MISSISSIPPI DIVISION OF MEDICAID

Office of Program Integrity and Office of Compliance

2018 – 2019 Work Plan

MISSISSIPPI DIVISION OF MEDICAID

A Message from the Chief Integrity Officer

I am pleased to serve as the Division of Medicaid's first Chief Integrity Officer. In this capacity, the Executive Director has assigned to me responsibility for supervising the Program Integrity, Compliance, and Third Party Recovery 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 2019 (July 1, 2018 to June 30, 2019).

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 lean into the managed care model, OPI will continue to adapt its workload to conduct and to coordinate fraud, waste and abuse control efforts to preserve and to recoup State and federal funds for all Medicaid activities. We expect to update this Work Plan on a quarterly basis throughout the year.

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

Bob Anderson
Chief Integrity Officer
October 1, 2018

Executive Summary

The Mississippi Division of Medicaid is the State's largest payer for health care and long-term care. Approximately 725,000 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 2019 is expected to be approximately $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, managed care organizations, transportation providers and others. While the vast majority of health care providers play by the rules, experience shows that a persistent 1-2% do not. 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 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.

OPI has the authority to pursue administrative recoupment actions against any individual or entity that engages in fraud, waste and abuse involving Medicaid funds. 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 to provide a roadmap for taxpayers, policymakers, providers, and managed care organizations to follow regarding the activities OPI and Compliance have planned for SFY 2019 to fight fraud, improve program integrity and quality, ensure compliance with the law and with contractual obligations, and save taxpayer dollars. OPI consists of five units (listed and described in alphabetical order):

Audit Contract Management Unit
The Audit Contract Management Unit is responsible for oversight and contract management of the Recovery Audit Contractor ("RAC") Program. This Unit also approves audits performed by the MCOs and assists in Requests for Proposals and contract implementation of external auditing entities.

Data Analysis Unit
The Data Analysis Unit is responsible for creating algorithms that uncover areas of 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, hotline referrals and other sources of information, including data from new collaborative efforts such as the Healthcare Fraud Prevention Partnership.

Investigation Review Division
Based upon data analysis, tips and referrals, the Investigation Review Division investigates and audits any type of provider or beneficiary who receives Medicaid payments to determine whether that provider or beneficiary has committed fraud or abuse. Suspected fraud is reported to local law enforcement or to the Medicaid Fraud Control Unit ("MFCU") for possible criminal or civil action, while other findings lead to potential recoupments from the providers.

Medicaid Eligibility Quality Review Division
The Medicaid Eligibility Quality Review 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 reviews, 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. As the Division of Medicaid undergoes the start-up of operations by a third MCO during SFY 2019, the Compliance Office is expected to grow to accommodate the additional workload.

Strategic Plan

Mission, goals and objectives of the Office of Program Integrity and Compliance	
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 by all.	**Objectives** • Engage in provider outreach and education through engagement and participation efforts • Streamline and improve monthly MCO reporting and feedback efforts with program staff
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.	**Objectives** • Reporting and supporting prosecution of cases related to suspected or confirmed allegations of fraud in partnership with the Attorney General's MFCU • Creating and developing a robust Health Care Working Group
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** • 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. 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 evaluate the actual (deliverable) care being provided by the MCOs each month for all covered services, including but not limited to primary care, hospital care, mental health and pharmacy, just to name a few.

During SFY 2019, Compliance will be updating, streamlining and improving the Reporting Manual process to assure that the reports generated each month are useful for evaluating the plans 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. Compliance will be tamping down on the exchange of information and demanding that MCOs make every effort for their "first try" at submitting these updated and streamlined reports to be in final form without requiring supplementation or revision.

The Liquidated Damages Process

To assure that providers and MCOs are complying with applicable law, Administrative Code and contract language, vendors must be held accountable for their obligations to beneficiaries and taxpayers 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 that seeks to address the administrative burden and expenses to the Division of Medicaid caused by a contracted vendor's failure to meet its contractual obligations. It is not a monetary penalty process. In a perfect world, Compliance would never need to impose liquidated damages. Experience has proven we do not live in a perfect world. Our contracted vendors have the right to dispute 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. Beginning in SFY 2019, the Division of Medicaid also will be undertaking its own in-house compliance training for our program personnel who interface with our contracted vendors and 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; home and community-based care waiver programs; long-term care services; hospital services; transportation services; and dental services.

In pursuing cases of Medicaid fraud, waste and abuse, OPI will continue to collaborate with federal, state and local law enforcement agencies and with our MCOs. OPI is pleased to announce in SFY 2019 the re-engagement of a state/federal and public/private cooperative effort known as the Mississippi Health Care Working Group. This Working Group will 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 opioid prescriptions or who appear to be doctor-shopping and providers who are writing excessive numbers of opioid prescriptions. OPI will make full use of Medicaid's lock-in program for 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 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. OPI will 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. Additionally, the first meeting of the Mississippi Health Care Working Group featured a presentation on the opioid epidemic.

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. Over 20,000 of the most vulnerable Mississippians participate in one of the waiver programs. There is a crucial need for oversight of these home-based care services.

- **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. Moreover, 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 Adult Day Care providers to assure that participants are receiving quality programming in safe and enjoyable environments. Providers who fail to maintain adequate programming or adequate facilities will be identified for corrective action plans and/or for termination if necessary.

- **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. Medicaid has adopted an electronic visit verification ("EVV") system called Medikey to track the visits made to be sure participants are getting the services they need. OPI will continue to audit and investigate Personal Care Services providers to be sure they are billing appropriately for the covered services they provide and to recoup any overpayments.

- **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 need to be 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, so it is important that these services not be

adversely impacted by improper billing by a provider. 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.

Long-Term Care Services

At the present time, long-term care services 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 community and home-based waivers, beneficiaries requiring long-term care reside in nursing facilities. Performance auditors with the Division of Medicaid regularly audit these facilities' costs reports for accuracy.

- **Nursing Facilities**
  Although much of the oversight of the care provided at nursing facilities is conducted through the resident case-mix assessment process, OPI will conduct audits to validate payments for services and to ensure that the documented needs of patients are being met. Through our Data Analysis Division and contract statistician, OPI may conduct sampling and extrapolate damages from statistically valid random samples.

- **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 historically, OPI will continue to audit hospice care for eligibility and for medical necessity.

Hospital Services

- **Emergency Department 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 Department ("ED") setting can divert and exhaust financial resources which are needed elsewhere in the Medicaid program. OPI will review ED billings and associated physician billings which include high-level Evaluation and Management codes in the ED to determine whether physicians and hospitals are billing for the appropriate level of care actually being rendered in ED visits.

- **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 DRG billings.

- **The Three-Day Payment Window Rule**
  Medicaid requires providers to adhere to the Three-Day Payment Window Rule, which requires that all inpatient claims, including diagnostic services provided to a beneficiary within three days prior to and including the date of inpatient admission be billed as part of the inpatient service including outpatient services unless those services are clinically distinct or independent from the reason for the beneficiary's inpatient admission. OPI or the Recovery Audit Contractor may conduct periodic audits to confirm that hospitals are properly applying the Three-Day Payment Window Rule.

Transportation Services

Medicaid pays for non-emergency transportation (or "NET") services for Medicaid fee-for-service patients to go to physician visits, dialysis, and related medical treatment. Most of the transportation is provided through a broker (or NET broker) which arranges for actual transport of beneficiaries through various subcontractors called network providers (NET providers). 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 in properly maintained and insured vehicles by properly credentialed drivers.

Because the NET broker is a contracted vendor, much of the oversight of its operations is done through Compliance, working with the Office of Medical Services. When instances of non-credentialed drivers arise, Compliance will gather appropriate information and apply all appropriate LDs in the NET broker contract to encourage prompt corrective action. Similarly, when MCOs provide transportation services, Medicaid will hold them fully accountable for providing the level of service for transportation as specified in their managed care contracts. When Compliance identifies a potential issue of patient endangerment, it will also make a referral to OPI for investigation.

Dental Services

Medicaid pays for dental services because families need proper dental care. Dentistry is an honorable field providing valuable medical treatment. However, there is the risk that dental care can lead to excessive and unnecessary spending by the Medicaid program for unnecessary procedures, 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.

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 reviewing 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 will transition this year into handling on-site visits for new providers enrolled in Medicaid which was formerly handled by Provider Beneficiary Relations.

- **Fee-for-Service Audits**
  OPI will continue to conduct audits of various FFS providers to meet its federal waiver oversight requirements and promote provider accountability. Programs or providers who may be audited include, but are not limited to:
    - Durable Medical Equipment Companies
    - Personal Care Homes
    - Home Health
    - Early and Periodic Screening, Diagnostic and Treatment Services
    - Mental Health Providers Billing Psychotherapy Codes with Evaluation and Management Codes

- **Investigations**
  The Investigation Review Division will continue to investigate both providers and recipients in response to referrals from the public 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, MCOs 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.

- **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. Those contracts that fail to meet the various requirements for serving the Medicaid population are either not allowed to be implemented or must be amended to ensure compliance before going into effect. The level of expertise and competence of Compliance in this regard grows week by week.

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.

Encounter Analysis
OPI will continue to analyze and evaluate the integrity of encounter data by performing comparative analyses of encounter data and other plan-submitted data. As appropriate, OPI will work with other data analysis partners such as Myers & Stauffer or the Data Services Division of the State Auditor's Office to test and confirm the accuracy of encounter data.

Recovery Audit Contractor
OPI will continue to collaborate and coordinate recovery initiatives with its RAC, Healthmind, LLC, (formerly known as Datametrix) to approve audit concepts and work plans submitted by the RAC. Recent audit concepts include the Three-Day Payment Window Rule, new patient visit E&M codes and claims analysis regarding add-on codes. The RAC will continue to develop new audit concepts throughout the year.

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 for program areas including:

hospital services, Personal Care Services, durable medical equipment providers, and hospice providers.

Third Party Liability Match and Recovery Activities

The Division of Medicaid procured a new three-year contract with its third party liability contractor, HMS. Under that contract, HMS will continue to conduct pre-payment insurance verification to identify and utilize third-party coverage for Medicaid beneficiaries, conduct third-party retroactive recoveries, engage in estate and casualty recoveries, and conduct "come behind" data analyses for potential additional third-party recoveries not identified by the MCOs.

The Healthcare Fraud Prevention Partnership

The Division of Medicaid has become a member of the Healthcare Fraud Prevention Partnership ("HFPP"). HFPP is a voluntary public-private partnership between the federal government, state and local government agencies, law enforcement, private health insurance plans, employer organizations, and health care anti-fraud associations that seek to identify and reduce fraud, waste and abuse across the healthcare sector.

HFPP partners collaborate, share information and data, and conduct studies using a unique cross-payer (de-identified) data set. Given its broad membership, HFPP is well positioned to examine – and to assist its members in examining – emerging trends and to develop key recommendations and strategies to address them.

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
DCT	Deliverables Compliance Tool
DOJ	U.S. Department of Justice
DRG	Diagnosis Related Group
ED	Emergency Department
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 Review (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