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MISSISSIPPI DIVISION OF
MEDICAID

June 3, 2026

Dr. Mehmet Oz
Administrator
Centers of Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

via programintegrity@cms.hhs.gov

RE: Mississippi Medicaid Comprehensive Two-Year Provider Revalidation Strategy

Dear Dr. Oz:

The Mississippi Division of Medicaid (DOM) is committed to working with your administration to ensure that the Medicaid program remains strong and effective for the millions of Americans it serves. We are pleased to submit a comprehensive two-year provider revalidation strategy, which includes activities that are currently underway in Mississippi as well as proposed improvements which will further strengthen the DOM's program integrity to achieve the shared goals of the Centers for Medicare and Medicaid Services (CMS) and the State of Mississippi.

Provider Screening and Enrollment Practices

In accordance with 42 CFR Part 455 Subparts B and E, 42 CFR §431.107 and the Medicaid Provider Enrollment Compendium (MPEC), all enrolling providers are screened at or above the risk levels established by CMS prior to the effective date of the provider agreement. Additionally, as required under 42 CFR 455 Subparts B and E and the MPEC, all providers are required to undergo revalidation at least every five (5) years. As part of the initial enrollment and revalidation screening process, the DOM relies upon the screening conducted by Medicare if all the required elements match as outlined in Table 1, the Minimum Required Data Elements to Compare for a Positive Match, in the MPEC. When the provider is not enrolled in Medicare or the data elements do not match, the DOM conducts screening in alignment with the risk level assigned by CMS or the elevated risk level assigned to the provider. Additionally, if the provider is enrolled in Medicare at a lower risk level than that assigned by the DOM, additional required screening is conducted, such as site visits and fingerprint-based background checks.

As outlined in 42 CFR §455.436, the DOM, through its contracted Fiscal Agent, conducts monthly screenings of all enrolled providers, as well as their owners and managing employees against the List of Excluded Individuals/Entities (LEIE), the Medicare Exclusion Database (MED), the System for Award Management (SAM), formerly known as the Excluded Parties List System (EPLS), the Social Security Administration (SSA) Death Master File, and the National Plan and Provider Enumeration System (NPPES) list of deactivated NPIs. If an enrolled provider is suspected of fraudulent activity during any of the above processes, the provider is promptly referred to the DOM's Office of Program Integrity for further investigation.

As defined by the MPEC, screening validates regulatory requirements prior to enrollment with any Medicaid program; whereas credentialing validates a provider's qualifications to participate as a network provider for the managed care organizations (MCO). Mississippi Medicaid screens all providers regardless of program participation (Fee-for-Service, MSCAN or MSCHIP) and credentials providers that desire to participate as a network provider for the managed care programs (MSCAN or MSCHIP).

Managed Care Provider Credentialing and MCO Data Maintenance

The DOM serves as the centralized credentialing authority for Mississippi Medicaid's MCOs. Providers are initially screened, credentialed, and recredentialed through state-approved processes to determine eligibility for participation in the managed care programs. MCOs are required to rely on these standardized determinations and related interface files for enrollment, contracting, and payment functions, rather than performing duplicate credentialing activities. Although federal regulations allow for the MCOs to pay providers as an out-of-network provider without first being screened by Medicaid agencies, the DOM identified this as a risk to its members and the integrity of the Medicaid program. MCOs have been instructed not to pay any providers that are not first screened and approved by the DOM.

Daily data exchanges between the DOM and the MCOs include provider requests to join a MCO's network after the successful completion of provider credentialing and notifications of provider terminations. MCOs are required to promptly update their systems by approving or denying provider contracting requests and by removing terminated providers. Provider status, enrollment updates, and related changes are communicated through these daily data exchanges to ensure MCOs have the most recent updates.

Based on the daily data exchanges, MCOs are responsible for promptly initiating outreach to the newly approved providers, beginning the contracting process, and meeting the established onboarding timelines, while also ensuring the MCOs have adequate network capacity by recruiting providers in underserved areas. The MCOs must continuously monitor provider status to identify providers that have become inactive, suspended, or otherwise ineligible and take appropriate action to disenroll the providers from their networks in compliance with all Medicaid requirements.

Provider affiliation and service location data are continuously maintained and reconciled between the DOM and the MCOs to ensure providers are properly enrolled and contracted to render services at the correct locations. This process requires ongoing validation, correction and monitoring to ensure providers remain active, compliant, and eligible for payment. In addition, supplemental data files support broader operational needs such as maintaining an accurate provider directory, tracking recredentialing timelines, validating network adequacy, reconciling encounters and identifying provider designations that affect reimbursement.

Throughout this process, MCOs are expected to actively monitor all provider-related files, resolve errors, notify members of potential disruptions in provider availability, and ensure claims are not submitted or paid for providers who are inactive or suspended.

To ensure compliance with the above procedures by the MCOs, all encounter claims must be submitted within two days of their financial cycle unless they have multiple financial cycles in a week, in which case, the encounters must be submitted within two days of the final financial cycle during the week. All encounter claims submitted by MCOs are processed as non-financial claim submissions (Shadow Priced) within the state claims system to validate provider eligibility on the date of service, among other things. If a provider is not properly enrolled or authorized at the service location, the system identifies the claim as ineligible for payment and the MCO is notified that the claim should have been denied due to provider ineligibility through an EDI response file. The MCOs are expected to recoup the payment from the provider and submit an adjustment as evidence of compliance.

Additionally, all encounters and adjustments including both the MCO paid/denied status and MESA Shadow Priced status are provided to the DOM's actuary to be utilized for the management and oversight of the managed care plans as well as the rate setting process.

DOM and MCO Provider Directory Accuracy

Effective July 1, 2025, in alignment with the Consolidated Appropriations Act of 2023, CMS' SHO-003, and ongoing efforts to maintain the accuracy and integrity of the Mississippi Medicaid Provider Directory, the DOM has implemented updated provider data collection and maintenance procedures. Mississippi Medicaid enrolled providers, including those enrolled in Fee-for-Service, MSCAN, and MSCHIP, were notified on July 9, 2025, of the updated data requirements and advised to review and validate their provider directory information at least every 90 days using their provider portal account. The DOM is awaiting regulations and further guidance from CMS concerning Section 116 of the Consolidated Appropriations Act of 2021 regarding provider directory data verification requirements and their applicability to Medicaid as discussed in CMS' *No Surprises Act Protections: Status of Implementation* document (as issued in August 2023), which reaffirmed the guidance set forth in the *FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 49* (as issued August 20, 2021). When such guidance is released, the DOM will enact adverse actions for provider failure to update their information within 90 days in alignment with CMS' regulations and guidance.

MCO Provider Directory Oversight

The DOM is compliant with the managed care regulations at 42 CFR §438.10, §438.68, and §438.206 regarding MCO provider directory accuracy. At the start of the MCO contract implementation in 2025, each MCO was required to demonstrate compliance with the provider directory standards in federal regulations, and MCOs are required to submit a Provider Network Adequacy Report quarterly. The DOM contracted with Constellation Quality Health to conduct ongoing reviews to ensure MCOs maintain adequate provider networks and comply with state and federal Medicaid managed care requirements, including 42 CFR §§ 438.358 and 438.68. These reviews are designed to confirm that MSCAN and MSCHIP members have timely access to covered healthcare services, assess compliance with contractual and regulatory network adequacy standards, and identify opportunities for improvement. The DOM's review process follows CMS External Quality Review Protocol 4: Validation of Network Adequacy and includes both a comprehensive desk review and a virtual onsite review with MCO staff.

To assess provider accessibility and directory accuracy, Constellation conducts a biannual two-phase review process. During the Provider Access Study, telephone surveys are conducted with sampled primary care providers (PCPs) to verify provider contact information, MCO participation, panel status, and appointment availability for routine and urgent care. In the Provider Directory Validation phase, Constellation compares verified provider information against the MCOs' online provider directories to measure accuracy rates for listings, phone numbers, addresses, and acceptance of new Medicaid patients. Results from both phases are used to calculate overall provider access and directory accuracy rates.

When deficiencies or noncompliance are identified, the DOM may require MCOs to implement corrective actions through formal Corrective Action Plans (CAPs). The DOM Office of Managed Care may also assess liquidated damages if repeated findings continue to happen from the External Quality Review Organization (EQRO) results.

The publication of network adequacy standards is also done by the EQRO and published on the DOMs website at https://medicaid.ms.gov/mississippican-resources/. The report can be found under External Quality Review, year 2025, Provider Access Study.

In the most recent EQRO review, MCOs with an established program presence in Mississippi prior to 2025 demonstrated meaningful improvement, with provider directory accuracy rates increasing by an average of 31 percentage points.

Risk Level Evaluation and Assignment

The DOM assigns provider risk levels in alignment with or above CMS established standards. Risk designations at the taxonomy level are reassessed with each MPEC update release, and any findings are evaluated as appropriate to adjust risk levels for individual providers or applicable taxonomy groups.

Consistent with MPEC guidance and Mississippi's program integrity risk evaluations, all waiver providers (atypical/non-NPI entities) and Community Mental Health Centers are designated as high risk at both initial enrollment and revalidation. In addition, providers may be elevated to high-risk status based on findings from Program Integrity audits or other relevant evaluations conducted by the DOM Office of Program Integrity.

The following taxonomies are deemed high-risk at initial enrollment:

251B00000X, Case Management
251E00000X, Home Health
251G00000X, Community Based Hospice Care
251S00000X, Community/Behavioral Health (non-NPI/Atypical)
253Z00000X, In Home Supportive Care (non-NPI/Atypical)
261QA0600X, Clinic/Center - Adult Day Care
261QM0801X, Clinic/Center - Mental Health (Including Community Mental Health Centers)
261QM1300X, Clinic/Center - Multi-Specialty
314000000X, Skilled Nursing Facility
3140N1450X, Skilled Nursing Facility - Pediatric Nursing Care
332B00000X, Durable Medical Equipment and Medical Supplies
332BC3200X, Durable Medical Equipment and Medical Supplies - Customized Equipment
332BP3500X, Durable Medical Equipment and Medical Supplies - Parenteral and Enteral Nutrition
332BX2000X, Durable Medical Equipment and Medical Supplies - Oxygen Equipment and Supplies
332U00000X, Home Delivered Meals (non-NPI/Atypical)
373H00000X, Day Training/Habilitation Specialist (non-NPI/Atypical)
3747P1801X, Technician - Personal Care Attendant (non-NPI/Atypical)

In addition, the following taxonomies are deemed high-risk at revalidation:

251B00000X, Case Management
251S00000X, Community/Behavioral Health
253Z00000X, In Home Supportive Care (non-NPI/Atypical)
261QA0600X, Clinic/Center - Adult Day Care
261QM0801X, Clinic/Center - Mental Health (Including Community Mental Health Centers)
261QM1300X, Clinic/Center - Multi-Specialty
332U00000X, Home Delivered Meals (non-NPI/Atypical)
373H00000X, Day Training/Habilitation Specialist (non-NPI/Atypical)
3747P1801X, Technician - Personal Care Attendant (non-NPI/Atypical)

Credible Allegations of Fraud Coordination

In accordance with federal requirements at 42 CFR §455.21, the DOM Office of Program Integrity (OPI) refers all cases involving credible allegations of fraud to the Medicaid Fraud Control Unit (MFCU), which operates within the state Attorney General's Office. The MFCU has statewide authority to prosecute individuals and entities for violations of laws with respect to fraud in the provision or administration of medical assistance under the Medicaid program.

The DOM OPI follows established procedures when referring suspected Medicaid fraud cases to the MFCU. Referrals must include comprehensive provider information, details of the alleged misconduct, supporting documentation, claims and payment data, relevant communications, and applicable regulatory or policy violations.

Upon receipt of a complaint or identification of potential fraud, waste, and abuse through data analysis, OPI conducts a preliminary review to determine whether a credible allegation of fraud exists. When credible allegations are identified, OPI coordinates with the MFCU to assess the case, determine whether payment suspension is warranted, and initiate formal referral for criminal investigation. This process includes required written notifications, evaluation of applicable good-cause exceptions, and ongoing coordination between OPI and the MFCU throughout the investigation.

Following referral, the MFCU must formally accept or decline the case within established timeframes. If a case is declined, OPI determines appropriate next steps, including pursuing administrative action, referring the matter to another law enforcement agency, or closing the case.

Resuming Revalidations

In alignment with SHO 20-004 dated December 22, 2020, the DOM resumed revalidations of all providers, regardless of risk level. Also, in alignment with Mississippi Code section 43-13-117 and 42 CFR 438 requirements, the DOM began serving as the centralized credentialing authority for all MCOs in the state on October 1, 2022, ensuring providers are properly credentialed and consistently maintained within the Medicaid delivery system.

To streamline processes for providers during the recredentialing process, each provider is also screened and revalidated. As such, since 2023, providers servicing MSCAN and MSCHIP populations have been revalidated every 3 years when they are recredentialed by the DOM.

The DOM implemented enhanced provider enrollment compliance measures designed to reduce fraud, strengthen program integrity, and encourage timely submission of revalidation and recredentialing applications. As such, providers who have failed to submit their required revalidation or recredentialing application by the established due date are subject to claim suspension until the required application is received.

Provider Revalidation Strategy

In accordance with the Updated Q&A guidance issued by the CMS Medicaid Provider Enrollment Team on May 29, 2026, all providers, regardless of risk level, who have not been newly enrolled, re-enrolled, or revalidated since April 22, 2025, will undergo revalidation within the next two years. Building on the momentum gained when the DOM resumed conducting revalidations in September 2023 the DOM is well positioned to conduct the revalidation of providers that have not been fully screened due to enrolling, re-enrolling, or revalidating since April 22, 2025.

The revalidation effort as part of this off-cycle revalidation strategy has commenced in conjunction with the DOM's previously scheduled revalidations, with a focus on high-risk providers, including those elevated to high-risk status because of program integrity audits or findings. Since April 22, 2025, the DOM has newly enrolled, re-enrolled, or revalidated 421 of its 909 active high-risk providers and have 100 high-risk providers that are currently undergoing revalidation. Since April 22, 2025, the DOM has newly enrolled, re-enrolled, or revalidated 913 of its 2,513 moderate-risk providers and have 202 moderate-risk providers currently undergoing revalidation. Since April 22, 2025, the DOM has newly enrolled, re-enrolled, or revalidated 6,442 of the 32,057 active limited-risk providers and have 3,670 limited-risk providers currently undergoing revalidation.

The DOM has adjusted the revalidation due dates of all high-risk providers not revalidated, re-enrolled, or initially enrolled since April 22, 2025, and have initiated the notice process to those providers. All high-risk providers impacted are now scheduled to complete revalidation no later than February 28, 2027.

Limited and moderate-risk providers due to revalidate prior to June 6, 2028, will maintain their previously established revalidation due date. The DOM will initiate the revalidation process no later than July 2026 for moderate-risk and limited-risk providers not already scheduled to occur prior to June 6, 2028. To accomplish this, the DOM is working with its fiscal agent to modify the next revalidation due date for the approximately 9,000 limited-risk providers and approximately 800 moderate-risk providers that are not scheduled to be revalidated until after June 6, 2028. These providers will be divided evenly across approximately seventeen months between January 1, 2027, and June 6, 2028. This will result in all moderate-risk and limited-risk providers not enrolled, re-enrolled or revalidated since April 22, 2025, completing the revalidation process prior to June 6, 2028.

The DOM is working to onboard additional staff necessary to ensure the proper vendor management and oversight is in place to maintain high quality and timely work during this effort. The DOM is also working with its fiscal agent to identify vendor staffing needs for provider enrollment analysts, call center staff, and provider relations staff necessary to meet the demands of this additional workload. The DOM's fiscal agent will utilize the time between the actual notice to the providers and the due date for application submissions to recruit, onboard, and train the necessary staff to ensure this critical work is completed timely and accurately.

Revalidation Familiarity and Communication

Most providers are already familiar with the process through prior revalidation and recredentialing activities. The DOM is exploring targeted communication strategies which may include email notifications to all providers registered for electronic communications, prominent announcements on the Provider Portal homepage, and coordinated social media outreach through the platforms available to the DOM.

Information will be published on the DOM website focused on the revalidation effort. The DOM will also collaborate with its MCOs and relevant provider associations to ensure consistent dissemination of information to providers.

Since the DOM resumed revalidations in 2023, the DOM has maintained a public facing list of all providers who have an upcoming revalidation or recrendentialing within the next 6 months.

In addition to the DOM's current outreach, providers may use the Provider Search Tool from the DOM website to check their status and identify the next date for revalidation or recredentialing.

Revalidation Metrics

To monitor the revalidation strategy, the DOM will report quarterly on the following metrics that measure the progress of its revalidation efforts. These metrics include:

1. The cumulative number of revalidation notifications generated;
2. Revalidation applications submitted;
3. Providers under payment suspension for failure to submit revalidation application within 60 days of the agency generating the revalidation notice;
4. Revalidation applications approved; and
5. Revalidation applications denied as part of this off-cycle revalidation.

Future Improvements

In accordance with CMS recommendations, the revalidation window has been modified from 5 years to 3 years as high-risk providers complete their upcoming revalidation.

The DOM, in conjunction with its fiscal agent, is developing a data update process that will capture of the date on which provider information is last reviewed and updated to ensure readiness to comply with any future guidance from CMS.

The DOM is evaluating the potential to automate the validation of provider-supplied information submitted through provider enrollment applications and revalidations. To support this objective, the DOM is exploring the development and integration of multiple Application Programming Interfaces (APIs), including the implementation of an Application Programming Interface Gateway (APIGW) to facilitate access to PECOS and NPPES data sources.

The DOM is evaluating potential integration with the Do Not Pay API, as discussed during the February CMS Provider Enrollment Technical Advisory Group (PE-TAG) call, to enable direct-source verification capabilities. To enhance data integrity, address standardization, and improve overall validation accuracy, the DOM is working with its fiscal agent to access the IRS Taxpayer Identification Number (TIN) Matching Tool and potential integration with the United States Postal Service (USPS) services, including the Enhanced Addressing 3.0 API and National Change of Address (NCOA) 3.0 API.

The DOM is also having preliminary conversations with the Mississippi Secretary of State's Office about establishing an API to verify owners and managing employees submitted on the provider disclosure.

Ongoing Dedication to Reducing FWA

As you stated in your April 23, 2026, letter, "the Medicaid program is threatened by a persistent and growing threat posed by sophisticated actors knowingly attempting to exploit these complex systems for financial gain." Provider enrollment is only one of the integral tools to address the risk of fraudulent activity from these bad actors. To that end, the Mississippi Division of Medicaid has other critical projects that warrant mentioning in this response as part of the overall fight against fraud, waste, and abuse in Mississippi.

First, the Mississippi Division of Medicaid is currently implementing a new program integrity application for improved identification of fraud, waste and abuse as well as improved case tracking, reporting, and automation. With the advanced algorithms, large language models (LLM), and artificial intelligence within the newly selected tool, the DOM will modernize its program integrity operations and better equip its investigators to root out the sophisticated actors and thereby preserve the limited resources of the Medicaid program. Second, the DOM is procuring professional services to conduct annual audits of all pharmacy claims processed by the DOM's pharmacy benefit administrator. Finally, the DOM is also currently procuring a contract for the full audit of all medical claims processed by the DOM's fiscal agent.

The DOM is committed to rooting out fraud, waste and abuse. Strengthening the DOM's provider revalidation processes is a major component in the objective. We look forward to working with your administration to reinforce these efforts to be good stewards of the taxpayer dollars while continuing to provide the needed care to those we serve.

Sincerely,

Cindy Bradshaw

Cindy Bradshaw
Executive Director
Mississippi Division of Medicaid