

MISSISSIPPI DIVISION OF MEDICAID



**Office of Program Integrity
and Office of Compliance**
2019-2020 Work Plan



MISSISSIPPI DIVISION OF
MEDICAID



A Message from the Chief Integrity Officer

I am pleased to continue to serve as the Division of Medicaid's Chief Integrity Officer. In this capacity, the Executive Director has assigned to me responsibility for supervising the Program Integrity, Compliance, Third Party Liability and Appeals operations of the Division of Medicaid. On behalf of the Office of Program Integrity ("OPI") and the Office of Compliance ("Compliance"), it is my privilege to share this Work Plan for State Fiscal Year 2020 (July 1, 2019 to June 30, 2020).

The Work Plan is intended to serve as a blueprint for OPI's activities across each of its operational divisions and for Compliance's interactions with contracted vendors and managed care organizations. As the health care delivery system in Mississippi continues to evolve and to mature into the managed care model, OPI will continue to adapt its workload to conduct and to coordinate fraud, waste and abuse control efforts designed to preserve and to recoup State and federal funds for all Medicaid activities.

This Work Plan also acknowledges the Division of Medicaid's growing efforts at compliance across all program activities and with all our vendors. Compliance will continue to hold contracted vendors and managed care organizations accountable for the assurances they made and the deliverables they promised in their contracts with the Division of Medicaid. This Work Plan focuses on three primary goals:

- Enhancing Compliance
- Fighting Fraud, Waste and Abuse
- Promoting Innovative and Actionable Data Analytics


Chief Integrity Officer

Executive Summary

The Mississippi Division of Medicaid is the State's largest payer for health care and long-term care. Approximately 720,000 Mississippians (almost 25% of the State's population) receive Medicaid-eligible services through a network of over 23,000 providers and three managed care organizations ("MCOs") as well as the Children's Health Insurance Program ("CHIP"). The total federal and State spending on Medicaid for SFY 2020 is expected to be slightly more than \$6 billion.

Health care fraud, waste and abuse takes many forms, and it can involve many different types of health care providers, including physicians, dentists, pharmacists, personal care aides, durable medical equipment companies, private duty nurses, managed care organizations, transportation providers and others. OPI's function and its mission is to oversee the investigation, detection, audit and review of Medicaid providers and recipients to ensure that they are complying with the laws and regulations governing the Medicaid program, including federal law, State law, the State Plan for Medicaid and the administrative code adopted by the Division of Medicaid. Compliance regularly tests the performance of the MCOs using an extensive Reporting Manual with monthly deliverables targets and mandates and monitors all contractor performance.

OPI has the authority to pursue administrative recoupment actions against any individual or entity that engages in fraud, waste and abuse involving Medicaid funds. As OPI discovers areas where excessive utilization suggests fraud, waste or abuse, we do data analysis and conduct audits. Compliance has the authority, working with the relevant program areas, to impose corrective action plans ("CAPs") and to assess liquidated damages ("LDs") upon MCOs and other contracted vendors doing business with the Division of Medicaid.

Information and evidence relating to suspected criminal acts by Medicaid-enrolled providers or Medicaid-eligible beneficiaries are referred to the Medicaid Fraud Control Unit ("MFCU"), an office within the Mississippi Attorney General's Office dedicated to handling these criminal matters.

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Introduction

This Work Plan is intended as a roadmap for taxpayers, policymakers, providers, and managed care organizations to follow regarding the activities OPI and Compliance have planned for SFY 2020 to fight fraud, improve program integrity, ensure compliance with law and with contractual obligations, and save taxpayer dollars.

OPI consists of five units (listed and described in alphabetical order):

- [Audit Contract Management Division](#)

The Audit Contract Management staff is responsible for oversight and contract management of the Recovery Audit Contractor (“RAC”) and audits performed by the current Coordinated Care Organizations. This group assists in Request for Proposals and contract implementation for all external auditing entities.

- [Data Analysis Division](#)

The Data Analysis Division is responsible for creating algorithms that uncover fraud and abuse in the Medicaid system. The algorithms are created through research using multiple means, such as Medicare Fraud Alerts issued by HHS-OIG, newspaper articles, websites, leads from other states and other sources of information.

- [Investigation Review Division](#)

The Investigation Review Division investigates any type of provider who receives Medicaid payments to determine whether that provider has committed fraud or abuse. Suspected fraud is reported to the Medicaid Fraud Control Unit (“MFCU”) for possible criminal or civil action, while other findings are developed and presented as formal audits with recommended administrative actions such as recoupments from the providers.

- [Medicaid Eligibility Quality Control Division](#)

The Medicaid Eligibility Quality Control Division (or “MEQC”) determines the accuracy of decisions made by the Division of Medicaid in enrolling beneficiaries. MEQC verifies that persons receiving Medicaid benefits are eligible and that no one is refused benefits for which they are eligible.

- [Medical Review Division](#)

The Medical Review Division utilizes Registered Nurses to review claims of both providers and beneficiaries to determine the medical necessity and appropriateness of services rendered and to assure quality of care.

- [Compliance Office](#)

The Compliance Office includes a Compliance Officer, a HIPAA Privacy/Civil Rights Officer, a Nurse Administrator and support personnel who conduct regular contract review, monthly deliverables assessment reviews, and *ad hoc* reviews (such as suspected instances of HIPAA privacy or security breaches) for both primary vendors and subcontractors for those vendors.

Strategic Plan

OPI/Compliance Strategic Plan

Mission

To enhance the integrity of the Mississippi Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program, assuring compliance by all providers and vendors, and recovering improperly expended Medicaid funds while promoting access to quality healthcare for vulnerable Mississippians.

Goal No. 1

Collaborate with Providers and MCOs to Enhance Compliance

Goal No. 2

Coordinate with partners, including law enforcement and managed care SIUs, to identify and address fraud, waste and abuse in the Mississippi Medicaid program.

Goal No. 3

Develop innovative data analytic capabilities to extract high-level data on fraudulent or wasteful Medicaid activities which lead to targeted investigative techniques.



Objectives

- Engage in provider outreach and education through engagement and participation efforts
- Streamline and improve monthly MCO reporting and feedback efforts with program staff



Objectives

- Reporting and supporting prosecution of cases related to suspected or confirmed allegations of fraud in partnership with the Attorney General's MFCU
- Create and develop a robust Health Care Working Group and participate as a law enforcement member in the National Health Care Anti-Fraud Association



Objectives

- Enhance multidisciplinary activities, including improved data access, storage and data mining capabilities
- Enhance use of Unified Program Integrity Contractor and partner with Healthcare Fraud Prevention Partnership for data analysis to improve audit and recovery efforts

Goal No. 1: Collaborate with providers and MCOs to enhance compliance

The Deliverables Compliance Tool Process

Compliance has developed an extensive Reporting Manual for all of the MCOs who provide services under MississippiCAN, the Mississippi Medicaid coordinated care program, and the Children's Health Insurance Program (CHIP). Each month, the collaborative Reporting Manual process generates reports across all the program areas from specific templates for each area in the Division of Medicaid. Compliance personnel review those reports with the program personnel using a Deliverables Compliance Tool ("DCT"). The purpose of the DCT process is not simply to create or review reports, but to test the actual (deliverable) care being provided by the MCOs each month across the full spectrum of all categories of care.

During SFY 2020, Compliance will complete its work to streamline and improve the Reporting Manual process to ensure that the reports generated each month are useful for testing the MCO performance each month. As always, Compliance seeks to assure that the data being reported is actionable, meaning that it is accurate and complete in all respects. Moreover, a full reworking of both the MississippiCAN and CHIP Reporting Manuals will be completed by the end of Calendar Year 2019 and submitted to the MCOs for implementation.

The Liquidated Damages Process

To assure that providers and MCOs are complying with applicable law, Administrative Code and contract requirements, there must be sanctions when they are not in compliance. Most of the contracts between the Division of Medicaid and its contracted vendors contain liquidated damages language. The liquidated damages process is a contractual remedy, not a monetary penalty process. Through the use of liquidated damages, Compliance seeks to generate remedial actions with our vendors. In a perfect world, Compliance would never need to impose liquidated damages. Experience has proven we do not live in a perfect world. Contracted vendors have a right to appeal any liquidated damages imposed to the Executive Director of the Division of Medicaid.

Compliance Reviews and Annual Compliance Training at DOM

Compliance demands that our various contracted vendors and MCOs conduct annual compliance training for their employees and officers and we will conduct annual program reviews to assure they are doing so. During SFY 2020, the Division of Medicaid has commenced its own in-house compliance training for our program personnel who interface with our contracted vendors and MCOs so that all operational personnel have a fuller understanding of the oversight work Compliance does and the role program area staff has in maintaining oversight of vendors and the MCOs.

Goal No. 2: Coordinate with partners, including law enforcement and managed care SIUs, to identify and address fraud, waste and abuse in the Medicaid program.

In addition to ongoing program integrity endeavors by OPI, the activities set forth in this section are centered on several priority areas for the current fiscal year: addressing prescription drug and opioid abuse; pharmacy services; home and community-based care waiver programs; private duty nursing; long-term care services; hospital services; transportation services; dental services; and mental health services.

In pursuing cases of Medicaid fraud, waste and abuse, OPI continues to collaborate with federal, state and local law enforcement agencies and with our MCOs. As OPI announced in SFY 2019, the state/federal and public/private cooperative known as the Mississippi Health Care Working Group continues to meet on a quarterly basis.

Addressing Prescription Drug and Opioid Abuse

To help fight opioid abuse, OPI will continue to dedicate resources to a variety of activities to reduce drug misuse, prescription opioid abuse, and drug diversion. Our Data Analysis Division has constructed reports to be used to assist in identifying beneficiaries and providers that may have issues with opioid abuse or over-prescribing of opioids. With access to the Mississippi Board of Pharmacy's Prescription Monitoring Program, OPI will review reports to identify possible issues with beneficiaries who are receiving duplicative or excessive drugs or doctor-shopping and providers who are writing excessive numbers of opioid prescriptions. OPI will make full use of Medicaid's lock-in program for fee-for-service beneficiaries who are identified as abusing opioids. Individuals who are believed to be obtaining drugs for diversionary purposes will be referred to the Mississippi Bureau of Narcotics.

OPI will continue to monitor MCO compliance with the lock-in program, as MCOs will also be directed to place members identified with abuse issues in their lock-in programs and to track beneficiaries who move from one MCO to another to make sure they remain on lock-in until the lock-in period is completed, regardless of their selected MCO.

OPI will review beneficiary data regularly to identify and investigate physicians prescribing excessive amounts of controlled substances or providing unnecessary services. As appropriate, OPI will refer beneficiaries and providers to MFCU for possible prosecution. As indicated, providers will also be referred to the Mississippi State Board of Medical Licensure.

OPI will collaborate with and review the recommendations made by the Governor's Opioid and Heroin Study Task Force. Last year, the first meeting of the Mississippi Health Care Working Group featured a presentation on the opioid epidemic.

Pharmacy Services

Pursuant to State Plan Amendment (SPA) 18-0011, Medicaid made some changes to pharmacy services to reimburse for certain physician-administered drugs (“PADs”) under the pharmacy benefit to improve beneficiary access. Under this SPA, certain drugs may now be billed either as medical claims or as pharmacy point of sale (“POS”) claims. During SFY 2020, OPI will be reviewing the accuracy of invoices, the accuracy of prescriptions, and confirming that beneficiaries actually sign for the drugs (acknowledging receipt of the drugs) which are billed to Medicaid given that they may now be delivered at the local pharmacy for administration in the physician office.

Home and Community-Based Waiver Programs

Home and community-based care services continue to grow as the population ages and the Medicaid program moves away from hospitalization and long-term care placements into numerous homebound and home-based services. Mississippi Medicaid has a number of home and community-based waivers under Sections 1915(b) and 1915(c) of the Social Security Act, including the Assisted Living Waiver, the Independent Living Waiver and the Elderly and Disabled Waiver. There is a crucial need for oversight of the home care services workers providing services to home-bound participants involved in each of these waiver programs and OPI recognizes vulnerabilities inherent in these home-based programs which require vigilance on the part of OPI.

Adult Day Care Services

Adult Day Care is available as part of the Elderly and Disabled Waiver. These providers must meet the needs of aged and disabled persons through an individualized Plan of Services and Supports and the facilities in which the programs are located must be physically accessible and well-maintained. OPI, in conjunction with our performance auditor partners in the Office of Financial and Performance Review, will assess the programs offered by these Adult Day Care providers to assure that participants are receiving quality programming in safe and secure environments. Providers who fail to maintain adequate programming or adequate facilities will be identified for corrective action plans and/or for termination from participation in Medicaid. Several such providers were terminated from participation in Medicaid during SF 2019.

Personal Care Services

Personal Care Services include non-medical support services provided to eligible persons by trained personal care attendants to assist the person in meeting daily living needs and to ensure optimal functioning at home and/or in the community. OPI will continue to audit and investigate Personal Care Services providers to determine whether they are billing excessively for covered services. Medicaid has adopted an electronic visit verification (“EVV”) system known as Medikey to track the visits made and compare them with billings submitted to Medicaid. OPI will continue to audit this system to identify and recoup duplicate or otherwise inappropriate payments.

Institutional or In-Home Respite Care

Respite Care provides non-medical care and supervision/assistance to persons unable to care for themselves in the absence of the person's primary, full-time, live-in caregiver(s) who are absent from the home on a short-term basis. Eligible persons may receive no more than 30 days of institutional respite care per fiscal year and no more than 60 hours of in-home respite care per month. Respite care is an important benefit both for caregivers and for the beneficiaries for whom they provide care. OPI will audit respite care providers to assure that they are not billing units in excess of the maximum allowed amount per month, per beneficiary.

Private Duty Nursing Services

Medicaid has a special eligibility category known as the Disabled Child Living at Home group, which allows certain children with long-term disabilities or complex medical needs to live at home with their families and to receive Medicaid services, including Private Duty Nursing. To qualify under this category, the child's medically documented institutional level of care is considered and the level of nursing care is provided based on a prior authorization process. Because this care occurs in the home, OPI will be conducting audits and review of the level of care provided, the accuracy of the billing, and any excessive billing detected beyond the levels approved by Medicaid.

Long-Term Care Services

At the present time, long-term care services (with the exception of hospice) are not covered under MississippiCAN by any of the MCOs. Thus, all institutional long-term care services provided are reimbursed on a prospective payment system through a cost-report process. Unless they elect to be covered under one of Medicaid's home and community-based waivers, beneficiaries in long-term care reside in nursing facilities. Although the Division of Health Facilities Licensure and Certification in the Mississippi Department of Health licenses nursing facilities, performance auditors with the Division of Medicaid regularly audit these facilities' cost reports for accuracy through the Office of Reimbursement.

Nursing Facilities

Much of Medicaid's oversight of the care provided at nursing facilities is conducted through the resident case-mix assessment process conducted by the Division's Case Mix Review nursing staff in conjunction with our consulting company, Myers and Stauffer. Based on the Case Mix Index, nursing facilities may see their per diem reimbursement rates go up or down. In order to ensure that the Case Mix Index is accurate, in June 2019, the Division of Medicaid implemented a Sanction Policy for Inaccurate Case Mix Assessments. OPI is responsible for enforcing the policy and for assessing sanctions against nursing facilities whose Case Mix Review reveals an error rate in excess of 25%. The sanction amount begins at a level of 10 times the facility's prevailing per diem and goes up based on a graduated scale. The Sanction Policy appears on the Division of Medicaid's website.

Hospice Care

Hospice is an essential benefit which provides palliative care and pain management for patients nearing the end of life. The Division of Medicaid covers medically necessary hospice services when properly documented by the beneficiary's medical prognosis for a life expectancy of six months or less if the terminal illness runs its normal course. Prior authorization for admission to hospice must be obtained and a plan of care must be developed for the beneficiary. Each period of hospice care requires a face-to-face encounter with a hospice physician or hospice nurse practitioner. Because the hospice benefit has been abused in many instances by placement of non-eligible beneficiaries into hospice, OPI will continue to audit hospice care claims for medical necessity.

Hospital Services

Emergency Room Care

Hospitals provide care which is urgent and truly life-saving – except when it actually is not. Excessive billing or upcoding in the hospital Emergency Room (“ER”) setting can divert and exhaust financial resources which are needed elsewhere in the Medicaid program. OPI will review ER billings and associated physician billings which include high-level Evaluation and Management codes in the ER and recoup excessive amounts.

APR-DRG Billings

Mississippi Medicaid reimburses hospital care through the Mississippi Medicaid APR-DRG prospective payment system. OPI's Medical Review Division, working with our Unified Program Integrity Contractor, will review and audit inpatient claims to ensure that appropriate DRGs are being billed and to recoup inappropriate APR-DRG billings.

Transportation Services

Medicaid pays for non-emergency transportation (or “NET”) services for Medicaid patients to obtain physician visits, dialysis, and related medical treatment. Most of the transportation is provided through a network broker (or NET provider), which arranges for actual transport of beneficiaries through various subcontractors. Review by OPI will be conducted to determine whether NET services were properly ordered, provided in a timely manner, submitted for reimbursement accurately, and provided with properly maintained and insured vehicles by properly credentialed and qualified drivers.

Because the NET provider is one of Medicaid's contracted vendors, much of the oversight of its operations is done through Compliance, working with the Office of Medical Services. When instances of non-credentialed drivers or separate drivers whose contracts have not been properly vetted by Compliance arise, Compliance will apply all appropriate liquidated damages in the NET contract to encourage prompt corrective action. Similarly, where MCOs elect to use their own transportation vendors in lieu of the NET provider, Medicaid will hold them fully accountable for providing the same level of service expected of the NET provider. When Compliance identifies a potential issue of patient endangerment, it will make a referral to OPI for investigation.

Dental Services

Medicaid pays for dental services because families need proper dental care. Dentistry is an honorable practice providing valuable medical treatment. However, there is the risk that dental care can lead to excessive and unnecessary spending by the Medicaid program for billing involving unnecessary procedures, billing for procedures that were never performed, billing Medicaid for substandard work, and disregard of ethical treatment standards by practices such as restraining patients or abusing patients. OPI will conduct audits of dental services and seek to recoup all payments identified as medically unnecessary, excessive, or otherwise inappropriate for reimbursement.

Mental Health Services

Medicaid provides mental health treatment in a variety of settings, depending on age and conditions. For example, Mississippi Youth Programs Around the Clock (“MYPAC”) provides a bundle of services for youth (individuals under age 21) in a home and community-based setting as an alternative to Psychiatric Residential Treatment Facilities. Adequate and proper documentation of the services provided is an issue OPI will continue to focus on during SFY 2020. Additionally, in the inpatient setting, excessive stays have resulted in significant overpayments to Medicaid in past years. OPI will continue to monitor lengths of stay in our inpatient mental health programs.

Ongoing Program Integrity and Compliance Activities

Many of the activities conducted by OPI and Compliance are ongoing in nature. For example, Compliance has the ongoing responsibility for review and approving all contracts Medicaid enters into with vendors. Similarly, whenever there are issues of patient jeopardy or potential harm, OPI responds by taking appropriate steps either to shut down abusive providers or to relocate their patients while an investigation ensues.

New Provider Enrollment and Eligibility Review

The MEQC Division in OPI will continue to investigate and determine the accuracy of Medicaid eligibility decisions made by Medicaid and the Department of Human Service. In addition, MEQC has transitioned into handling the on-site visits for new providers enrolled in Medicaid which was formerly handled by the Office of Client Relations.

Fee-for-Service Audits

OPI will continue to conduct audits of various FFS providers in areas of concern or to meet its federal waiver requirements. Programs or providers who may be audited include, but are not limited to:

- Durable Medical Equipment Companies
- Personal Care Homes
- Home Health
- Outpatient Services

- Early and Periodic Screening, Diagnostic and Treatment Services
- Mental Health Providers Billing Psychotherapy Codes with E&M Codes

Investigations

The Investigation Review Division will continue to investigate both providers and recipients in response to referrals from the public via our hotline or other sources to identify those who abuse the Medicaid program.

Mississippi Health Care Working Group and NHCAA

The Division of Medicaid coordinated the re-engagement of a federal-state and public/private cooperative known as the Mississippi Health Care Working Group. This Working Group is populated by state and federal law enforcement, program personnel from Medicaid, representatives of private health care associations, and various state licensing boards and agencies. The Working Group will meet on a quarterly basis to discuss tips, trends and trials related to health care fraud, waste and abuse. In the kickoff meeting for the Working Group, a speaker from the United States Attorney's Office for the Southern District of Mississippi presented an overview of the opioid epidemic, including a summary of recent prosecution efforts by DOJ. DOM also recently joined the National Healthcare Anti-Fraud Association ("NHCAA") as a law enforcement liaison member.

Health Care Fraud Prevention Partnership

The Division continues to look for opportunities to leverage its use of data analysis with other providers or regulators. One of those opportunities is the Health Care Fraud Prevention Partnership ("HFPP"), a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations such as the NHCAA. The Division joined HFPP and entered into a Data Use Agreement with its Trusted Third Party to permit data sharing and to participate in fraud prevention studies with some 175 other members through which Mississippi's Medicaid data can be run against fraud schemes discovered by HHS-OIG, other Medicaid programs, or private entities such as Special Investigative Units in private insurance plans. The HFPP also offers OPI personnel regular training, outreach and information sharing events.

Contract Review by Compliance

Compliance continues to develop and expand its contract review activities as part of its role in providing oversight for our contracted vendors and MCOs. Each and every contract and subcontract submitted to DOM by our MCOs and other contracted vendors receives a thorough review by Compliance. The contract review begins as early as the procurement process and continues through award of the contract and implementation to the operational stage of new contracts. The level of expertise and competence of Compliance in this regard continues to improve and expand.

Goal No. 3: Develop innovative data analytic capabilities to extract high-level data on fraudulent or wasteful Medicaid activities leading to targeted investigative techniques

Encounter Analysis

OPI will continue to analyze and evaluate the integrity of encounter data and to perform comparative analyses of encounter data and other plan-submitted data to evaluate the consistency and completeness of MCO encounter reporting. As appropriate, OPI will work with other data analysis partners such as the Data Services Division of the Office of the State Auditor or the UPIC to test and confirm the accuracy of encounter data.

Recovery Audit Contractor

OPI will continue to collaborate on and coordinate recovery initiatives with its Recovery Audit Contractor (“RAC”), Discovery Health Partners, and to approve audit concepts and work plans submitted by the RAC. Audit concepts which continue to be worked by the RAC include the Three-Day Payment Window Rule, new patient visit E&M codes, unbundling of radiology codes and claims analysis regarding add-on codes billed with another primary CPT code.

Unified Program Integrity Contractor

OPI will continue its collaboration with Qlarant (formerly Health Integrity) under CMS’s Unified Program Integrity Contract (“UPIC”). The UPIC has the unique ability to access both Medicare and Medicaid data to analyze and compare billing procedures and trends across both programs. Qlarant and OPI have several pending projects and they meet on a monthly basis to discuss data analysis ideas, audits, investigations and pre-payment review covering a variety of program areas including: hospital services, Personal Care Services, hospice and other areas.

Third Party Liability Match and Recovery Activities

In 2018, the Division of Medicaid procured a new three-year contract with its third party liability contractor, HMS, under which HMS will continue to conduct pre-payment insurance verification to identify third-party coverage for Medicaid beneficiaries, to conduct third-party retroactive recoveries, to engage in estate and casualty recoveries, to collect credit balances and to conduct “come behind” data analyses for potential additional third-party recoveries not identified by the MCOs.

Results Achieved – SFY 2018 Compared to SFY 2019

Office of Compliance – Liquidated Damages Assessed vs. Collected

SFY 2018 (ending 6/30/2018)	\$ 544,750.00	\$ 532,250.00*
SFY 2019 (ending 6/30/2019)	\$13,967,800.00	\$2,089,200.00*

*[Note: Assessed LDs may be reduced or remitted/waived on appeal.]

Office of Program Integrity – Overpayments Identified vs. Collected YTD

SFY 2018 (ending 6/30/18)	\$ 1,150,219.18	\$ 826,195.97±
SFY 2019 (ending 6/30/19)	\$13,803,640.11	\$2,502,672.89±

± [Note: Collected amounts do not include matters on appeal or providers who have been terminated from participation in Medicaid with outstanding/unpaid balances.]

Work Plan Acronyms and Abbreviations

APR-DRG	All Patients Refined Diagnosis Related Groups
CAP	Corrective Action Plan
CHIP	Children’s Health Insurance Program
CCO	Coordinated Care Organization (also known as MCO)
Compliance	Office of Compliance, Mississippi Division of Medicaid
CPT	Current Procedural Terminology
DCT	Deliverables Compliance Tool
DOJ	U.S. Department of Justice
DRG	Diagnosis Related Group
ER	Emergency Room
E&M	Evaluation & Management
EVV	Electronic Visit Verification
HFPP	Healthcare Fraud Prevention Partnership
HHS-OIG	U.S. Department of Health and Human Services, Office of Inspector General
HIPAA	Health Insurance Portability and Accountability Act
LD	Liquidated Damages
MCO	Managed Care Organization (also known as CCO)
MEQC	Medicaid Eligibility Quality Control (part of OPI)
MFCU	Medicaid Fraud Control Unit, Mississippi Attorney General’s Office
Mississippi CAN	Mississippi Coordinated Access Network
NET	Non-Emergency Transportation
NHCAA	National Healthcare Anti-Fraud Association
OPI	Office of Program Integrity, Mississippi Division of Medicaid
RAC	Recovery Audit Contractor
UPIC	Unified Program Integrity Contractor