57
Program Oversight: Program Integrity, Contract Monitoring, Pharmacy	15	17	20	20	22	23	31	44	63	48
Health and Medical Services: LTC* & Medical Services, Quality Management & Casemix, LTC, Health Services Bureau, Medical Services Bureau	20	19	19	19	20	36	32	50	47	27
DP* Systems	7	11	10	10	11	15	22	23	28	21
Managed Care/Provider and Beneficiary Relations	4	6	6	8	8	12	15	19	24	20
Administrative/Executive Support: Human Resources, Administration & Executive Services, Accounting and Finance	27	26	29	44	32	28	29	34	46	19
Reimbursement	5	5	6	7	8	10	19	19	20	15
EPSDT*/Maternal Child Health	6	6	6	7	8	8	13	14	18	12
Programs Review/TPL*	24	24	27	29	32	32	36	29	31	7
Policy: Policy Planning &Research/QA* & Policy and Special Projects/Medical Policy	5	7	11	12	10	13	17	11	11	6
Total	264	271	280	314	304	346	424	508	596	332

* DP--Data Processing; EPSDT--Early and Periodic Screening, Diagnosis and Treatment; LTC--Long Term Care; QA--Quality Assurance; TPL--Third Party Liability

SOURCE: PEER analysis of Division of Medicaid data

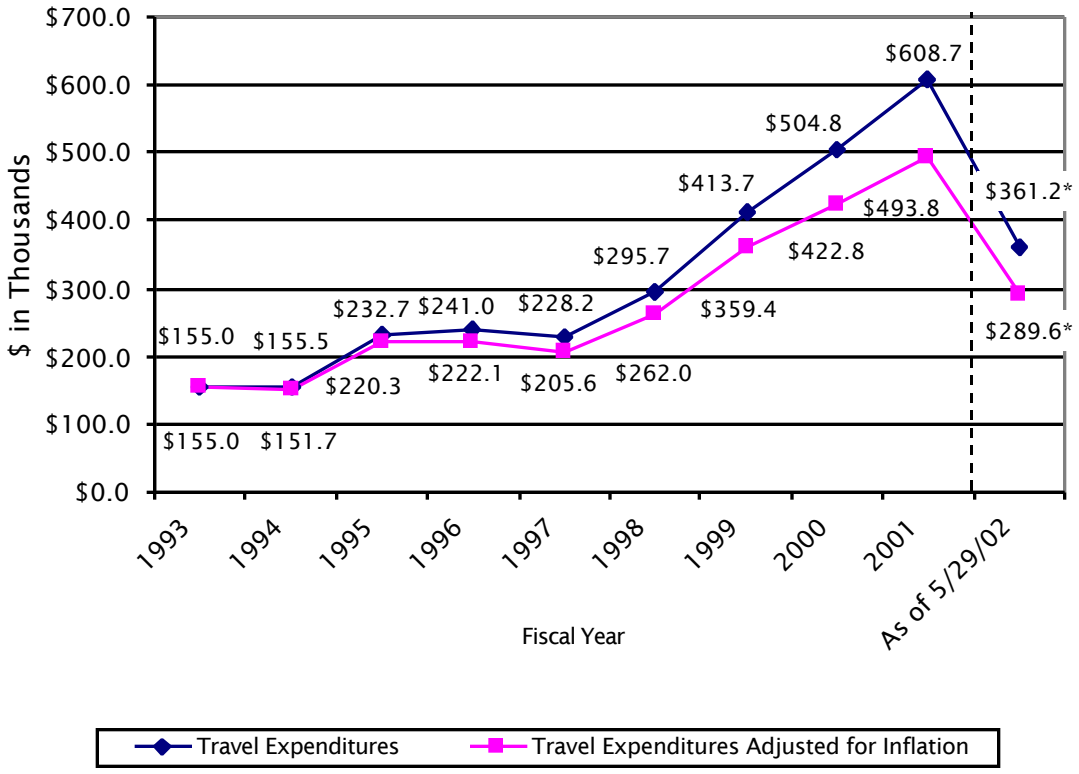
Review of DOM Travel Expenditures

Although DOM travel expenditures grew by an inflation-adjusted 219% from FY 1993 through FY 2001, DOM travel expenditures represent only 1% of DOM total administrative expenditures. In FY 2002, DOM reduced its travel expenditures significantly as a result of the division's restrictions on travel.

As shown in Exhibit 15 on page 35, from FY 1993 through FY 2001, DOM travel expenditures increased by 219%, from $154,966 to $493,798, adjusted for inflation. As Exhibit 15 also shows, in FY 2002 (through May 29), DOM travel expenditures declined by 41% as a result of the agency's restrictions on travel.

Exhibit 15

Travel Expenditures of the Division of Medicaid for State Fiscal Years 1993 through 2001 and through May 29 of FY 2002



* Consists of interim period numbers as of May 29, 2002. The state fiscal year ends on June 30. In addition, funds obligated through June 30 but paid through August 31, 2002, will be accounted for as expenditures in FY 2002.
SOURCE: Mississippi Statewide Automated Accounting System, U. S. Department of Labor Bureau of Labor Statistics CPI data

On a per person basis, DOM travel expenditures increased from $587 in FY 1993 to $1,021 in FY 2001, or an average of 7% per year.

Factors driving up DOM travel expenditures include increases in mileage reimbursements and Medicaid program expansion. Mileage reimbursements increased from $0.20 per mile in FY 1993 to $0.325 cents in FY 2001.

An increase in the number of nursing homes, pharmacies, providers and contractors has raised the travel costs incurred by the DOM employees who must travel to these sites to perform their work.

Review of FY 2001 travel expenditures for selected DOM employees

PEER determined that DOM travel expenditures were not excessive in FY 2001 for the fourteen individual cases reviewed.

PEER reviewed in detail the travel expenses of the fourteen DOM employees whose FY 2001 total travel expenditures were $6000 or higher. The fourteen individual cases reviewed by PEER included eight nurses, two Medicaid investigators, two auditors, a branch director and the Executive Director.

In FY 2001, yearly travel reimbursements for the fourteen cases reviewed by PEER ranged from a high of $19,163 for an Early Periodic Screening, Diagnosis, and Treatment Program Nurse to a low of $6,419 for the Executive Director.

According to DOM supervisors, DOM nurses and field auditors/investigators spend most of their work time (three to four days per week) in out-of-town locations. For example, each of DOM's five case mix nurses performs nursing home reviews in an assigned region of the state. DOM's auditors/investigators conduct fieldwork all over the state and are not restricted to one specific district.

DOM's Bureau of Accounting, Budget and Finance is responsible for issuing travel reimbursements and has established oversight procedures for verifying mileage and hotel stays. For example, DOM Bureau staff utilize Internet travel programs to compare actual miles from one location to another to miles reported by DOM staff on their travel vouchers. DOM Bureau staff also review each travel voucher that includes overnight lodging to determine whether it would have been cheaper for the employee to return to his or her home rather than spend the night in a motel.

PEER found no excess spending in regards to mileage and overnight lodging for the fourteen cases reviewed.

Medicaid Eligibility Determinations

Based on FY 2003 budget projections, every 1% increase in Medicaid enrollment results in an annual increase of $6 million in general fund expenditures. PEER found deficiencies in the current eligibility determination process, which if corrected could lead to reductions in Medicaid expenditures.

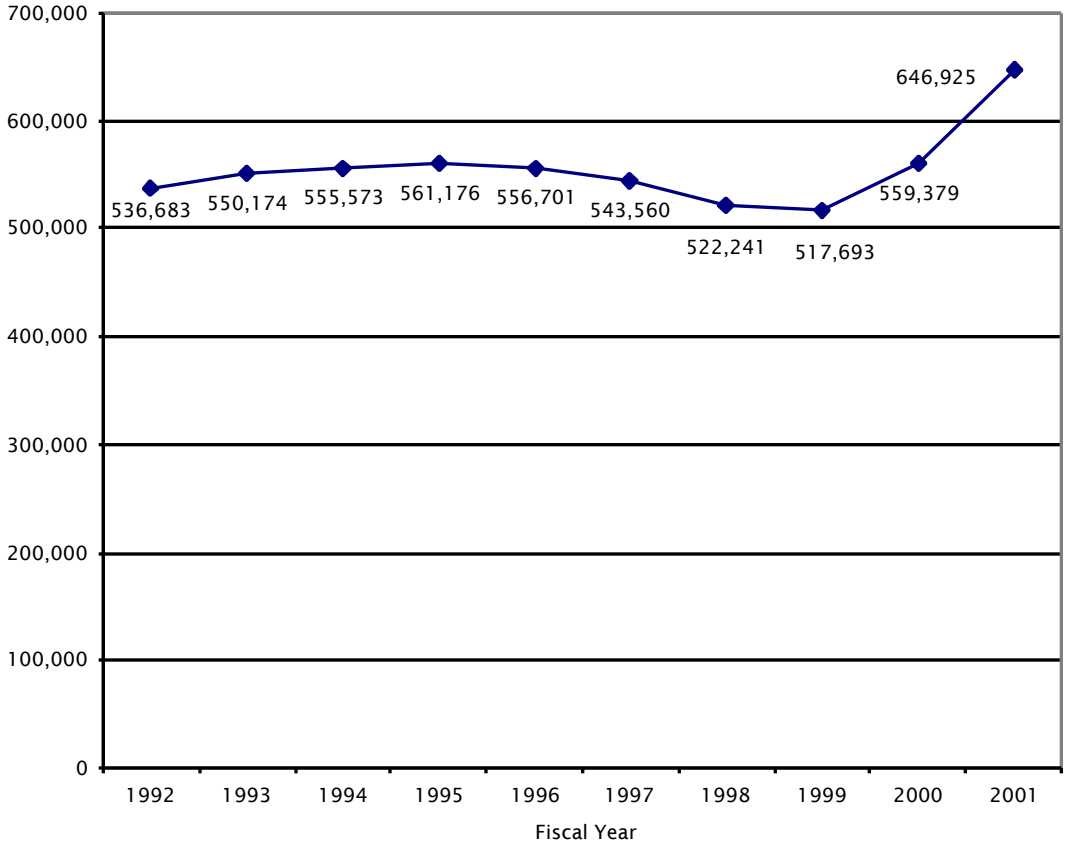
Number of Medicaid Eligibles During Past Decade

As illustrated in Exhibit 16 on page 38, the number of Medicaid eligibles remained fairly stable from FY 1992 through FY 2000. The greatest annual increase occurred from FY 2000 to FY 2001, when the number of Medicaid eligibles grew by 15.7%, from 559,379 to 646,925. According to DOM, the primary reasons for this recent increase in Medicaid eligibles are:

- outreach associated with implementation of the Children's Health Insurance Program, which identified many children who were eligible for Medicaid benefits but who were not previously enrolled in the program; and,
- the increase in the allowable income level for poverty-level aged and disabled from 100% of the federal poverty level to 135% (MISS. CODE ANN. Section 43-13-115 [11]), which went into effect in 2000.

Exhibit 16

Division of Medicaid Trends in Numbers of Certified Eligibles for Fiscal Years 1992 to 2001



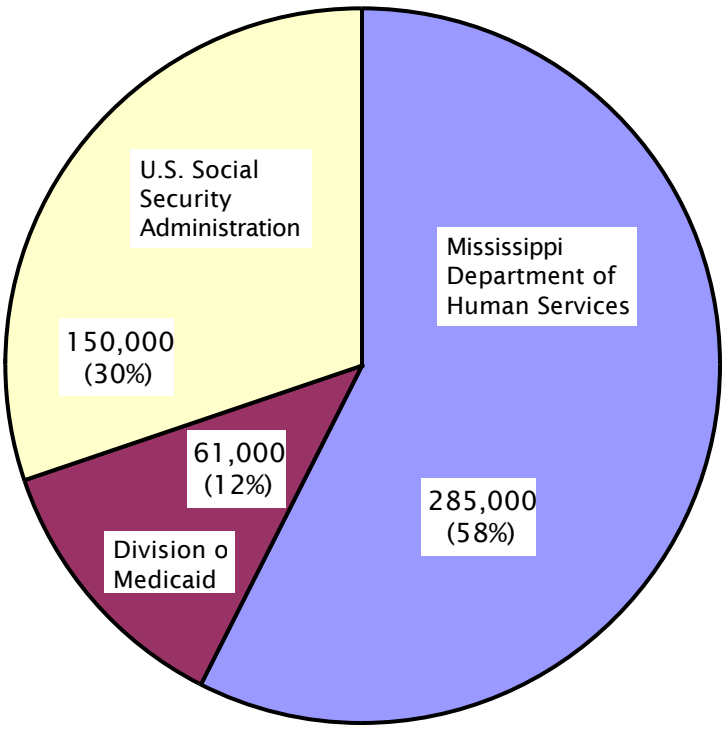
SOURCE: Division of Medicaid

Agencies Responsible for Determining Medicaid Eligibility

As previously noted (refer to page 5), in Mississippi, three entities have the authority to determine Medicaid eligibility for specific sub-populations of the Medicaid eligibility pool: the Division of Medicaid, the Social Security Administration, and the Department of Human Services. Appendix A on page 63 contains a breakdown of the sub-populations for which each entity is responsible. Exhibit 17 on page 39 shows a breakdown of the number and percentage of persons enrolled in Medicaid by each of the three agencies in FY 2000.

Exhibit 17

Numbers of Medicaid Recipients Determined Eligible in FY 2000, by Agency Making the Determination



* The percentages shown above may include rounding errors, as the figures in the source document were rounded by the Division of Medicaid.
SOURCE: FY 2000 Annual Report of the Division of Medicaid

DOM's Eligibility Determination Process

DOM's process for verifying resources of Medicaid applicants is insufficient to ensure that only qualified applicants are enrolled.

DOM's Medicaid Specialists make eligibility determinations strictly on the basis of information provided by the applicant on the application form. Information requested on the form includes:

- applicant identification;
- spouse or parent identification;
- veteran status;
- retroactive Medicaid;
- resources (i.e., any asset that can be converted to cash, such as retirement funds, contents of safe deposit boxes, bank accounts, promissory notes, loan or property agreements, stocks, bonds, savings bonds, home property, other real property, household goods/personal property, automobiles, life insurance, burial space and burial funds);
- income and work history;
- statement of citizenship or alienage;
- assignment of rights to third party payment, cooperation requirement and estate recovery requirement;
- Privacy Act and computer matching notice; and,
- applicant responsibilities.

While DOM Medicaid Specialists ask applicants questions concerning their resources, they do not attempt to independently verify the existence of an applicant's resources (e.g., by contacting local banks, reviewing court records, or visiting the applicant's residence). Medicaid Specialists told PEER staff that they attempt to uncover unreported resources by cross-checking documentation that the applicant has provided. For example, if an applicant has reported no income but has provided documentation showing that his or her shelter and utilities payments are current, the Medicaid Specialist would seek more information from the applicant to explain how the person could make the payments with no income.

In addition to the effect that failure to verify resources can have on the state's Medicaid rolls, DOM's failure to verify resources violates federal regulations contained in Code of Federal Regulations (CFR) Title 42 Section 435.948.

In 1986, Congress created the Income and Eligibility Verification System (IEVS) in an effort to reduce errors in determining eligibility for various federally funded programs, including Medicaid. IEVS mandates that states

match case records to verify the following basic income information from program applicants:

- state wage information that is kept by the state wage information collection agency during the time of application and then reported at least on a quarterly basis;
- net earnings from self-employment, wage and payment of retirement benefits maintained by the Social Security Administration (SSA);
- other benefit information from the Social Security Administration that applicants may be receiving under Titles II (social security disability insurance) and XVI (supplemental security income disability) of the Social Security Act;
- unearned income information, such as interest, pensions, and annuities that is available from the Internal Revenue Service;
- unemployment compensation information that is maintained by the agency that administers state unemployment compensation laws; and,
- any other information relating to additional income, resource, or eligibility information that is relevant to determining eligibility or correct payment amounts of medical assistance payments from other state agencies that administer (i) AFDC (Aid to Families with Dependent Children), which is now known as TANF (Temporary Assistance to Needy Families); (ii) Medicaid; (iii) state-administered supplementary payment programs under Section 1616 (a) of the Social Security Act; (iv) state wage information collection data (SWICA); (v) unemployment compensation; (vi) food stamps; and (vii) any state program administered under a plan approved under Titles I (assistance to the aged), X (aid to the blind), XIV (aid to the permanently and totally disabled), or XVI (aid to the aged, blind and disabled) of the Social Security Act.

From approximately 1986 to 1998, DOM obtained Internal Revenue Service unearned income data from Mississippi's Department of Human Services to match against the unearned income reported on Medicaid applications. However, in 1998 the Internal Revenue Service notified Mississippi's Division of Medicaid that according to IRS Code 6103 (1) (7) state agencies that are under different department heads must submit separate requests for tax information and that tax information cannot be shared with any other state agency.

DOM's failure to obtain unearned income information from the IRS since 1998 undermines the agency's ability to make accurate determinations of eligibility.

Mississippi Department of Human Services' Eligibility Determination Process

Income Verification at Application

The Mississippi Department of Human Services does not verify income for all Medicaid applicants before awarding benefits.

According to Department of Human Services county workers, departmental policy does not require verification of a Medicaid applicant's income prior to awarding benefits. The five Department of Human Services workers interviewed by PEER from Bolivar, Hinds, Jones, Lauderdale, and Washington counties stated that the main goal as told to them by management in the state office (in Jackson) was to enroll as many people in Medicaid as possible and to simply accept whatever income the applicant reported on the application form.

The Mississippi Department of Human Services processes two categories of applicants for Medicaid benefits: those who are also applying for or already receiving Temporary Assistance for Needy Families (TANF) and/or food stamps, and those who are not. According to MDHS policy, MDHS verifies income for the former group as part of its TANF/food stamp eligibility determination process. In this process, the Department requires the applicant to submit pay stubs, W-2 documents, etc., as documentation of income.

Those individuals applying for Medicaid benefits through MDHS who do not participate in the TANF or food stamp programs may, but do not have to, submit income documentation at the time of application. MDHS allows these applicants to provide the social security numbers for all legal custodial parents in the home rather than submitting income documentation. When a Medicaid applicant submits a social security number to MDHS, the Department sends an overnight query to the Social Security Administration to verify that the number reported matches the applicant's name. The system also tells the MDHS eligibility worker whether the person is receiving social security, unemployment, or Supplemental Security Income (SSI) benefits. Once the social security numbers are matched, MDHS uses the adult income reported by the applicant but not verified by MDHS to determine whether the applicant qualifies for Medicaid benefits. Approved applicants begin receiving benefits within approximately thirty days.

The Department of Human Services' income verification process is untimely for those Medicaid applicants who do not receive TANF benefits or food stamps.

According to MDHS policy, to verify the income of Medicaid applicants who were approved on the basis of social security numbers, MDHS uses the federal Income Eligibility Verification System (IEVS) (see section on DOM's Eligibility Determination Process on page 40). MDHS implements this program by sending adult social security number(s) that need to be verified/matched with reported wage information to the Mississippi Employment Security Commission (MESC) via electronic tapes twice a month. The MESC matches the Social Security number(s) of the client or the adult guardian(s) with quarterly income declared in employer reports. However, the income information is at least four months old (and could be over six months old) when actual verification takes place due to the procedures MESC requires employers to follow for reporting income of their employees. Employers report income information quarterly (every three months), and often, employers submit information late. Once information is reported, MESC then has up to three additional months to enter all employer information received from all employers during the previous quarter into their wage record files. Once this is done, the electronic tapes sent by MDHS are sent back to MDHS with matching information.

Department of Human Services policy does not require workers to verify that the wage income reported is the only income the applicant's household receives.

MDHS workers from the five counties interviewed stated that they do not check for unlisted spouses or second incomes in the home. The only social security numbers that are checked through the IEVS system are the ones on the application; therefore, it is possible that there are other incomes in the home that could disqualify the applicant.

Income Verification at Renewal

Medicaid recipients must apply for renewal of benefits annually. At the time of renewal (one year after initial award has been granted), recipients must complete a one-page document stating whether any changes have been made in income, residence or family status. If the recipient reports no changes, the recipients are not required to do anything further and will continue to receive benefits. IEVS reports are again generated to match stated income with actual income (see "Revocation of Medicaid Benefits" on page 44 regarding what occurs when recipients are proven unqualified for benefits).

Revocation of Medicaid Benefits

The Department of Human Services rarely revokes Medicaid benefits, even when falsification of information is discovered.

According to the Mississippi Department of Human Services workers interviewed by PEER, the infrequent circumstances under which the Department rescinds benefits are when a recipient moves out of state, is accepted for award of benefits from some other program, no longer qualifies for Medicaid benefits (e.g., due to an increase in income), or is more than two months past delivery, if she was pregnant at the time of application and does not qualify for Medicaid benefits based on her income level.

Another instance in which the Mississippi Department of Human Services may rescind benefits is when it is proven that a recipient purposely misreported his/her income or job status. According to the eligibility workers interviewed by PEER, this rarely happens because the untimeliness of the IEVS report hinders workers from discovering the discrepancies between stated and actual income. As stated previously, the Department of Human Services does not place emphasis on verification of income even though IEVS reports are generated, so eligibility workers may not examine the reports. Also, the information is at least four months old (and could be as much as ten months old if employers are late in reporting to MESC) when it becomes available. A Mississippi Department of Human Services spokesperson stated that if it is discovered that income has been underreported, in most instances outright fraud has not occurred because even at these times, most recipients will qualify for some Medicaid assistance because the additional income discovered is not that significant. Usually, the recipients will simply be reclassified and begin receiving a reduced amount of benefits rather than no benefits.

In addition, the five MDHS county workers PEER staff spoke to stated that if they discover, after a child has received benefits, that a child Medicaid recipient does not actually meet qualifications, they cannot rescind the reward of Medicaid benefits until the reward year has expired.

Other States' Income Verification Policies

Other states do not determine eligibility by stated income alone.

PEER staff contacted Human Services departments in Arkansas and Tennessee to determine their methods of income verification for Medicaid applicants. The workers

stated that they utilize pay stubs, W-2s, and other tax forms to verify income for applicants. Neither of the states uses self-declared income information alone to determine eligibility.

Change of DOM Income Verification Policy Effective June 1, 2002

Policy will require proof of income at time of application.

According to a May 16, 2002, Mississippi Department of Human Services Division of Economic Assistance bulletin, income verification requirements for health benefits (Medicaid and Children's Health Insurance Program) will change on June 1, 2002. For all Health Benefits applications received on or after June 1, 2002 and July 2002 renewals, all applicants/recipients of Health Benefits must provide documentary evidence of income (e.g., check stubs, wage forms) prior to an eligibility determination.

Medicaid Eligibility Quality Control Unit Review Process

From 1993 through 2000, the percentage of Mississippi Medicaid applicants who were incorrectly deemed eligible averaged 7.34%.

The Division of Medicaid (DOM) established the Medicaid Eligibility Quality Control unit (MEQC) within the Bureau of Program Integrity to determine the accuracy of Medicaid eligibility decisions made by Medicaid Regional Offices and the Department of Human Services. The unit uses two separate processes to review eligibility accuracy: active case review and negative case action review. The active case review determines whether persons receiving benefits are eligible for benefits, while the negative case action review evaluates application denials and case closures to determine if the negative action against the client was appropriate. Active case reviews are a two-part process which includes determining the actual number of ineligible cases and the misspent claims dollars associated with those cases.

The federal Centers for Medicare and Medicaid Services (CMS) determined, based on Medicaid's eligible caseload, that DOM's Quality Control Unit must review 350 active cases annually. Because DOM's Quality Control Unit operates on two six-month sample periods (October-March and April-September), the Unit must complete 175 case reviews in each period. DOM's Quality Control unit

randomly selects cases for review from all active cases in the sample period. This sample is generalizable to all Medicaid cases determined eligible by DHS and DOM. CMS approves DOM's sample plan prior to each sample period.

Field Investigation

DOM Quality Control Unit Investigators perform an independent audit on each case selected in the sample to determine accuracy of the eligibility determination. The Quality Control Unit Investigators conduct a much more thorough review of applicant income and resources than the reviews performed by DHS and DOM eligibility workers. For example, Quality Control Unit Investigators conduct recipient and collateral interviews, make field contacts with banks and employers, and research courthouse documents pertaining to property and vehicle ownership.

If an Investigator deems that a case is ineligible, he or she examines other Medicaid programs to determine if placement in one of these is appropriate. If the eligibility requirements for all other programs cannot be met, the case is ruled ineligible. At the completion of the review, DOM's Quality Control Unit sends a case status memorandum on all cases reviewed to the agency responsible for eligibility determinations, either DHS or DOM.

All cases which were found ineligible during the field investigation phase result in the state's case error rate. For the six-month sample period, the case in error rate results from all cases that are ineligible. For example, for the October 1999-March 2000 sample period, Quality Control Unit Investigators reviewed 205 cases and determined that 12 of those cases were in error, resulting in a case error rate of 5.85%.

Over the eight-year period from October 1992 to September 2000, sixteen samples were conducted, resulting in an average case error rate of 7.34% (refer to Appendix H on page 86).

Claims Payment Review

After completing the field investigation, the next phase of the review process is the claims payment summary. Medicaid payments for services rendered must be calculated for the review period to determine the raw payment error rate. The raw payment error rate as

determined by DOM's Quality Control Unit is based on misspent dollars and not on case errors. In order to tabulate the raw payment error rate, a Medicaid fiscal agent must identify any services rendered within the review period for which Medicaid had made a payment. The raw payment error rate examines the relationship between correctly paid claims versus incorrectly paid claims (ineligible recipients). For example using the six-month sample period October 1999-March 2000, four of the twelve sample cases found in error during the field investigation had associated claims in the review month, resulting in a raw payment error rate of 3.07%. For a case to be included in the raw payment error rate it must have associated claims during the sample period. If an ineligible case has no associated claims then it will not be included in the error rate.

Federal Requirements for Active Case Review (Case Errors versus Claims Errors)

The State Medicaid Manual published by the CMS lists the established guidelines states must follow when performing active case reviews. From these reviews states derive a lower limit rate which is reported to CMS to ensure continued federal funding of the state's Medicaid program. The lower limit rate is a weighted rate, based on DOM's total number of cases and the total error claims dollars for the six-month period.

The only statistical information required by the federal government is the lower limit rate. Computer software generates the lower limit rate which CMS uses to calculate any disallowance for the state. The law allows a 3% error tolerance per federal fiscal year. If the lower limit rate exceeds 3%, the state is subject to a disallowance of federal funds. The disallowance is based on the weighted annual rate, which is a combination of the rates for both six-month periods. For FY 2000 the raw payment error rate was 2.4489% and the lower limit error rate was .5280%.

Although MEQC follows all federal standards, the raw payment error rate and lower limit error rate tabulated for CMS only examines misspent dollars, not ineligible cases. For the six-month period of October 1999-March 2000 the case error rate was 5.85% compared to the raw payment error rate of 3.07%. Over an eight-year period from 1993 to 2000 the case error rate average was 7.34% and the average raw payment error was 1.91%. Utilizing the current statistical formula the raw error rate only reflects the ineligible cases that had claims associated with the case for the six-month period. During October 1999-March 2000, twelve cases were found in error, but only four were included in the raw payment error rate.

Ineligible Recipients

Although Medicaid meets all federal requirements, no oversight is present within DOM to ensure that ineligible recipients are removed from the Medicaid rolls.

The Division of Medicaid's MEQC Unit complies with all federal standards and continues to fall below the 3% lower limit rate allowed by federal guidelines. This lower limit rate examines misspent dollars due to claims payment in the six-month sample period. The case in error rate actually examines individuals who are ineligible for Medicaid benefits. Over the last eight years the average case in error rate was 7.34%. Over the eight-year period the case in error rate has ranged from 2.53% to 11.34%. Once the ineligible individuals are identified, a memo is sent to the agency responsible for determining eligibility. After the memo is sent, Quality Control Unit staff performs no follow-up to ensure that necessary changes have been made to recipients' benefits. The responsibility to remove ineligible recipients from Medicaid rolls lies with the agency that determined eligibility. There is no oversight authority to ensure that all ineligible recipients are removed from the rolls.

Pilot Program in Arizona

Pilot programs allow Investigators to sample target populations and take a problem-specific approach to quality control.

There is currently a trend among the states to utilize pilot programs to perform quality control responsibilities. Many states are abandoning the traditional active case review process for more innovative and problem-specific quality control reviews. CMS encourages all states to participate in pilot programs that replace or are performed in conjunction with traditional quality control reviews. Instead of submitting a sample plan, states will submit a waiver that explains the details of the proposed pilot plan. If approved the states then conduct the pilot program for the six-month review period. Currently forty-four states are participating in pilot programs; however, Mississippi continues to utilize traditional quality control measures.

Arizona

The State of Arizona is conducting a pilot program that focuses on long term care (LTC) programs and stratifies the sample into regions and metropolitan offices. Under the original pilot program, the LTC program was found to have a 6.06% case in error rate. The 1994 pilot program focused on identifying root causes of the case in error

rate, implementation problems and tracking of effective corrective action. For three days during each review period, a statewide corrective action team meets to discuss the quality control findings and to brainstorm new ideas for reducing error rate. The LTC case error rate has been reduced to 2.16%.

In 1998 the concept of Corrective Action Teams was expanded to cover regional offices, and now each regional office had its own Corrective Action Team. Nine teams analyzed the errors and deficiencies from each review period for their own regional and local offices. Each team developed their own Corrective Action Plan with proposed recommendations for improvements that could be implemented at the statewide or local administrative level. Arizona's focus shifted from simply tabulation of the state error rate to monitoring corrective action. Stratifying the sample by districts allows investigators to examine where problems and inconsistencies are occurring, and the regional Corrective Action Teams are useful in developing recommendations and implementation improvements.

Florida

CMS issued Florida a waiver to conduct a quality review of the KidCare program, a health insurance program for children from birth though age eighteen. The KidCare program uses a simplified application process in which a parent or guardian's income is self-declared and this figure is used to determine eligibility. A total of 1,391 cases were sampled during the sample period from October 2000 through September 2001. The purpose of the review is to evaluate the simplified application process utilized by the agency in determining the eligibility of individual KidCare children receiving Medicaid services.

Quality Control staff used only the information provided on the application to determine if income was listed correctly. There were no face-to-face interviews conducted with parents. The staff verified earned and unearned income through computer matching systems, phone calls to employers and data exchange systems. The three possible analyst findings included correct cases with full verification, correct cases with limited verification of one or more elements, or ineligible due to a technical or income error. If a case was found correct with limited verification, there was no way to prove with certainty that the income was correct. For example, if an employer did not contact the Quality Control Analyst the income received a limited verification.

The Quality Control Unit completed reviews on a total of 1,391 KidCare cases during the review period. Of the total completed reviews:

- 201 cases were found to be correct with full verification of all elements;
- 865 cases were found to be correct with limited verification;
- 283 cases were found to be in error; and,
- 42 cases were removed from the sample.

Based on the findings of the study from the sample reviewed, Florida concluded that over one-fifth of the Medicaid cases processed with KidCare simplified application forms were approved in error. In error cases, a majority of the applications were completed by the parent or guardian with incomplete or incorrect information regarding their earned income or unearned income.

Projected Medical Services Expenditures for FY 2003

Division of Medicaid's Revised FY 2003 Budget Request

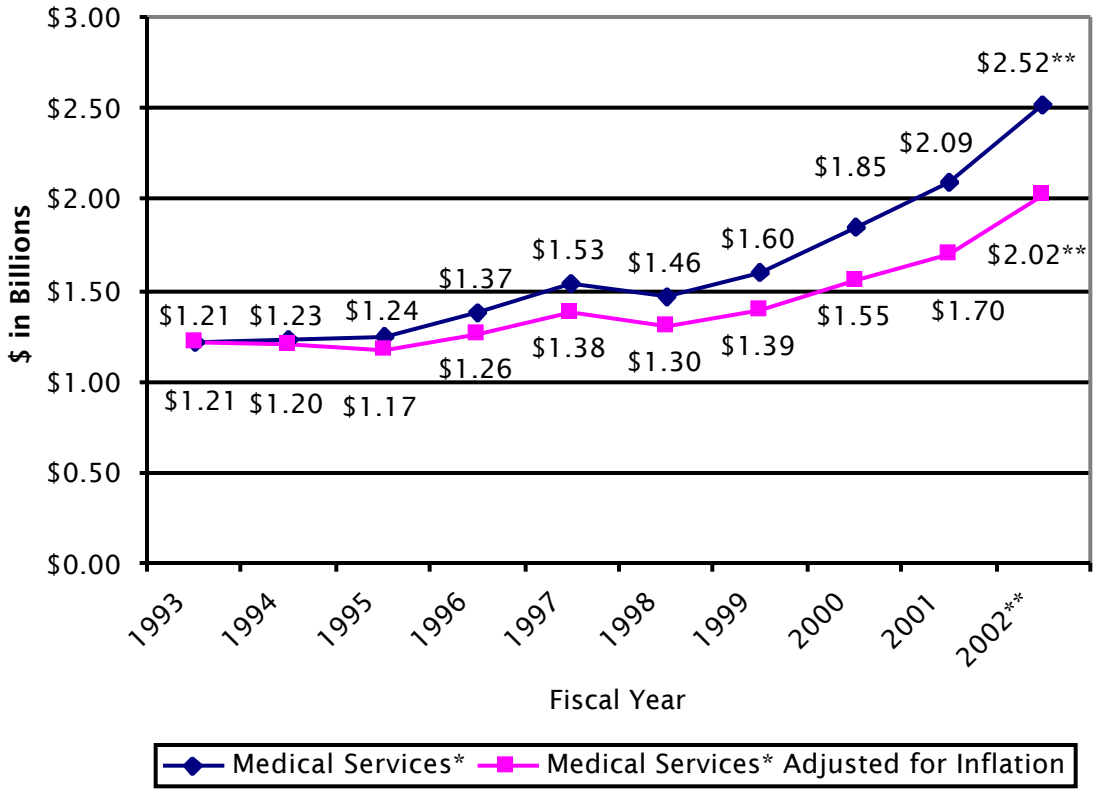
DOM's revised FY 2003 budget request may be overstated by $307 million. The 22.5% growth rate used in the revised request is based on the combined opinion of DOM management without clear supporting evidence of the external factors driving the growth rate above the statistically projected growth rate of 9.7%.

Exhibit 18 on page 52 shows growth in DOM medical services expenditures for the period FY 1993 through FY 2001. As shown in Exhibit 18, DOM medical services expenditures grew from $1.21 billion in FY 1993 to $2.09 billion ($1.7 billion adjusted for inflation) in FY 2001, or 40% when adjusted for inflation.

DOM is projecting a 25% growth rate in medical services expenditures for FY 2002. This unprecedented growth rate resulted in a shortfall of approximately $148 million that the Legislature addressed during its 2002 Regular Session. DOM is projecting a budget shortfall of $120 million for FY 2003, based on a revised funding request of $2.9 billion for medical services.

Exhibit 18

Medical Services* Expenditures of the Division of Medicaid for State Fiscal Years 1993 through 2001 and 2002 estimate**



* Excludes Children's Health Insurance Program (CHIP), Disproportionate Share payments, and Upper Payment Limits expenditures. For FY 2001, CHIP expenditures totaled $34,297,389, Disproportionate Share payments totaled $181,348,104, and Upper Payment Limits expenditures were $0.
** Based on ten months' actual medical services expenditures and PEER statistical trend analysis for the remaining two months of FY 2002.
SOURCE: PEER analysis of Department of Finance and Administration Annual Report of Budgetary Basis Expenditures for FY 1993-2001, Division of Medicaid legislative budget requests and financial reports, and Consumer Price Index data from the U. S. Department of Labor's Bureau of Labor Statistics.

PEER sought to determine the reasonableness of DOM's FY 2003 funding request, as discussed below.

Funding DOM based on the division's statistically projected growth rate of 9.7% reduces the division's revised FY 2003 federal and state funding request by a total of $307 million, of which $73 million is state funds.

Budget Request for FY 2002 and FY 2003

As shown in Exhibit 19, below in the fall of 2001, DOM estimated expenditures for medical services in FY 2002 would be $2.0 billion and submitted an FY 2003 budget request of $2.56 billion for the continuation of medical services in FY 2003.

Exhibit 19

Comparison of the DOM Estimated FY 2002 Expenditures and the FY 2003 Request Submitted to the Legislature in the Fall of 2001

Expenditures	FY 2002 Budget Estimate	FY 2003 Budget Request
Medical Services	$1,983,374,089	$2,562,089,000
Hospital Upper Payment Limits Program*	$150,000,000	$200,000,000
Disproportionate Share Payments*	$173,850,000	$165,158,000
CHIP II	$50,000,000	$55,000,000
Administration	$85,108,434	$116,441,767
Total	$2,442,332,523	$3,098,688,767
Funding		
General Funds	$249,486,308	$446,630,564
Federal Funds	$1,891,068,495	$2,352,394,803
Funds from Other Agencies	$85,000,000	$132,820,000
Medical Care Fund	$184,847,720	$134,913,400
Health Care Expendable Fund (Tobacco)	$31,930,000	$31,930,000
Total	$2,442,332,523	$3,098,688,767

* State matching funds for these programs are provided by participating hospitals.

SOURCE: Legislative Budget Requests and PEER analysis.

As shown in Exhibit 20 on page 54, in the spring of 2002, DOM increased its FY 2002 estimated expenditures for medical services to $2.4 billion and revised the FY 2003 budget request to include $2.9 billion for medical services.

Exhibit 20

Comparison of the DOM's Revised FY 2002 Expenditures and FY 2003 Request Submitted to the Legislature in the Spring of 2002

Expenditures	Revised FY 2002 Estimate	Revised FY 2003 Request
Medical Services	$2,394,258,065	**$2,932,966,130
Hospital Upper Payment Limits Program*	$100,000,000	$200,000,000
Disproportionate Share Payments*	$173,850,000	$165,158,000
CHIP II	$70,000,000	$55,000,000
Administration	$82,790,646	$105,898,684
	$2,820,898,711	$3,459,022,814
Funding		
General Funds	$397,486,308	$537,420,121
Federal Funds	$2,138,580,403	$2,621,939,293
Funds from Other Agencies	$113,730,000	$132,820,000
Medical Care Fund	$139,172,000	$134,913,400
Health Care Expendable Fund (Tobacco)	$31,930,000	$31,930,000
	$2,820,898,711	$3,459,022,814

* State matching funds for these programs are provided by participating hospitals.

** Composed of DOM's statistically projected medical services of $2.63 billion and a $307 million cushion.

SOURCE: DOM projections for FY 2003 and PEER analysis.

DOM officials stated the revisions for FY 2002 were based on projections for FY 2002 that included six months of actual expenditures for FY 2002. The revised projections for FY 2002 indicated an extraordinary growth rate of 25% for Medicaid's medical services programs. The revised budget request for FY 2003 incorporated the higher projected expenditures for FY 2002.

Statistical Trend Analysis Process

PEER reviewed DOM's revised FY 2003 budget request and determined that DOM used a statistical trend analysis process to calculate a portion of the revised FY 2003 budget request. DOM incorporates changes in state law and other factors affecting costs, such as changes in the number of Medicaid eligible beds or changes in payment factors, into the appropriate medical services category as

part of the statistical trend analysis process and refers to these factors as "add-ins."

Including "add-ins," DOM's statistical trend analysis projected $2.63 billion for the continuation of medical services expenditures for FY 2003, which represents a 9.7% growth rate for FY 2003 over the projected 25% growth in FY 2002. The Congressional Budget Office projects a federal FY 2003 (ending September 2003) Medicaid growth rate of 6%, followed by annual growth rates of 8% to 9% through 2012. Louisiana is projecting a growth rate in its Medicaid program of 10.9% for FY 2003.

However, in the combined opinion of DOM management, FY 2003's growth rate for medical services should be 22.5% due to the increasing number of eligibles, the increasing cost of prescription drugs, and the continuing effects of the recession. Therefore, DOM management added $307 million in additional "add-ins" to the revised FY 2003 request, which results in a growth rate of precisely 22.5% over the revised FY 2002 expenditures. DOM reported additional "add-ins" in four categories: Net New Eligibles, Prescription Drugs, Physician Services, and Hospital Services.

DOM Requested $307 Million in Funding above Statistically Projected Expenditures

As shown in Exhibit 21, below PEER analyzed the $307 million for FY 2003 which was requested in addition to DOM's statistically projected expenditures for FY 2003 and determined that it was composed of four categories: Net New Eligibles, Prescription Drugs, Physician Services, and Hospital Services.

Exhibit 21

Components of the $307 Million in Requested Funding that Exceeded Statistical Projections
Spring of 2002

Net New Eligibles	$213,060,000
Prescription Drugs	$20,000,000
Physician Services	$25,000,000
Hospital Services	$49,102,557
Total	$307,162,557

SOURCE: DOM projections for FY 2003 and PEER analysis.

Net New Eligibles Category

The addition of new eligible individuals to the Medicaid program in FY 2002 and FY 2003 and the expenses associated with the new eligible individuals are incorporated into the statistical trend analysis process. Therefore, a specific funding request related solely to the expenses associated with new eligible results in a double counting of expenditures.

Net New Eligibles accounts for $213 million of the total $307 million in funding which was requested above the statistically projected expenditures for FY 2003. According to DOM officials, this category represents the projected costs associated with approximately 35,000 new eligibles projected to be added in FY 2002 and an estimated 18,000 new eligibles projected to be added in FY 2003.

However, the 35,000 new eligibles of FY 2002 represent anyone added to Medicaid rolls during FY 2002, even if a person was later dropped from Medicaid rolls during FY 2002. The costs of the new eligibles for FY 2002 and the projected new eligibles for FY 2003 are incorporated into DOM's statistical trend analysis projections for FY 2003. Therefore, the Net New Eligibles category represents a double counting of expenditures.

Prescription Drugs Category

DOM added $20 million to the revised FY 2003 budget request based on the possibility that the cost of prescription drugs in FY 2002 may be $20 million higher than original estimates. Any potential shortfall in FY 2002 should be incorporated into the statistical trend analysis process and not added as an additional amount for FY 2003.

The prescription drugs category accounts for $20 million of the $307 million funding which was requested above the statistically projected expenditures for FY 2003. Per DOM officials, the revised FY 2002 projection for prescription drugs is approximately $20 million higher than the original FY 2002 projection. Therefore, DOM added $20 million to the revised FY 2003 request. However, a projected shortfall in FY 2002 should not be added to an FY 2003 request. For example, a projected increase in prescription drugs over the original projection should be incorporated into the statistical trend analysis and not added as another category to a future year's request. DOM's statistical trend analysis incorporated a 20% increase for prescription drugs in FY 2003 without the additional $20 million found in Exhibit 21.

Physician Services Category

DOM projected that expenditures for physician services in FY 2002 may be $35 million higher than originally projected. However, DOM departed from the methodology followed in the prescription drug category previously discussed and added $25 million to the revised FY 2003 budget request.

The physician services category accounts for $25 million of the $307 million funding which was requested above the statistically projected expenditures for FY 2003. Per DOM officials, the revised FY 2002 projection for physician services is approximately $35 million higher than the original FY 2002 projection. However, DOM only added $25 million to the FY 2003 revised request, which represents a departure from the methodology used to determine the prescription drug category discussed above. DOM's statistical trend analysis for FY 2003 incorporates an 8.8% increase for physician services without the $25 million found in Exhibit 21 on page 55.

Hospital Services Category

DOM projected that expenditures for hospital services in FY 2002 may be $32 million higher than originally projected. However, DOM added over $49 million to the revised FY 2003 budget request.

The hospital services category accounts for $49 million of the $307 million funding which was requested above the statistically projected expenditures for FY 2003. Per DOM officials, the revised FY 2002 projection for hospital services is approximately $32 million higher than the original FY 2002 projection. However, DOM added $49,102,557 to the FY 2003 revised request. DOM's statistical trend analysis for FY 2003 incorporates an 8.1% increase for hospital services without the $49 million found in Exhibit 21.

Conclusion

Funding DOM based on the agency's statistical trend analysis growth rate of 9.7% and excluding the $307 million of additional "add-ins" proposed by DOM management would reduce DOM's FY 2003 general funds needs by $73.4 million.

Recommendations

Contractual Services

1. To ensure the procurement of quality services at a cost effective rate, the Division of Medicaid should adopt internal procurement guidelines based on generally recognized elements of effective contracting (refer to page 5). DOM should pay particular attention to the development of guidelines addressing needs assessments, systematic review of proposals, and contract monitoring.
2. The Division of Medicaid should consider two options concerning its contract with the Mississippi Hospital Association:

   - Consider asking the Legislature to amend MISS. CODE ANN. Section 43-13-117 (1972) to remove the requirement that the Division of Medicaid contract with the Mississippi Hospital Association for the administrative support of the Medicare Upper Payment Limits program and Disproportionate Share Hospital program so that DOM could perform the task in-house. This would include the reclassification of several vacant positions in order to meet staffing needs.
   - The Division of Medicaid should reduce the contract price to include only those costs associated with the tasks required by state and federal law and regulations. The Division of Medicaid should complete a cost analysis for these services to ensure a fair and competitive contract price.

   If the division wants to pursue other special projects that could benefit the Medicaid program and its beneficiaries, they should define the tasks that they want to accomplish and issue a Request for Proposals to obtain the desired services in a competitive environment.

3. The Division of Medicaid should consider more cost effective ways of providing information on long term care alternatives to Medicaid beneficiaries. In considering whether to terminate its ten contracts with the Area Agencies on Aging, DOM should review the

efforts of the entities that already provide these services, such as eligibility workers and hospital and nursing home discharge planners and social workers. The Division of Medicaid should also consider requiring medical providers to share this information with Medicaid beneficiaries.

4. The Bureau of Compliance and Financial Review should seek more cost effective methods of eliminating the backlog of cost report reviews, including the possibility of discontinuing its use of multiple CPA firms and seeking individual contractors or a single CPA firm to perform these services.

5. The Division of Medicaid should consider a more cost effective method for providing peer review organization services including, but not limited to, the termination of its current contract with Healthsystems of Mississippi and performance of these required services in-house. If DOM chooses to continue the use of the current contractor, it should consider establishing a new method of payment other than a per member per month fee in order to control costs.

6. The Division of Medicaid should consider a more cost effective method of providing prior approval and drug utilization services, including discontinuing the contract with Health Information Designs. DOM could perform prior authorization services in-house by using current vacancies to allocate additional staff to the Bureau of Pharmacy. DOM's Bureau of Pharmacy could perform the drug utilization function by using data and reports generated by the Division's Surveillance and Utilization Review Subsystem and Medicaid Management Information Retrieval System and any additional reports that can be generated by the fiscal agent.

7. The Division of Medicaid should identify methods of controlling expenditures for the non-emergency transportation (NET) program, including, but not limited to:

   a. Elimination of staff

      Other states operate their NET programs with limited staff. For example, Louisiana's dispatch contractor operates the NET program with a staff of thirty-six including twenty to twenty-five call center unit staff. Louisiana utilizes three state staff to monitor the contract and assist with audit functions. Alabama operates their program with a staff of twenty employees including ten regional coordinators, one call center supervisor, one call center secretary, three

call center operators, two directors, one clerical employee, and two inmates for office support. DOM should consider reducing the number of NET staff by reducing the number of NET regions to six regions with eighteen NET Coordinators. This could result in additional general funds savings of $464,062.

b. Implementation of retrospective reviews of claims

DOM should implement a retrospective review of claims to ensure that the beneficiary actually attended his/her scheduled medical appointment. Alabama conducts a retrospective review from a sample selected each month.

c. Establishment of monthly reporting requirements

DOM should establish monthly reporting requirements to identify process improvement.

d. Building of relationships with other transportation entities

DOM's Bureau of Compliance and Financial Review should work with public transportation companies to provide transportation services to medical appointments for those beneficiaries who are physically able to use these services. The division should also work with various community transportation resources who could potentially transport beneficiaries for reduced rates or rates that are lower than those of current group providers.

e. Identification of new methods of provider reimbursement

Current group provider rates are not cost efficient. DOM should identify a new method of reimbursement for transportation services. States such as Louisiana have capped rates based on the miles traveled, whereas Alabama uses a voucher system and reimburses for miles traveled.

f. Enhancement of NET system capabilities

DOM's Bureau of Compliance and Financial Review should work with the Division's Information Technology staff to enhance the capabilities of the NET computer system. The system should be capable of tracking information that would assist the division in controlling costs and formulating policy. The Bureau of Compliance and Financial Review should be able to generate these reports on request.

g. Amendment of NET policy to eliminate the ability of providers to file claims over a twelve-month time period

The Division of Medicaid should amend the requirement that allows the provider twelve months to file claims. The provider should be given a shorter time frame in which to file claims. All group providers are required to file claims electronically, so this should not be an imposition to the provider. The state of Texas requires providers to file claims within ninety-five days of appointment confirmation. Texas' group providers' contracts state that a provider waives his right to file the claim after the ninety-five days have passed. This will provide the agency with a more accurate accounting of program costs.

Eligibility Determination Process

8. DOM should develop cost effective options and procedures for receiving information from the IRS for verification of eligibles' income. DOM should report these options and the associated cost of each option to the Legislature by the beginning of the 2003 Regular Session.

9. DOM eligibility workers or Medicaid Eligibility Quality Control unit investigators should conduct random samples to verify the declared assets and search for undeclared property of Medicaid applicants at the time of application.

10. The Medicaid Eligibility Quality Control unit should investigate the use of pilot programs for identifying ineligible recipients, such as those programs implemented in Arizona and Florida. These programs sample target populations in high cost areas, such as long term care.

11. The Medicaid Eligibility Quality Control unit should establish a procedure for follow-up on cases they determine to be ineligible in order to ensure local offices take appropriate action to terminate benefits. A case review should be completed within ninety days of referral to the local office.

Medical Services Expenditures

12. The Legislature should require the Division of Medicaid to provide documentation to support the agency's claimed need for funding to support a 22.5% growth rate in FY 2003. In the event that the Division cannot provide documentation detailing the specific external factors driving a 22.5% growth rate, the Legislature should fund program growth in line with the 9.7% projection derived from the Division of Medicaid's own statistical model.

Appendix A: Categories of Individuals for Whom the Division of Medicaid, Department of Human Services, and the Social Security Administration Determine Eligibility

Division of Medicaid

- Persons in medical facilities who would qualify for Supplemental Security Income (SSI) except for their institutional status
- Persons in institutions who are eligible under a special income level who remain institutionalized for 30 consecutive days or longer
- Persons who are age 64 or over or disabled whose income does not exceed 100% of the federal poverty level and whose resources do not exceed $3,000 for an individual and $4,000 for a couple
- Qualified Medicare Beneficiaries who are entitled to Medicare Part A, whose income is below 100% of the federal poverty level. There is no resource test for this group, which is eligible for Medicare cost sharing only.
- Certain former SSI eligibles who are "deemed" Medicaid eligible because of specified circumstances
- Certain qualified working disabled persons who are only eligible for Medicaid to pay their Part A Medicare premiums
- Certain disabled children under age 18 who live at home but who would be eligible if they lived in a medical institution as certified by DOM
- Specified Low-Income Medicare Beneficiaries who are entitled to Medicare Part A whose income does not exceed 120% of the federal poverty level. There is no resource test for this group. The only benefit paid by Medicaid for this group is the Medicare Part B premium. (These individuals must be entitled to Part A Medicare benefits under their own coverage, as Medicaid does not pay the Part A premium for them.)
- Individuals receiving hospice services who would be eligible for Medicaid if they were living in a Medicaid-certified institution as certified by DOM

- Individuals who meet the qualifications for participation in the Home and Community-Based Waiver Programs whose income and resources do not exceed prescribed limits for participation

- Working disabled individuals whose earnings do not exceed 250% of the federal poverty level and whose unearned income does not exceed 250% of the federal poverty level and whose unearned income does not exceed the SSI limit. Disabled workers qualify for full Medicaid benefits but may have to pay a premium to buy into Medicaid if earnings exceed 150% of the poverty level

- Qualifying Individuals who qualify for payment or partial payment of their Medicare Part B premium, provided the individual has Medicare Part A. QI-1s can have income between 120% to 135% of the federal poverty level for payment of their Medicare Part B premium. QI-2s can have income from 135% to 175% of the federal poverty level for partial payment of Medicare Part B premiums. There is no resource test for this group.

Department of Human Services

The Mississippi Division of Medicaid's Annual Report for Fiscal Year 2000 states that the Mississippi Department of Human Services determines eligibility for the following categories:

- Low-income families with children who receive Medicaid-only or TANF (Temporary Assistance for Needy Families)

- Children in licensed foster homes or private child-care institutions for whom public agencies in Mississippi are assuming financial responsibility

- Children receiving subsidized adoption payments

- Children under age six whose family income does not exceed 133% of the federal poverty level

- Pregnant women and children under age one whose family income does not exceed 185% of the federal poverty level. Infants born to Medicaid-eligible mothers are eligible for the first year of the child's life, if the child resides with the mother. Eligible pregnant women remain eligible for 60 days after the pregnancy ends.

- Children under age 19 whose family income does not exceed 100% of the federal poverty level.

Children born before October 1, 1983, who are under age 19 are eligible under the Children's Health Insurance Program (CHIP) Medicaid expansion.

- Uninsured children under 19 whose family income does not exceed 200% of the federal poverty level. Children who meet this criteria are eligible for health insurance coverage under the Children's Health Insurance Program (CHIP)

Social Security Administration

MISS. CODE ANN. Section 43-13-115 gives the Social Security Administration authority to make eligibility determinations for certain pools of individuals.[2] The Office of the Social Security Administration makes eligibility determinations for the following group:

- Persons who are age 65 or over, blind, or disabled who receive Supplemental Security Income (SSI) cash assistance

[2] Public Law 92-603 gave states the option to grant Medicaid to all individuals receiving Supplemental Security Income (SSI). If states chose this option they were designated 1634 states because Section 1634 of the Social Security Act allows for the Secretary of Health and Human Services to enter into an agreement with a state (upon that state's request) whereby the Social Security Administration makes eligibility determinations for certain aged, blind and disabled individuals. Under a 1634 agreement an SSI application is also an application for Medicaid.
In the 1980 Session of the Mississippi Legislature, via the passage of Senate Bill 2118, Mississippi decided to grant Medicaid to all persons who receive SSI benefits. As a result of Mississippi becoming a 1634 state, the Social Security Administration (SSA), which is the federal agency responsible under the federal Social Security Act for determining who is eligible for SSI, gained a role which directly affected those who would also qualify for Medicaid benefits.

Appendix B: Ranking by State of Administrative Cost per Enrollee for Federal FY 2001*

State	Number of FY 2001 Enrollees	Total Medicaid Expenditures	State and Local Administration	Admintrative Cost per Enrollee	U. S. Rank
New Hampshire	77,600	$922,260,770	$49,011,939	$632	1
Michigan	1,161,600	$7,892,072,640	$673,375,527	$580	2
Washington	802,000	$4,769,737,694	$464,013,447	$579	3
Oregon	389,300	$2,877,746,620	$219,388,229	$564	4
Alaska	84,800	$623,849,658	$47,263,457	$557	5
Montana	74,400	$522,262,125	$39,904,721	$536	6
North Dakota	46,300	$429,684,824	$23,266,231	$503	7
Utah	143,700	$905,205,923	$71,485,808	$497	8
Wyoming	42,400	$264,187,162	$20,778,235	$490	9
Vermont	94,700	$647,676,351	$46,209,258	$488	10
Minnesota	498,000	$4,076,897,096	$241,026,517	$484	11
Connecticut	353,700	$3,379,452,846	$165,604,760	$468	12
Illinois	1,446,700	$8,421,128,340	$656,516,988	$454	13
Maryland	531,100	$3,494,364,509	$237,787,627	$448	14
Kansas	204,900	$1,774,905,778	$88,495,234	$432	15
Delaware	100,500	$634,627,717	$42,653,471	$424	16
Rhode Island	164,000	$1,255,255,995	$67,375,176	$411	17
Maine	182,100	$1,387,289,958	$71,766,795	$394	18
Idaho	136,400	$745,855,247	$52,649,649	$386	19
New York	2,849,800	$32,454,578,319	$1,087,113,680	$381	20
Wisconsin	534,500	$4,178,643,338	$202,500,424	$379	21
Iowa	230,100	$1,750,634,100	$83,710,399	$364	22
Texas	1,847,300	$12,240,275,240	$656,595,682	$355	23
Colorado	301,400	$2,246,846,225	$104,816,374	$348	24
Dist. Of Col.	112,700	$1,019,107,672	$39,166,567	$348	25
California	5,638,600	$25,783,182,157	$1,912,661,153	$339	26
Virginia	487,700	$3,201,548,208	$164,701,821	$338	27
Nevada	125,100	$715,657,410	$41,319,522	$330	28
Oklahoma	454,600	$2,170,592,307	$149,559,238	$329	29
Massachusetts	965,500	$6,935,485,066	$315,960,095	$327	30
Nebraska	199,000	$1,252,239,800	$65,002,223	$327	31
Pennsylvania	1,464,300	$11,386,112,560	$477,769,414	$326	32
Ohio	1,337,500	$8,857,117,272	$423,705,111	$317	33
Indiana	632,100	$4,199,897,954	$191,085,097	$302	34
North Carolina	967,500	$6,429,406,966	$278,725,379	$288	35
Arizona	550,800	$2,823,419,372	$158,158,044	$287	36
Georgia	970,400	$5,314,515,759	$277,430,878	$286	37
New Jersey	848,700	$7,361,441,113	$237,787,125	$280	38
Florida	1,783,800	$9,046,039,737	$488,243,434	$274	39
Missouri	831,600	$4,963,312,151	$218,348,725	$263	40
West Virginia	268,500	$1,617,888,766	$69,489,949	$259	41
Arkansas	382,600	$1,947,212,803	$95,036,257	$248	42
Hawaii	165,000	$675,387,513	$40,605,543	$246	43
New Mexico	319,300	$1,544,568,698	$77,150,962	$242	44
Alabama	592,900	$2,987,666,155	$112,293,202	$189	45
South Carolina	631,200	$3,120,234,851	$100,847,623	$160	46
South Dakota	83,500	$477,246,104	$12,790,635	$153	47
Kentucky	630,200	$3,398,140,533	$94,086,870	$149	48
Louisiana	742,700	$4,309,670,892	$107,688,302	$145	49
Mississippi	**555,700**	**$2,516,554,645**	**$77,574,664**	**$140**	**50**
Tennessee	1,464,000	$5,666,150,234	$164,838,081	$113	51
Totals	35,502,800	$228,026,089,368	$11,867,746,776	$334	

* The federal fiscal year end is September.

SOURCE: HCFA Summary of State Total Expenditures by Program Data for FY '01 based on CMS-64 State Reporting & enrollee "point-in-time" data based on Medicaid Program Enrollment Update thru Sept. 2001 reported by states to Health Management Associates & released June 2002 by the Kaiser Commission on Medicaid & the Uninsured

Appendix C: Summary of Contracts Reviewed by PEER

Contract: fiscal agent

Contracting Party: ACS/Consultec

Annual Contract Expenditures: $24,127,040 under the previous provider, EDS; Consultec's charge is $1.656 per Medicaid enrollee per month for operating expenses.

Contract Expiration Date: December 31, 2005

Contract Purpose:

MISS. CODE ANN. Section 43-13-123 (2) authorizes the Division of Medicaid to contract with a company to perform fiscal agent services. These services include claims processing, audits, data processing and other related functions to maintain, enhance and run the Medicaid Management Information System. The contractor is also responsible for provider enrollment, recipient education, enrollment in the primary care case management program, the Managed Care Hotline and Enrollment Line.

Contract: non-emergency transportation

Contracting Party: 22 different group providers (e.g., Lefleur's Transportation)

Annual Contract Expenditures: $17,298,414 ($13 million of the total is paid to group providers)

Contract Expiration Date: June 30, 2002

Contract Purpose:

DOM contracts with group providers to transport Medicaid beneficiaries to medical appointments. The state of Mississippi operates the NET program as an administrative service, which allows for a 50% federal matching rate. The administrative option allows the state to restrict the beneficiary's freedom of choice in selecting a transportation provider in an effort to control costs.

Contract: peer review

Contracting Party: Louisiana Health Care Review (Healthsystems of Mississippi)

Annual Contract Expenditures: $6,613,528; per member per month fee of $1.0587 for year 1 of the contract, $1.0808 for year 2 of the contract and $1.0980 for year 3 of the contract

Contract Expiration Date: June 30, 2004

Contract Purpose:

The purpose of this contract is to provide utilization and peer review services to DOM relative to inpatient hospital services, swing bed facilities, psychiatric residential treatment facilities, private duty nursing services, home health services, and durable medical equipment. The contractor reviews inpatient hospital care and monitors admissions, length of stay and quality of care to Medicaid patients. The contractor monitors utilization trends and quality of care patterns evidenced by analysis of abstracted hospital discharges and on-site monitoring.

The contractor employs 63 staff including nurses, contract physicians and support staff. The contractor reviews the condition and the suggested treatment and compares it to standard Inter-Qual criteria to ensure that the treatment is necessary for the condition. Work volume for FY 2001 totaled 159,508 reviews, or an average of 13,292 reviews per month.

****

Contract: administration of Medicare Upper Payment Limits and Disproportionate Share Hospital programs

Contracting Party: Mississippi Hospital Association

Annual Contract Expenditures: $5,000,000

Contract Expiration Date: June 30, 2004

Contract Purpose:

The purpose of this contract is to administer the state's Disproportionate Share Hospital program and the Medicare Upper Limits Payment program. The Medicare Upper Payment Limits (UPL) program is a federal program that provides subsidies for the cost of treating Medicaid

recipients. Under UPL regulations, the federal government provides matching funds to the state so it can make additional reimbursement to hospitals. The UPL regulations allow states to make payment to hospitals for Medicaid services based on an estimate of what Medicare would have paid for the same services, resulting in higher reimbursement.

Federal statute requires that states consider the special payment needs for hospitals that service a disproportionate number of uninsured patients when determining payment rates for hospital care. Through the Disproportionate Share Hospital Program, the federal government provides matching funds for state Medicaid expenditures to assist states in reimbursing hospitals.

****

Contract: pharmacy benefits management/drug utilization review

Contracting Party: Healthsystems of Mississippi

Annual Contract Expenditures: $1,691,667; reflects average annual expenditure for three year contract of $5,075,000

Contract Expiration Date: December 31, 2004

Contract Purpose:

The services will assist DOM in ensuring the appropriate utilization of high cost, high risk medications. Prior authorization services include prior authorization for drugs listed on the non-preferred drug list. Due to 2002 legislative action, prior authorization also includes prior approval for each Medicaid recipient's sixth and seventh prescription. The purpose of the prior authorization program is to promote the most appropriate utilization of high risk, high cost, or problem prone medication. Drug utilization review includes pro-drug utilization reviews and retro drug utilization reviews. Pro-drug utilization review includes the screening of drug claims on-line against predetermined medical standards or criteria and promotes clinical safety, therapeutic efficacy and appropriate drug use with the goal of initiating appropriate interventions. Retrospective drug utilization review identifies trends and patterns of drug use that are inconsistent with optimal quality of care and contemporary standards of care.

The contractor employs a pharmacist, a registered nurse, a licensed practical nurse, and hired staff from an

employment agency to serve as pharmacy technicians. Staff is expected to total 15 to 20 employees.

****

Contract: long term care alternatives

Contracting Party: Mississippi's ten Area Agencies on Aging

Annual Contract Expenditures: $943,720

Contract Expiration Date: June 30, 2002

Contract Purpose:

The contractor provides information to Medicaid beneficiaries and applicants regarding long term care alternatives. Pursuant to this contract, each Area Agency on Aging employs a social worker and a clerical support person, in either a full-time or part-time capacity.

****

Contract: cost report review

Contracting Party: 12 CPA firms

Annual Contract Expenditures: $ 908,977

Contract Expiration Date: Multiple dates – June 30, 2002, and October 31,2001

Contract Purpose:

DOM conducts audits of long term care facilities, rural health care facilities and qualified health care centers to verify the accuracy and reasonableness of the financial and statistical information contained in Medicaid cost reports. The contractors assist DOM in conducting cost report financial reviews for selected facilities enrolled in Mississippi's Medicaid program.

****

Contract: medical coding

Contracting Party: Information and Quality Health Care Service

Annual Contract Expenditures: $50,000

Contract Expiration Date: June 30, 2002

Contract Purpose:

The purpose of this contract is to check procedure codes against diagnosis codes on medical documentation submitted to DOM by its providers and to assist in training providers on how to correctly complete the required paperwork for claims submittals.

****

Contract: CPA consulting

Contracting party: Thames and Associates

FY 2001 Contract Expenditures: $75,000

Contract Expiration Date: November 30, 2001

Contract Purpose:

The purpose of this contract was to prepare desk reviews of Medicaid Cost Reports filed by DOM medical service providers (nursing facilities, intermediate care facilities for the mentally retarded, psychiatric residential treatment facilities, home health agencies, and hospitals) to determine compliance by the respective facilities with the Medicaid state plan. The contractor reviews the work completed by DOM's Bureau of Reimbursement before the reports are sent to the provider.

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Contract: Children's Health Insurance Program outreach assessment

Contracting party: Pathfinders

FY 2001 Contract Expenditures: $50,000

Contract Expiration Date: December 31, 2001

Contract Purpose:

The purpose of this contract was to provide an analysis of the effectiveness of DOM's outreach activities in facilitating enrollment in the Children's Health Insurance Program. The contractor collected, analyzed and interpreted DOM outreach data in order to identify "best practices" and "lessons learned."

****

Contract:	management/training consulting
Contracting party:	Whitten Group
Annual Contract Expenditures:	$15,000
Contract Expiration Date:	June 30, 2002

Contract Purpose:

The purpose of this contract is to provide consulting services for the Division of Medicaid to assist with the reorganization efforts and training.

SOURCE: Analysis of DOM contracts and DOM expenditure data

Appendix D: Personal Services Contract Review Board Contracting Regulations, by Element of Effective Contracting Reviewed by PEER

ELEMENT	PERSONAL SERVICES CONTRACT REVIEW BOARD REGULATION
1: Needs Assessment	
2: Request for Proposals or Qualifications	·Regulation 3-202(2) requires that an Invitation for Bids include a purchase description and all contractual terms and conditions applicable to the procurement, including bid submission requirements, evaluation factors and delivery or performance standards. ·Regulation 3-204.03.01 requires no fewer than 3 bids for services greater than $50,000 and not exceeding $100,000. ·Regulation 3-204.05 states that the head of a purchasing agency must adopt operational procedures for making purchases less than $50,000. ·Regulation 2-103(2) states that contracts greater than $100,000 require approval by the Personal Services Contract Review Board.
3: Notice of Intent	·Regulation 3-206.06.1 states that Invitations for Bids or Notices of Availability of Invitations for Bid shall be mailed or otherwise furnished to a sufficient number of bidders for the purpose of securing competition. ·Regulation 3-202.06.2 requires agencies to publicize for procurement of services greater than $100,000. It also requires agencies to advertise in a newspaper published in a county or municipality in which the agency is located. Although it is not required, the Contract Review Board recommends that the agency advertise in a newspaper of general circulation in the area pertinent to the procurement, in an industry publication, and in a government publication designed for giving public notice.
4: Systematic Review of Proposals	·Regulation 3-202.14.1 requires the agency to award the contract to the lowest responsible bidder whose bid meets the requirements and criteria set forth in the request or invitation. No bid shall be evaluated for any requirement that is not disclosed in the request or invitation. ·Regulation 3-202.13.2 states that the agency may use a numerical rating system in order to evaluate proposals or bids, but they are not required.
5: Written Contract	·Regulation 3-102.08 states that all contracts for services shall include a list of contract specifications or deliverables. The description of services to be performed should be results, not procedure oriented, and should at a minimum include what service is to be performed, when the service is to be performed, how frequently the service is to be performed, where the service is to be performed, how much it will cost, and why the service is necessary.
6: Contract Monitoring	·Regulation 5-102 states that, in conformity with sections 7-7-3 (6)(d) and 25-9-12(3) of the Mississippi Code (rev.1997), each state agency (through its governing board or executive head) should maintain continuous internal audit covering the activities of such agency affecting its revenues and expenditures for personal and professional service contracts. It also requires that each maintain an internal system of pre-auditing claims, demands and accounts against the agency to adequately ensure that only valid claims, demands and accounts will be paid.
	SOURCE: PEER analysis of the State Personnel Board's Personal Services Contract Review Board contracting regulations

Appendix E: Problems in DOM's Non-emergency Transportation (NET) Program Identified by PEER

PEER's review of NET data and interviews with NET coordinators revealed the following problems:

- Some of the point of trip origin data maintained in the NET system is inaccurate, which prevents DOM from properly analyzing costs of providing non-emergency transportation by length of trip. DOM staff told PEER that the problem arose when data from DOM's Medicaid Eligibility Determination System (e.g., a recipient's change of address) overrode NET Transaction Summary data.

- The Division of Medicaid's provider manual states that NET services are available only as a last resort. The provider manual requires NET Coordinators to use other resources before procuring the services of a NET provider. In interviews, NET Coordinators stated they have been instructed by the Bureau of Compliance and Financial Review that if the person seeking transportation services is a Medicaid beneficiary, then he or she is to receive NET services regardless of whether or not other resources may be available.

- There is no effort on the part of the division to forge relationships with community providers in order to utilize these community resources. PEER surveyed a sample of community resources and public transportation entities and found there are transportation services available that are free of charge for the elderly and disabled population. Reservation time frames range from 24 hours to 14 days in advance. These services are either free or available for a minimal charge to those who qualify. There are also facilities that transport the elderly and disabled who have scheduled appointments at their facility. Of course many of these resources place restrictions on the times of day they will provide transportation and recommend that appointments be made in the morning. Since this transportation is deemed non-emergency, beneficiaries can be flexible when scheduling their appointments in order to take advantage of community transportation resources.

- DOM should take advantage of the public transportation services available in urban areas. According to NET Coordinators, beneficiaries do

not want to use public transportation services because they like the "door to door" service they receive. If a beneficiary is physically able to use public transportation, then he or she should be required to use public transportation. If a beneficiary states he or she cannot use public transportation, then medical certification should be required. DOM should work closely with public transportation entities across the state to devise a method of payment for these services such as issuance of a special bus pass for Medicaid beneficiaries which could be mailed to beneficiaries prior to their medical appointments.

- NET Coordinators have no way of identifying all of the medical services available in their communities and in surrounding communities. With no way to identify medical providers, the agency has no method of determining if beneficiaries could receive medical treatment locally or in a surrounding county, thereby reducing transportation costs. NET Coordinators are required to verify that a local medical provider is used for medical treatment when available. This includes facilities and practitioners. For example, a beneficiary may not choose to see a practitioner located outside his or her community when there is a practitioner available locally. With the assistance of health care entities such as the Mississippi State Board of Medical Licensure, DOM could also compile a list of physicians, their specialties and locations for use by NET Coordinators in determining if there are physicians available within a closer radius. This could eliminate excessive transportation costs.

- The provider contracts state that the provider has 12 months to file claims. The 12-month time period prevents the division from identifying true costs of program operations. Claims submitted for payment during one fiscal year may actually be claims for services performed in the current and previous fiscal year.

- Group provider intra-city transportation routes account for 25% to 30% of monthly transportation costs, and group provider rates are not cost effective for intra-city transportation. For example, in July 2001, the Division of Medicaid spent $315,045 for local transportation. For 9,879 one-way trips, that is an average of $32 per local trip regardless of the mileage. The exhibit below provides examples of local transportation routes and the associated costs for July 2001.

Vendor Reimbursed	City Location of Reimbursed Trip (Within City)	Number of One-way Trips	Actual Rate per Local One-way Trip	Amount Paid for All Local Trips in July 2001
LeFleur of Natchez	Jackson	1,243	**$19**	$23,617
LeFleur of Tupelo	Tupelo	162	**$25**	$5,670
Delta Transfer	Grenada	462	**$34**	$15,402
Southaven Taxi	Southaven	74	**$45**	$3,330
Washington Transportation	Woodville	99	**$50**	$4,950
King Charter Service	Lucedale	100	**$19**	$1,900
Cletus Brewer, Inc.	Laurel	859	**$28**	$24,052
Medstat, Inc.	Greenwood	657	**$28**	$18,396
NTC Transportation	Greenville	1,661	**$30**	$49,830
Transfer of Central MS	Rolling Fork	58	**$44**	$2,552
J&E Cab Company	Clarksdale	1,214	**$40**	$48,560
Magnolia Ambulance Company	Indianola	220	**$40**	$6,600
Coast Transfer, Inc.	Picayune	146	**$35**	$5,110
Holmes Transportation	Columbus	357	**$29**	$10,353
Regency Transportation	Magee	99	**$39**	$3,861
King's Daughter's Medical	Tylertown	109	**$50**	$5,540
JD&M Transportation	Aberdeen	165	**$29**	$4,785

- By identifying excessive costs for local transportation, the agency could have looked to the best practices of other states, including Alabama and Louisiana, to see if these practices could be applied in Mississippi. PEER compared these states' methodologies and found for intra-city transportation provided by group providers:

  the Louisiana model, which uses capitated rates, could potentially save the state $241,000 to $278,000 per month ($120,000 to $139,000 in state funds)

  the Alabama model, which uses a voucher system, could potentially save the state $265,650 per month ($133,000 in state funds).

- By identifying excessive costs for transportation to dialysis, therapy, and other repetitive treatments, DOM could have looked at options available such as capping rates for repetitive trips in order to control costs. In July of 2001, DOM completed 13,075 trips classified as repetitive trips for a total

cost of $455,181. In Louisiana, repetitive trips that exceed 10 per month are capped at the regular rate multiplied by 10. Repetitive trips that exceed 20 per month are capped at the regular rate multiplied by 20 in an effort to save money and still provide the necessary transportation.

SOURCE: PEER analysis of DOM contracts, NET program data, NET coordinator interviews; interviews with NET program coordinators in Louisiana and Alabama; and Centers for Medicare and Medicaid Services data

Appendix F: Explanation of Potential General Fund Savings

NET Contracts

	Annual Contract Expenditures	Annual General Fund Expenditures	Matching Rate (State/Federal)	FY 2003 Potential General Funds Savings
Non-Emergency Transportation Contracts	$17,298,414	$8,649,207	50/50	$5,000,000

Alabama and Louisiana use models, which allow them to spend considerably less in the operation of their transportation programs. These two states have similar Medicaid populations (Alabama has approximately 700,000 eligibles and Louisiana has approximately 800,000 eligibles). Alabama expends approximately $5 million annually and Louisiana expends an average of $6-8 million annually for NET services. If the Division of Medicaid would utilize aspects of these models (e.g., rates based on mileage, capitated rates, capitated rates for repetitive trips) the agency could save approximately $5 million in general funds.

This figure comes from reviewing FY 2001 expenditures. If you subtract the average of the other states' annual expenditures from DOM's annual expenditures, it results in total savings of approximately $10 million. With 50/50 matching, this would result in savings of $5 million in general funds. Mississippi should be able to operate its transportation program within the amounts expended by Alabama and Louisiana.

The Bureau of Compliance and Financial Review should also reduce the number of NET Coordinators from 48 to 18. DOM could use the remaining 30 positions to fill positions needed for the PRO and PBM/DUR contracts (this is approximately $900,000 including salaries and fringe benefits). DOM could divide the state into six districts based on utilization, each with three NET Coordinators. In FY 2001 only 21,645 eligibles received NET services. According to the Request for Proposals, in FY 2000 group providers completed 296,501 trips. With 18 NET coordinators, this is equivalent to eight reservations per hour (excluding individual provider reservations). Alabama and Louisiana operate their programs with less staff (Alabama, 20 employees, and Louisiana, 39 employees) and still maintain an acceptable level of service while controlling costs.

The Bureau of Compliance and Financial Review could operate this program with 18 NET Coordinators and continue to utilize the 13 program office staff. However, the program office staff should be re-organized to ensure that adequate staffing is designated to perform monthly retrospective reviews of claims as a method of containing costs.

PRO Contract

	Annual Contract Expenditures	Annual General Fund Expenditures	Matching Rate (State/Federal)	FY 2003 Potential General Funds Savings
Peer Review Organization Contract	$6,613,528	$1,581,295	.2391/.7609	$1,358,931

Based on the tasks required to provide this service, it could be performed in-house for a cost of $930,600, or $222,363 of general funds including salary and fringe benefits. The

tasks associated with this contract include using standard criteria to determine if medical services are necessary and appropriate. This includes reviewing documentation received from medical providers and comparing the data to the national standard. Reviews include those of inpatient facilities, swing bed facilities, psychiatric residential treatment facilities, PDNs, home health services, and DMEs. Nurses review documentation provided to the PRO staff to determine if the course of treatment matches the standard medical criteria for the condition. If nurses are unable to determine if the treatment correlates to the diagnosis, they refer the case to a physician for resolution.

The contractor employs 63 staff including 44 professional staff, 14 technical staff and 5 vacancies. Professional staff includes contract physicians, registered nurses, licensed practical nurses, accounting staff, human resources staff, and various levels of management. To operate this service in-house no technical staff is required because the division can utilize the Bureau of Systems Management for technical support. This support could include assistance in tracking cases, report generation, and generation of other documents such as approval and denial letters. There is also no need for human resources staff and accounting staff because support for payroll and human resources can be provided by the Bureau of Human Resources. This function could be placed within the Bureau of Program Integrity or within the Bureau of Policy and Medical Services. There is adequate management available within either bureau to oversee the peer review organization services.

There is a need for physicians, nurses, medical records support staff and clerical office support staff in order to perform the responsibilities associated with this contract. The following positions are necessary, and costs associated with these positions were calculated based on the minimum starting salary: two physicians, fourteen nurses, two medical records support staff, two clerical office support. All positions are full-time positions.

The PRO completed 159,508 reviews in FY 2001 for an average of 13,292 per month, or 3,067 per week. With 14 nurses available to review documentation, a nurse could review approximately 44 per day.

Administrative Support Contract for the Medicare Upper Payment Limits program and the Disproportionate Share Hospital program

	Annual Contract Expenditures	Annual General Fund Expenditures	Matching Rate (State/Federal)	FY 2003 Potential General Funds Savings
Administrative Support contract for the Medicare Upper Payment Limits Program and the Disproportionate Share Hospital Program	$5,000,000	$0	50/50	($61,875)

Calculations of hospital assessments, UPL payments and DSH payments are formula driven. States such as North Carolina and Alabama do not contract out these services.

Alabama uses one staff member and readily available software to calculate UPL and DSH payments. Louisiana uses an accountant and software to calculate the UPL and DSH for hospitals, and they use a contractor to calculate UPL for their long term care facilities for less than $100,000 per year. The accountant maintains accurate records regarding hospital costs and utilization in order to calculate DSH and UPL payments. A large responsibility is converting the Medicaid unit of payment to the Medicare unit of payment, the DRG. States surveyed indicate that computers are a good tool for administering this program.

The Accountant III position meets the description of tasks to be performed for the UPL and DSH contract. The average salary range is $30,000 to $52,000. In order to attract and retain the level of experience needed for this position, the cost for performing this service is based on the high end of the range, $50,000. The total costs of performing this service in-house with 2 Accountant III positions is $123,750 including salary and fringe benefits or $61,875 of general funds.

Pharmacy Benefits Management and Drug Utilization Review

	Annual Contract Expenditures	Annual General Fund Expenditures	Matching Rate (State/Federal)	FY 2003 Potential General Funds Savings
Pharmacy Benefits Management and Drug Utilization Review	$1,691,667	$845,833	50/50	$735,696

The contractor plans to hire 15 to 20 people to operate the Prior Approval process. This includes 1 pharmacist, 1 registered nurse, 1 licensed practical nurse, and pharmacy technicians. The pharmacy technicians were hired through a local employment agency and will remain employees of the employment agency. The contractor is currently seeking certification from the Board of Pharmacy for the individuals hired to work as pharmacy technicians. The requirements for this certification are completion of an application, payment of the application fee and being of good moral character.

The services included within the scope of this contract can be performed in-house with existing technical resources and staff. The Prior Authorization process can be operated by the Bureau of Pharmacy with their current staff of 4 as well as the addition of 7 staff obtained through current vacancies. The cost for the additional staff, including fringe benefits, is $220,275.

The drug utilization process can also be performed in-house with current technical resources. Data from claims is captured by the fiscal agent. Reports of the data can be run which show spikes in drug utilization, prescribing patterns, etc. DOM currently has two systems, which can provide this type of information. The Program Integrity unit uses data obtained from the Medicaid Management Information Retrieval System (MMIRS) and the Surveillance and Utilization Review System (SURS) for similar services and can be utilized for the DUR function as well.

The SURS system provides for flexibility in data analysis and exception reporting for profile analysis and treatment analysis activities. The major file inputs for the system include a provider master file, beneficiary eligibility file, drug formulary file, adjudicated claims file, provider history file, beneficiary file and a diagnosis file. The MMIRS system is used for fiscal planning and policy development and provides information on provider enrollment, beneficiary participation and service delivery analysis. It accommodates rapid, efficient, powerful processing of requests for information. It can process and evaluate services rendered to Medicaid beneficiaries, measure performance and interaction of populations and providers and assess the volume and costs of medical services for groups of beneficiaries.

Long Term Care Alternatives Contracts

	Annual Contract Expenditures	Annual General Fund Expenditures	Matching Rate (State/Federal)	FY 2003 Potential General Funds Savings
Long Term Care Alternatives	$943,720	$225,643	.2391/.7609	$225,643

The Division of Medicaid's contracts with the 10 Area Agencies on Aging result in a duplication of services. The Area Agencies on Aging provide information to beneficiaries about long term care alternatives. Once a beneficiary is approved for nursing home care, the medical provider submits a form to the DOM stating that the beneficiary is eligible for nursing home care but is physically able to consider other long term care alternatives. The DOM then submits the beneficiary's name to the Area Agency on Aging. The social worker from the Area Agency on Aging contacts the beneficiary and shares information about what options are available from the Area Agency on Aging. (This entity administers the Home and Community Based Services waiver program.) If the beneficiary is interested in the program he or she is then referred to the case worker for the waiver program.

DOM eligibility workers provide information about long term care alternatives to Medicaid beneficiaries at the point of application as well as during the re-determination process. Re-determination letters contain language informing the beneficiary that they meet the criteria for the waiver program and provide them a number for the Bureau of Long Term Care or the Area Agency on Aging.

DOM has printed materials that eligibility workers provide to beneficiaries. Hospital discharge planners and hospital social workers also provide information about long term care alternatives to beneficiaries. Medical providers, such as physicians, could also provide this information to beneficiaries once they approve them for nursing home care. This could be incorporated into their provider contract.

To ensure that long term care alternative information is shared with Medicaid beneficiaries, DOM could designate a liaison to work with the Area Agencies on Aging and other medical providers to ensure this information continues to be shared with beneficiaries. The agency should consider not renewing this contract since services are already being performed by a number of entities.

The Division of Medicaid contracted with the Area Agencies on Aging in FY 2002 for $943,720.00, or general funds of $225,643.45. Actual FY 2001 expenditures were not used because they were not an accurate reflection of the contracted amount due to vacant social worker and clerical support positions.

Cost Report Review Contracts

	Annual Contract Expenditures	Annual General Fund Expenditures	Matching Rate (State/Federal)	FY 2003 Potential General Funds Savings
Cost Report Review Contract	$908,977	$454,489	50/50	$324,551

The Bureau of Compliance and Financial Review contracted with 12 CPA firms to assist in the elimination of a backlog of cost report reviews. These cost report reviews include reviews of the rural health care centers, long term care facilities, and federally qualified health care centers. The Bureau of Compliance and Financial Review inherited the backlog from another bureau as well as the fiscal agent.

The Bureau of Compliance and Financial Review currently has 7 Accountant IIIs that complete cost report reviews. However, from FY 2000 through FY 2002, the bureau has only completed 19 audits with internal staff. According to Bureau of Compliance and Financial Review staff, the lack of reviews completed in-house is the result of the use of contract CPA firms. The time devoted by in-house staff assisting contractors in completing the reviews and participating in the procurement process prevents the internal staff from being able to complete the required audits, thus preventing the elimination of the backlog. Bureau of Compliance and Financial Review staff stated they believed the backlog could be eliminated in one to two years. However, if internal staff is unable to complete current audits, then the backlog will continue to grow.

The Director of the Bureau of Compliance and Financial Review stated she believed the current staffing level could handle annual audits once the backlog is eliminated. By relying on the current staffing level and contracting out the services of 7 additional accountants to assist with the elimination of the backlog instead of hiring multiple CPA firms, the division could have saved $324,551 in general funds. This figure is derived by using the base salary plus fringe benefits of an Accountant III position and subtracting the cost from the annual expenditures. The resulting savings is $649,102, or $324,551 of general funds.

CPA Consultant

	Annual Contract Expenditures	Annual General Fund Expenditures	Matching Rate (State/Federal)	FY 2003 Potential General Funds Savings
CPA Consultant	$75,000	$37,500	50/50	$29,765

The Bureau of Reimbursement entered into a contract with a CPA firm to provide assistance in the review of cost reports completed by agency staff. This was a five-month contract valued at $75,000, or 37,500 of general funds. By contracting with an individual accountant at a base salary of $30,000 rather than a CPA firm, the division could have saved $37,875, or $18,937.50 in general funds for a year. For a five-month period based on a $30,000 annual salary, the monthly expenditures would be $3,094,

including fringe. For a five-month period, the expenditures would have been $15,470, or $7,735 in general funds.

Overall savings would be $59,531.25, or $29,765.62 in general funds.

CHIP Outreach Assessment Contract

	Annual Contract Expenditures	Annual General Fund Expenditures	Matching Rate (State/Federal)	FY 2003 Potential General Funds Savings
CHIP Outreach Assessment Contract	$50,000	$25,000	50/50	$25,000

Due to the tasks associated with the administration of this contract, these duties could have been provided in-house at a reduced cost. The purpose of this contract was to measure the effectiveness of various outreach methods used by the Division of Medicaid. This included determining the effectiveness of various media including television, radio, etc., as well as other methods such as shopping mall campaigns. This information could have been gathered by in-house personnel who could have simply tracked the methods by which beneficiaries heard of the CHIP program resulting in their decision to complete an application. This could have been as simple as a survey distributed to all beneficiaries who enrolled in the CHIP program or could have been included as part of the application process.

By performing these services in-house, the division could have saved the entire amount of the contract, or $25,000 in general funds.

Medical Coding Contract

	Annual Contract Expenditures	Annual General Fund Expenditures	Matching Rate (State/Federal)	FY 2003 Potential General Funds Savings
Medical Coding Contract	$50,000	$25,000	50/50	$9,531

This contract's purpose was to provide training in medical coding for medical providers and Division of Medicaid staff to ensure that providers were entering medical codes (procedure codes vs. diagnostic codes) correctly and that division staff were evaluating the entry of codes accurately to prevent errors and delay in provider payment. The contract administrator stated she does not believe this contract will be renewed upon its expiration in June 2002.

There are currently no medical coding staff employed by the Division of Medicaid, so the division had to seek an external source of information. The agency contracted with an organization to provide these services, but could have saved money had they gone with a single subject matter expert. In Mississippi, the average annual salary for a medical coding expert is $25,000. Mississippi Hospital Association data confirmed this average salary. This would result in savings of $19,062.50, or $9,531.25 in general funds.

Management/Training Consultant Contract

	Annual Contract Expenditures	Annual General Fund Expenditures	Matching Rate (State/Federal)	FY 2003 Potential General Funds Savings
Management/Training Consultant Contract	$15,000	$7,500	50/50	$7,500

The Division of Medicaid could have used internal resources to assist with the facilitation of Medicaid retreats rather than contracting with an external organization. The Bureau of Human Resources has staff designated for training and should have been asked to oversee the retreats. The staff could have facilitated the meetings and reported the results of the meetings to the Executive Director.

The Division of Medicaid provided documentation of the work completed by the contractor. The contractor provided summaries to the Executive Director on June 20,2001, August 29, 2001, and October 8, 2001. These summaries included strengths, weaknesses, organizational values, and potential solutions to problems identified by Medicaid staff during the retreats. The Division of Medicaid provided no documentation that the contractor provided any services other than facilitating three Division of Medicaid retreats.

According to the contract, the purpose of the contract was to facilitate meetings, planning sessions, etc., as needed to support Medicaid in their efforts to address possible reorganization efforts, develop and facilitate an implementation plan to achieve the goals and provide supportive development activities for Medicaid staff, provide consultation on management issues and perform other related professional services as directed by the Executive Director.

SOURCE: PEER analysis of DOM contracts, DOM program data, DOM staff interviews, DOM contractor interviews, and DOM and contractor documents

Appendix G: Provision of Non-emergency Transportation Services as an Optional Medical Service versus the Administrative Option

States have two options for providing non-emergency transportation services:

1. Optional Medical Service

   When a state elects to operate its program as an optional medical service it receives a federal matching rate equal to the state's federal medical assistance percentage (FMAP). This option carries more federal restrictions including the requirement that states allow Medicaid recipients the freedom to choose their own service providers. As applied to transportation, this rule generally limits a state's flexibility to design cost-effective schemes for coordinating medical transportation services.

   Under this option, the state must meet the requirement of freedom of choice. This allows the beneficiary to select his or her transportation provider from any qualified Medicaid provider. This does not mean that the clients can choose the medical providers of their choice and have the state bear the expense of transportation to that provider. It simply means that a beneficiary may choose from among the least expensive, most appropriate modes of transportation. However, the state must ensure that the same level of service is available across the state and must provide the same level of service to all clients with similar needs.

   Transportation can be claimed as an optional medical service only when provided by a vendor to whom the Medicaid agency makes a direct payment. According to FY 2000 data, thirty-one states including the District of Columbia claim transportation as an optional medical service.

2. Administrative Option

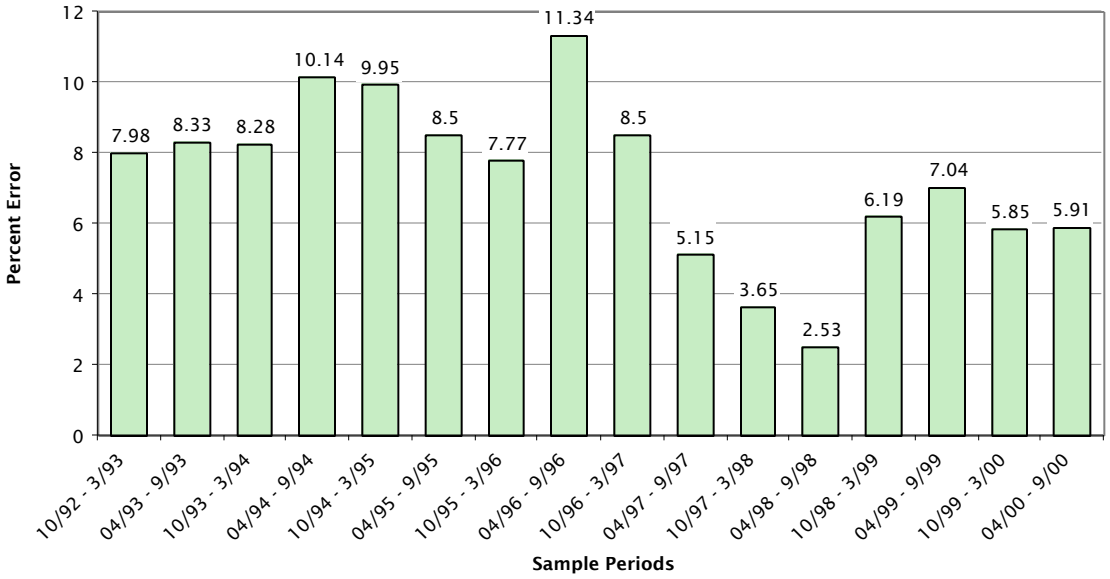
   When a state elects to operate its program as an administrative option it receives a federal matching rate of 50%. This option provides for more flexibility and control over administrative services. In order for states to set up brokerages of other coordinated transported programs, states must claim their transportation costs as administrative services.

   Under this option, the state is not required to allow freedom of choice. The state may designate allowable modes of transportation or arrange transportation on a pre-paid or contract basis with transit companies. This includes the use of vendors, reimbursement to the client and direct vendor payment.

   According to FY 2000 data, twelve states claim transportation as an administrative cost.

   SOURCE: *A Guidebook for State Medicaid Agencies*, Centers for Medicare and Medicaid Services; *Medicaid Transportation: Assuring Access to Health Care, A Primer for States, Health Plans, Providers and Advocates*, January 2001, Community Transportation Association of America

Appendix H: Case Error Rates for Periods 10/92-9/00



SOURCE: Medicaid Eligibility Quality Control unit data.

Agency Response

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

RICA LEWIS-PAYTON
EXECUTIVE DIRECTOR

June 21, 2002

Dr. Max Arinder, Executive Director
Miss. PEER Committee
P. O. Box 1204
Jackson, MS 39215-1204

Dear Dr. Arinder,

The attached document is in response to recommendations contained in the draft report, "A Review of Administrative Expenditures and Selected Administrative Functions of Mississippi's Division of Medicaid". While we do not agree with many of the statements and conclusions in the report, we appreciate the external review by PEER staff.

As Executive Director of the Medicaid Program, my goal is to ensure the program is operated in an effective and efficient manner. The fact that in FY '01 the administrative expenses were only 2.9% of the budget, our efforts in achieving this goal are being clearly demonstrated. When comparing our administrative costs to other Medicaid programs in the nation, Mississippi's is the second lowest. I am extremely proud of the hard work accomplished by employees in the Division of Medicaid.

We will continue to identify and implement procedures to improve the administrative processes in Medicaid and appreciate the efforts of PEER staff in this regard.

Sincerely,

Rica Lewis-Payton

RLP/rc

Enclosure

Suite 801, Robert E. Lee Building, 239 North Lamar Street, Jackson, MS 39201-1399, (601) 359-6050

Agency Response to the Draft
A Review of Administrative Expenditures and Selected Administrative Functions of Mississippi's Division of Medicaid

Contractual Services

1. To ensure the procurement of quality services at a cost effective rate, the Division of Medicaid should adopt internal procurement guidelines based on generally recognized elements of effective contracting (refer to page X). DOM should pay particular attention to the development of guidelines addressing needs assessments, systematic review of proposals, and contract monitoring.

   The Division of Medicaid (DOM) follows the procurement regulations of the PSCRB and the applicable federal procurement requirements at 45 CFR Parts 74 and 95. DOM has competitively bid its contracts based on these requirements, thus obtaining the lowest and best proposals. The Division will formalize its needs assessment process to include documentation as suggested in the report.

2. The Division of Medicaid should consider two options concerning its contract with the Mississippi Hospital Association:

   a. Consider asking the Legislature to amend Miss. Code Ann. §43-13-117 (1972) to remove the requirement that the Division of Medicaid contract with the Mississippi Hospital Association for the administrative support of the Medicare Upper Payment Limits program and Disproportionate Share Hospital program so that DOM could perform the task in-house. This would include the reclassification of several vacant positions in order to meet staffing needs.

   b. The Division of Medicaid should reduce the contract price to include only those costs associated with the tasks required by law. The Division of Medicaid should complete a cost analysis for these services to ensure a fair and competitive contract price.

      If the division wants to pursue other special projects that could benefit the Medicaid program and its beneficiaries, they should define the tasks that they want to accomplish and issue a Request for Proposals to obtain the desired services in a competitive environment.

The Division of Medicaid did not request that the Legislature mandate the contract with the Hospital Association, and thus, will not request that the Legislature amend this requirement. The PEER Committee, being comprised of members of the Legislature, is in the best position to make this request. It should be noted however, that the Division of Medicaid does not have the in-house expertise to fulfill this function and will not be able to successfully recruit qualified staff at current state salary levels. Should this mandate be lifted, the Division will issue a Request for Proposal in compliance with the PSCRB regulations to obtain any services it may need to continue bringing in additional dollars to the state's hospitals through the DSH and UPL programs.

The decision regarding the payment for the contract services provided by the Mississippi Hospital Association was based on prices identified in revenue maximization proposals that had been submitted to the Division of Medicaid. The prices identified in these proposals were 12% to 15% of the federal funds drawn down. In FY 2002, the State of Mississippi received $157 million in the UPL program and $150 million in the DSH program. At 12%, the contract price for this service could have been $38 million dollars compared to the $5 million charged by the Hospital Association.

Additionally, there are no state dollars involved in the costs for these two programs. In fact, the DSH program generates approximately $120 million in state funds. The state's share, including the cost of the contract, is provided by hospitals.

3. The Division of Medicaid should consider more cost effective ways of providing information on long term care alternatives to Medicaid beneficiaries. In considering whether to terminate its ten contracts with the Area Agencies on Aging, DOM should review the efforts of the entities that already provide these services such as eligibility workers and hospital and nursing home discharge planners and social workers. The Division of Medicaid should also consider requiring medical providers to share this information with Medicaid beneficiaries.

The Division of Medicaid has already begun plans to bring this program in house. Staff will be placed in the Medicaid Regional offices to provide information to applicants and beneficiaries, not only on LTC programs but also information as to the array of Medicaid benefits.

4. The Bureau of Compliance and Financial Review should seek more cost effective methods of eliminating the backlog of cost report reviews, including the possibility of discontinuing its use of multiple CPS firms and seeking individual contractors or a single CPA firm to perform these services.

Due to the substantial number of reviews to be performed by DOM, contracting with numerous CPA firms was necessary to perform the reviews within the required time frame.

Once the backlog of cost report reviews has been completed, DOM will not contract with numerous CPA firms.

5. The Division of Medicaid should consider a more cost effective method for providing peer review organization services including, but not limited to, the termination of its current contract with HealthSystems of Mississippi and performance of these required services in-house. If DOM chooses to continue the use of the current contractor, it should consider establishing a new method of payment other than a per member per month fee in order to control costs.

The Division of Medicaid (DOM) is charged with providing only those medical services that are deemed reasonable and medically necessary. In order to accomplish this requirement, an array of physician specialists and nurses are necessary (more than the number identified in the PEER report). Given current state salary levels, it will be impossible to hire qualified physicians and difficult to hire a sufficient number of qualified nurses to fulfill this responsibility. The Division of Medicaid currently experiences difficulty in recruiting and retaining qualified nurse staff.

Given the increases in enrollment, the Division of Medicaid has decided to request an amendment to the contract in an effort to change the payment method and reduce the cost of this contract.

6. The Division of Medicaid should consider a more cost effective method of providing prior approval and drug utilization services, including discontinuing the contract with Health Information Designs. DOM could perform prior authorization services in-house by using current vacancies to allocate additional staff to the Bureau of Pharmacy. DOM's Bureau of Pharmacy could perform the drug utilization function by using data and reports generated by the Division's Surveillance and Utilization Review subsystem (SURS) and Medicaid Management Information Retrieval System (MMIRS) and any additional reports that can be generated by the fiscal agent.

In order to accomplish this requirement, it will be necessary for the Division of Medicaid to hire staff pharmacists. Given current state salary levels, it will be impossible to hire the requisite number of qualified pharmacists to perform this function. Although recruiting efforts have been ongoing for more than a year, the Division of Medicaid has not been able to hire a Bureau Director for the Pharmacy Program.

The contract price for Health Information Designs (HID) for the first year of operation is $1,350,000. The conservative estimated savings in the pharmacy program as a result of this contract is $44 million for the first year, and has been taken into consideration in the reduction of the FY '03 projected shortfall. The Division of Medicaid does not have qualified staff nor systems and processes in place to achieve these savings.

7. The Division of Medicaid should identify methods of controlling expenditures for the non-emergency transportation program, including, but not limited to:

   a. Elimination of Staff

   Other states operate their NET programs with limited staff. For example, Louisiana's dispatch contractor operates the NET program with a staff of 36 including 20 to 25 call center unit staff. Louisiana utilizes 3 state staff to monitor the contract and assist with audit functions. Alabama operates their program with a staff of 20 employees including 10 regional coordinators, 1 call center supervisor, 1 call center secretary, 2 directors, 1 clerical employee, and 2 inmates for office support. DOM should consider reducing the number of NET staff by reducing the number of NET regions to 6 regions with 18 NET Coordinators. This could result in additional general funds savings of $464,062.

   DOM disagrees with PEER's claim that NET could be operated with a staff of 18 coordinators at six locations. Calculations based on dollar amounts are not an accurate method to make staffing decisions. These decisions should be based on the number of transactions that coordinators are required to arrange along with other factors such as the average number of calls per day. This information is vital to determine how many coordinators are needed to ensure that beneficiaries are able to get through to the coordinators to arrange transportation.

   b. Implementation of retrospective reviews of claims

   DOM should implement a retrospective review of claims to ensure beneficiaries actually attended their scheduled medical appointments. Alabama conducts a retrospective review from a sample selected each month.

   During the provider's annual assessment, a random sample of claim forms (95% confidence sample) are reviewed (retrospectively). This includes a check to ensure the number of units that were billed can be verified by the claim form documentation and that the claim form contains an original signature from the medical provider's office.

The BCFR has added a step to the claims monitoring procedure for the BCFR to research 10% of the random sample of claims. The beneficiary medical history will be researched in the Medicaid claims system to ensure a medical procedure was billed by the medical provider indicated on the transaction summary for the same date of the transport. If the trip cannot be verified through the Medicaid claims system (e.g., the medical provider has not yet billed for the medical service) the medical provider that is indicated on the claim form will be contacted to verify the visit.

c. Establish monthly reporting requirements

DOM should establish monthly reporting requirements to identify process improvement.

Currently, BCFR staff pull reports from MMIRS to monitor overall program operations. These reports are a more reliable source of objective data and information.

d Build relationships with other transportation entities

DOM's Bureau of Compliance and Financial Review should work with public transportation companies to provide transportation services to medical appointments for those beneficiaries who are physically able to use these services. The division should also work with various community transportation resources who could potentially transport beneficiaries for reduced rates or rates that are lower than those of current group providers.

The Division of Medicaid is currently reassessing the NET program in an effort to reduce costs. All options, including those recommended in the PEER report, will be considered.

e Identify new methods of provider reimbursement

Current group provider rates are not cost efficient. DOM should identify a new method of reimbursement for transportation services. States such as Louisiana have capped rates based on the miles traveled whereas Alabama uses a voucher system and reimburses for miles traveled.

These options will be considered as part of DOM's reassessment of the NET program.

d. Enhance NET system capabilities

DOM's Bureau of Compliance and Financial Review should work with the Division's Information Technology staff to enhance the capabilities of the NET computer system. The system should be capable of tracking information that would assist the division in controlling costs and formulating policy. The Bureau of Financial Review and Compliance should be able to generate these reports on request.

Presently, DOM is working with the fiscal agent, ACS, on a major renovation of the Mississippi Management Information System to make it HIPAA compliant. As part of this renovation, BCFR staff will work with both our internal Information Technology staff and ACS to make enhancements in the area of NET reporting needs.

e. Amend NET policy and eliminate the ability of providers to file claims over a 12 month time period

The Division of Medicaid should amend the requirement that allows the provider 12 months to file claims. The provider should be given a shorter time frame in which to file claims. All group providers are required to file claims electronically, so this should not be an imposition to the provider. The State of Texas requires providers to file claims within 95 days of appointment confirmation. Texas' group providers' contracts state that a provider waives his right to file the claim after the 95 days have passed. This will provide the agency with a more accurate accounting of program costs.

Presently, DOM policy allows all Medicaid providers up to 12 months to bill; however, providers are encouraged to file timely. This policy is based on both state (Miss. Code Ann. §43-13-113) and federal requirements (42 CFR §447.45 (d)(1)) which require providers to submit all claims no later than 12 months from the date of service.

Eligibility Determination Process

1. DOM should develop cost effective options and procedures for receiving information from the IRS for verification of eligibles' income. DOM should report these options and the associated cost of each option to the Legislature by the beginning of the 2003 Regular Session.

The Division of Medicaid can and will pursue reinstatement of IRS matches and has already been in contact with IRS to see if they will provide hardcopy information since they will not allow electronic matches via a fiscal agent.

Discussions have begun with the IRS to allow DHS to get the electronic connection that IRS requires.

2. The Division of Medicaid eligibility workers or MEQC investigators should conduct random samples to verify the declared assets and search for undeclared property of Medicaid applicants. DOM should also perform random samples to verify the declared assets and search for undeclared property of approved eligibles.

MEQC currently conducts statistically valid, random sample audits which capture both new applicants and existing recipients. The MEQC field investigation protocol requires reverification of all declared assets, and also requires investigation for undeclared property and other undeclared assets when resources impact the recipient's eligibility.

It must be noted that while specific data were available on payment error rates, these data were not used in calculating the estimated $5 million cost for errors in every 1% increase in the Medicaid population. Thus, the conclusions regarding dollar savings as a result of errors in eligibility determination are skewed.

3. The Medicaid Eligibility Quality Control unit should investigate the use of pilot programs for identifying ineligible recipients, such as those programs implemented in Arizona and Florida. These programs sample target populations in high cost areas, such as long term care.

Mississippi MEQC has elected to continue "traditional" sampling methodology and do "targeted" samples when needed. CMS allows states to reduce their sample size by 25% to do targeted sampling, the only requirement is that the same or more effort must be expended as when full sampling is conducted. Mississippi MEQC has conducted some targeted samples. Those targeted samples included DHS Extended Medicaid Cases; DOM long term care examination of unreported assets; CWS Foster Care; and a HealthMacs Recipient Satisfaction Survey.

4. The Medicaid Eligibility Quality Control Unit should establish a procedure for follow-up on cases they determine to be ineligible in order to ensure local offices take appropriate action to terminate benefits. A case review should be completed within 90 days of referral to the local office.

The Eligibility Bureau has the responsibility for reviewing QC findings and following up on corrective actions. It is not necessary to duplicate this activity.

Medical Services Expenditures

1. The Legislature should require the Division of Medicaid to provide documentation to support the agency's claimed need for funding to support a 22.5% growth rate in FY 03. In the event that the Division cannot provide documentation detailing the specific external factors driving a 22.5% growth rate, the Legislature should fund program growth in line with the 9.7% projection derived from the Division of Medicaid's own statistical model.

   The Division of Medicaid uses regression analysis as the baseline in its budgeting process. Consideration is then given to program changes that occur but are not part of the model. Our original projection of 12.66% continuation growth was presented to the LBO on August 7, 2001, and is shown on Page 69 of the FY 2003 LBO budget document. This growth rate was based on data through May 2001. As the 2002 Legislative Session began, the growth rate was revised using more current data. The use of regression analysis to determine the growth rate must be coupled with a short-term analysis that takes into consideration month by month expenditure patterns and planned program changes.

   It should be noted that documentation for justification of DOM's FY2003 budget has already been submitted to, and accepted, by the LBO budget analyst.

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