MISSISSIPPI DIVISION OF
MEDICAID

Internal Control Plan

July 1, 2021

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This Internal Control Plan for the Mississippi Division of Medicaid is updated periodically but no less than annually to document the Agency's commitment to maintaining strong and effective internal controls.

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Agency Information and Division of Responsibilities

In 1969, the Mississippi Legislature established a Medicaid program in Mississippi. The Mississippi Division of Medicaid (DOM) is the managing agency for this federal/state program created by the Social Security Amendments of 1965 (PL 89-97) and authorized by Title XIX of the Social Security Act to provide health coverage for eligible, low-income populations. All 50 states, five territories of the United States and the District of Columbia participate in this voluntary matching program. Each state runs its own Medicaid program within federal guidelines, jointly funded by state and federal dollars.

DOM also administers the Children's Health Insurance Program (CHIP), a separate federal/state program established by Congress for low-income children whose family income is too high to qualify for Medicaid. While each state runs its own Medicaid program, beneficiary eligibility is determined by household income and Supplemental Security Income (SSI) status, based on the Federal Poverty Level (FPL) and family size. FPL is set by the Department of Health and Human Services, and DOM is obliged to adhere to the federal requirements.

For Medicaid, the Federal Medical Assistance Percentage (FMAP) is used to calculate the amount of federal matching funds for state medical services expenditures. Currently, Mississippi has the highest FMAP in the country.

WHO WE SERVE

DOM pays for health coverage for eligible, low-income Mississippians. Roughly one in four Mississippians receive health benefits through Medicaid or CHIP. These populations primarily include children, the aged and disabled, low-income parents/caretakers, and pregnant women. Eligible members do not directly receive money from Medicaid for health benefits. Enrolled and qualified Medicaid providers are reimbursed for health services they provide to eligible members.

MISSISSIPPICAN and CHIP

Authorized by the state Legislature in 2011, DOM oversees a Medicaid managed care program for beneficiaries, the Mississippi Coordinated Access Network (MississippiCAN). Advantages to managed care include increasing beneficiary access to needed medical services, improving the quality of care, and cost predictability. MississippiCAN is administered by three different coordinated care organizations (CCOs), and approximately 65 percent of DOM beneficiaries are enrolled in the program. The agency has over 900 employees throughout its one central office, 30 regional offices, and over 80 outstations across Mississippi.

CHIP provides health coverage for children up to age 19, whose family income does not exceed 209% of the federal poverty level (FPL). To be eligible for CHIP, a child cannot be eligible for Medicaid. Also, at the time of application, a child cannot be covered by another form of insurance to qualify for CHIP. Since 2015, CHIP services have been provided through CCOs with contractual arrangements paid using actuarially-sound per member per month capitation rates. Because of a smaller eligible population, DOM only utilizes two CCOs to provide CHIP services. Currently, Molina Healthcare and UnitedHealthcare Community Plan serve as the CHIP vendors.

Mission Statement

(Currently, the DOM Mission Statement is in the process of being updated)

The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians.

Workplace Values

(Currently, the DOM Workplace Values are in the process of being updated)

An organization's values underpin its operation and philosophy of doing business, which set the tone for the entire organization. DOM is committed to investing in a healthier Mississippi through access to quality services with the values of **Accountability**, **Consistency** and **Respect**. The agency is focused on providing excellent customer service, acting with fiscal prudence, and operating with high integrity.

Executive Director's Statement of Affirmation for Internal Controls

To the Staff of the Division of Medicaid:

In conjunction with the Division of Medicaid in the Office of the Governor's (DOM) adoption of an Internal Control Plan, I would like to express my full support of the concept for the need to establish and maintain effective internal controls. As an agency of state government, we must remember that our internal control policies and procedures, our Mission Statement and the Adopted Workplace Values set the tone for ensuring that we always strive for accountability, consistency, and respect to both the public and to the beneficiaries we serve.

Our goal of maintaining an effective control environment is to promote the safeguarding of the State's assets and to ensure the proper use of State resources. All staff members serve a very important role in ensuring that DOM's adopted policies and procedures are followed as we strive to accomplish our mission and meet the day-to-day responsibilities that staff is charged with fulfilling.

Three expectations of mine that I would like to share with each of you are that we as an agency of government must strive to provide outstanding customer service to the beneficiaries we serve, the providers who care for them, and the roughly three million residents of the state and our partners in government. Secondly, we must be fiscally responsible and make every effort possible to contain costs associated with the program. Finally, we must operate with high integrity. We must exemplify integrity in our business processes, compliance obligations and contracting practices. We also must maintain integrity in our data and in the way we treat people. Integrity must be at the center of everything we do.

Throughout the past year, the Division has continued responding to the impacts of the COVID-19 pandemic. Due to the enhanced Federal Medical Assistance Percentage (FMAP) provided by Section 6008 of the Families First Coronavirus Response Act (FFCRA), which allowed the Division to carry forward $198 million from SFY 2020 into SFY 2021, the Division has increased its vigilance and stewardship to meet the added federal requirements these funds carry with them. At the same time, FFCRA also required that individuals enrolled for benefits at the date of enactment were to be treated as eligible for benefits through the end of the emergency period. As a result, enrollment has increased roughly 16% since February of 2020.

As we prepare for the eventual lifting of the federal Public Health Emergency, the Division will continue striving to remain a high-functioning government agency that aims to improve the health and the life outcomes of the people it serves, and in turn, Mississippi as a whole, while optimally managing public funding and public trust to ensure the Medicaid program remains stable and sustainable.

This document represents the adopted Internal Control Plan for the DOM. The purpose of this document is to describe policies and procedures in place to safeguard all assets against improprieties and to ensure that DOM complies with all applicable federal and state laws and that the objectives of management are being met. This plan helps to identify management's idea of how activities should be operating.

The plan will be reviewed and updated periodically as needed, but no less than annually, to incorporate any procedural changes at the agency level as well as any changes that need to be made to ensure compliance with federal and state laws. The development and annual assessment of the plan helps to allow management the opportunity to determine if the actual activities are operating as expected and helps to identify if there are any control weaknesses that should be corrected or improved.

Our goal is to change the public's perspective of the Division to understand that we are not just a payer of medical claims, but a driving force in ensuring quality health coverage is available for eligible Mississippians. Thank you for your very important and continual commitment for service with DOM. Your service helps to make a difference in the lives of people who need assistance.

Sincerely,

Drew L. Snyder
Executive Director
July 1, 2021

Major Areas of Operation within the Division of Medicaid

Executive Director

In January 2018, Drew L. Snyder was appointed Interim Executive Director of the Mississippi Division of Medicaid by Governor Phil Bryant. On March 28, 2018, under Senate Nomination 65 of the 2018 Regular Legislative Session, Mr. Snyder was confirmed by the Legislature to serve as the Executive Director for a term beginning March 20, 2018, at the will and pleasure of the Governor. Current Governor Tate Reeves nominated him to continue as director, which was confirmed by the state Senate on May 27, 2020. Mr. Snyder has served in several public sector leadership roles including Deputy Chief of Staff, Policy Director, and legal counsel for Governor Bryant.

Executive Leadership

The Executive Director is responsible for the overall administration of the Mississippi Division of Medicaid (DOM) which includes working with staff from CMS to maintain compliance with federal laws and regulations, monitoring state legislative activity regarding Medicaid, presenting budget information to the Governor and to the Legislature, and networking with other agencies and organizations for improved health care and program effectiveness. Also, the Executive Director is ultimately responsible for the implementation of the appropriate levels of internal control for DOM operations. The responsibility for carrying out the functions of implementing and maintaining internal control extends to the individuals designated within DOM as part of senior leadership and who report directly to the Executive Director. These individuals within this core group of senior leadership assist the Executive Director to ensure proper direction is both communicated and provided to the staff.

The Executive Director's senior leadership includes the following positions:

- **Deputy for Eligibility** (Regional Offices, Eligibility Policy and Training, State Eligibility Operations and Systems)
- **Deputy of Managed Care Operations**
- **Deputy for Health Policy and Services** (Communications, Long Term Care Services and Supports, Medical Services, Mental Health, Pharmacy, Policy)
- **Deputy of Beneficiary and Provider Solutions** (Beneficiary Relations, Provider Enrollment, Provider Relations, Eligibility Systems, Innovations, MES/DSS, and MRP)
- **Director of External Affairs**
- **Chief Legal Counsel**
- **Deputy of Appeals**
- **Deputy for Accountability and Compliance** (Compliance, Financial and Performance Audit, Program Integrity)
- **Director of Internal Audit**
- **Deputy for Finance** (Financial Administration, Finance, Procurement, Reimbursement and Pricing Strategy, Healthcare Pricing, Managed Care Financial Oversight, Third Party Recovery, Property Management, and Imaging/Document Management)

Office of Eligibility

Eligibility is the largest area within the Division of Medicaid in terms of staff and locations throughout the State. Over 650 staff members are in 30 regional Medicaid offices and the central office in Jackson. The **Office of Eligibility** is responsible for Medicaid and CHIP eligibility policy, coordination of policies, procedures, and staff training. Their primary function is to determine eligibility and enroll eligible individuals and families into health coverage through Medicaid and CHIP. The **Office of Eligibility** includes oversight for the following Eligibility sub-units: **State Operations and Regional Office Administration.**

State Operations provides oversight, supervision, training, and other supportive services to the regional office staff. Staff within the central office manages the online eligibility system and develops policy and operational procedures used by regional offices to make eligibility decisions. The central office is responsible for all aspects of the eligibility process and as such, has various duties and responsibilities in administrative oversight, policy, systems, and specialized eligibility functions. Eligibility systems staff provides technical assistance to the regional offices, assists in resolution of case issues resulting from system or data problems, and works with the eligibility system contractor and DOM system staff of system security, access and functionality and on system projects in development.

Regional Office Administration oversees the administration of 30 regional offices throughout the state. Regional offices are responsible for the determination of eligibility for the aged, blind, and disabled groups, as well as families and children.

Office of Coordinated Care Operations

The **Office of Coordinated Care (OCC)** oversees the DOM managed care programs, which are Mississippi Coordinated Access Network (MississippiCAN) and the Children's Health Insurance Program (CHIP), which are statewide managed care programs designed to improve beneficiary access to needed medical services; to improve the quality of care; and to improve program efficiencies as well as cost predictability. The office oversees contracts regarding the operation and performance of MississippiCAN and CHIP, ensures that the coordinated care organizations (CCOs) submit policies, communications, data and reports for review, and coordinates this oversight with other DOM offices based on functional expertise.

Health Policy and Services

(Communications, Long Term Care Services and Supports, Medical Services, Mental Health, Pharmacy, Policy)

The **Office of Communications** is responsible for messaging to DOM's internal and external audiences, which includes the design, writing, layout, and editing and distribution process for the external DOM website, publications, collateral materials, and digital media and radio messages. The Communications office handles public relations, issues official statements and is the contact for news media requests.

The **Office of Long Term Care Services and Support (LTSS)** houses both institutional long term care and four of DOM's Home and Community Based Services (HCBS) waivers along with Hospice coverage. The office oversees certain policy and logistical components of DOM's nursing facility coverage in collaboration with the Office of Financial Administration. Additionally, this area is responsible for oversight and operations of the Elderly and Disabled, Traumatic Brain/Spinal Cord Injury, Independent Living, and Assisted Living Waivers, including system components such as eLTSS and Medikey. LTSS also performs provider enrollment functions for all HCBS providers.

The **Office of Medical Services** oversees the delivery of health care in over 30 medical program areas and includes: medical and operational services, expanded Early and Periodic Screening Diagnosis and Treatment (EPSDT) and professional/ancillary services, preventive services and administrative services related to transportation, medical equipment, medical supplies and appliances. This unit also conducts data analysis on provider claims, operations, and activities.

The **Office of Pharmacy** is responsible for the development and administration of evidenced-based medication use strategies that enhance eligible beneficiary and population health outcomes while optimizing health care resources. The Medicaid prescription drug programs include application of systems and data collection necessary to manage, analyze, and review drug adherence, management of quality and cost-effective pharmacy benefits and the Medicaid Drug Rebate Program including supplemental rebates. Other responsibilities include management and oversight of contracted vendors that maintain pharmacy systems, Preferred Drug List processes, Pharmacy Fee for Service Prior Authorization (PA) program and provider and beneficiary assistance in problems regarding drug coverage.

The **Office of Mental Health** oversees various mental health services available through provider agencies enrolled with Medicaid, such as Community Mental Health Centers, Private Mental Health Centers, Mental Health Clinic Groups, Federally Qualified Health Centers, Rural Health Clinics, Psychiatric Residential Treatment Centers, Psychiatric Hospitals, Psychiatric Units in General Hospitals, Independent Licensed Providers (Psychiatrist, MH Nurse Practitioner, LCSW, LPC and LMFT), IDD Home and Community Based Waiver providers, IDD Community Support Programs and ICF/IID facilities. The office is comprised of two divisions: Special Mental Health Initiatives, and Mental Health Services.

The **Office of Policy** is responsible for the development and maintenance of policies for Medicaid programs and handles State Plan Amendments as well as the Mississippi Administrative Code and the Provider Reference Guide.

Office of Provider and Beneficiary Solutions

(Beneficiary Relations, Provider Enrollment, Provider Relations, Eligibility Systems, Innovations, MES/DSS, and MRP)

The **Office of Provider and Beneficiary Solutions** participates in outreach and educational events for providers and beneficiaries about Medicaid programs, services, and eligibility, serving as a point of contact to Medicaid's beneficiaries and providers. This office is also responsible for maintaining DOM's switchboard, provider and beneficiary call centers, and ensuring required screenings are completed on enrolling Medicaid providers wishing to render services for Medicaid beneficiaries.

Eligibility Systems provides project management and technical expertise to support the Office of Eligibility and serves as the primary point of contact for managing the agency's outsources eligibility system vendor, Conduent Solutions.

Innovations provides project management and technical expertise to support the agency's Clinic Data Interoperability Solution that allows for providers to send and receive Consolidated Clinical Document Architecture (CCDA) on Medicaid Beneficiaries at the point of care. This office is also responsible for working with DOM business areas to promote and improve data utilization to increase data-driven decision making for improved health outcomes and improved agency efficiency and effectiveness.

MES/DSS provides project management and business analysis services to support DOM business areas with system modifications that are needed to ensure the agency operates in accordance with federal and state regulations as well as other modifications that can improve the efficiency and effectiveness of the agency. It also provides oversight of the Conduent MMIS and DSS systems to ensure contract compliance.

MRP provides project management oversight of the incoming fiscal agent, Gainwell Technologies, as it relates to the design, development, and implementation of the new fiscal agent.

Office of External Affairs

The **Office of External Affairs** is the primary point of contact for elected officials and legislative staff as the legislative liaison and leads Government Relations. The Director of External Affairs oversees operations for Government Relations.

Government Relations coordinates and responds to external legislative, congressional, and related requests for information and is responsible for establishing and maintaining positive relationships with Mississippi's elected officials. Government Relations assists legislators and staff with constituent inquiries and general policy questions and advises the Executive Director on matters of policy, strategy, and politics.

Office of Legal Counsel

(Also includes the Office of Privacy and Civil Rights)

The **Office of Legal Counsel** is staffed by both DOM attorneys and attorneys from the Attorney General's Office. This office is responsible for providing legal consultation and representation to DOM in a variety of areas: personnel issues, statutory and regulatory issues, procurements and contracting, recovery efforts, garnishments, levies, bankruptcies and tax liens. The attorneys represent the agency at various administrative hearings, provide guidance on policy drafting and filing, assist the Requests for Information Officer with public records requests and serve as legal liaisons to the Medicaid Fraud Control Unit within the Attorney General's Office through their assistance to the Program Integrity division. In addition to administrative hearings, the attorneys also represent DOM before the Employee Appeals Board, United States Equal Employment Opportunity Commission, and state and federal courts.

The **Office of Privacy and Civil Rights** is in charge of Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance and houses the Privacy Officer. All DOM employees are required to complete HIPAA training and pass a test at the completion of the training. Data-use agreements are required to be signed by parties being given access to Medicaid data agreeing to use the data for only approved and appropriate purposes. Also, this area oversees the use of Business Associate Agreements which are implemented to ensure that the Business Associate will comply with and appropriately safeguard all Protected Health Information (PHI).

Office of Appeals

The **Office of Appeals** resolves conflicts that may arise when a Medicaid beneficiary questions services or categories of coverage for which they are eligible or when a provider questions reimbursement, methodology for services provided or a decision affecting their enrollment in the program. The **Office of Appeals** is also responsible for coordinating, scheduling, and facilitating appeals for Medicaid beneficiaries and providers.

Office of Accountability and Compliance

(Compliance, Financial and Performance Audit, Program Integrity)

Compliance is responsible for informing key senior staff of federal and state regulatory changes that directly or indirectly impact DOM and is responsible for ensuring that DOM contractors, vendors, and providers comply with the terms of their contracts, rules, laws, and regulations. Additionally, because this office operates both internally and externally, it assists in reviewing contracts prior to execution and helps in creating procedures for contract monitoring throughout the agency. The Office of Compliance works closely with program area contract managers to review documents and deliverables submitted by contractors in relation to the implementation of their contracts, as well as to determine steps to be taken in cases of breach or non-compliance of a contract. Through its review of CCO-submitted data, compliance raises the level of CCO accountability, along with the accountability of the agency.

Accountability and Compliance works with Internal Audit to manage external audits and audit responses, and assists other areas by advising them on the need for audit or investigative referrals, as well as organizational and structural policies, workflows, and operations to improve responsiveness both internally and externally.

Program Integrity audits and investigates activities related to alleged provider and beneficiary fraud and/or abuse in the program. Its work includes financial, performance, and investigative audits. Program Integrity acts as a liaison to the MFCU (Mississippi Fraud Control Unit) of the Attorney General's Office.

Based on analysis of provider billing patterns that indicate possible overpayments by DOM, the Office of Program Integrity will initiate either a desk or field audit. A desk audit is done entirely on the basis of billing records and/or actual claims records, or it can mature into a field audit in which the Medicaid auditor goes to the provider's place of business to conduct the record review and any related interviews of medical staff and providers such as physicians or hospital personnel. If the audit indicates the provider has likely abused the Medicaid system by generating unnecessary costs to Medicaid from excessive or unnecessary services, the auditor will prepare and present a formal audit report file. The provider then has an opportunity to appeal adverse audit findings and/or request an administrative hearing before a Hearing Officer, who will thereafter make a written recommendation to the DOM Executive Director for a final decision. Should the provider disagree with the Executive Director's decision, then the provider may file an appeal with the courts.

Investigative Audit and Referral Process – Examples of possible fraud or abuse include falsifying certificates of medical necessity or plans of treatment, and medical records to justify payment; soliciting or receiving kickbacks; and inappropriate billing practices such as upcoding.

Often, what begins as a routine audit may mature into a full-blown investigation if the auditor suspects or identifies that the provider has engaged in conduct beyond mere abuse and committed fraud. Some of these investigations may result in recovery of funds from the provider for improper claims. However, if the evidence supports a credible allegation of fraud by the provider, then the case is referred to MFCU in the Office of the Attorney General for possible criminal prosecution or civil action.

Data Analysis and Medical Review – Key to the development of audits is the use of data analysis tools such as algorithms that uncover areas of potential fraud and abuse in the Medicaid system. The algorithms are created through research using multiple means such as Medicare Fraud Alerts, newspaper articles, websites, and other sources. The Division does not have a full-time statistician or data analyst, and this is an addition which could significantly augment and improve the work of Program Integrity. Program Integrity works closely with multiple external partners and contracted vendors providing a range of different services, such as creating reports, auditing claims, and providing research for provider reviews.

When investigations involve issues of medical judgment, or the medical necessity of treatment and services, the registered nurses in the **Medical Review Division** review claims of both providers and beneficiaries to determine the medical necessity and appropriateness of services rendered and to ensure quality to meet professionally recognized standards of health care.

Medicaid Eligibility Quality Control – Persons initially determined to be eligible for Medicaid may not continue to remain eligible. The team of investigators in the Medicaid Eligibility Quality Control Division regularly verify continued eligibility based on data analysis and reviews, referrals, whistleblower complaints, etc.

Financial and Performance Audit performs compliance and financial audits of contractors and providers including individuals, state agencies, and various organizations to ensure they are compliant with applicable state and federal Medicaid rules, regulations, and laws. Financial and Performance Audit has three distinct teams consisting of provider cost report auditing for long term care facilities; electronic health record system audits (EHR) of providers who have implemented EHR systems and received CMS/Health Information Technology incentive payments; and numerous types of audits of providers who utilize waiver programs. Those waiver programs include:

1. Elderly and Disabled Waiver (E&D Waiver)
    a. Personal Care Services (PCS)
    b. In-Home Respite Services (IHR)
    c. Adult Day Care (ADC)
    d. Case Management
    e. Home Delivered Meals
2. Independent Living (IL) provided through MS Dept. of Rehab Services
    a. Case Management
    b. Related Services
3. Traumatic Brain Injury (TBI)/Spinal Cord Injury (SCI) provided through MS Dept. of Rehab Services
    a. Case Management
    b. Personal Care Services (PCS)
    c. In-Home Respite Services (IHR)
    d. Related Services
4. Assisted Living (AL) providers (personal care homes)
5. Intellectual Disabilities/Developmental Disabilities (ID/DD) (not done one of these yet)
    a. ADC
    b. PCS
    c. IHR
    d. Case Management
    e. Other services
6. False Claims Act
7. Patient Trust Fund Audits (due to covid these have not been performed in a while)
8. Disability Determination Services invoice audit

Office of Internal Audit

The **Office of Internal Audit** is an independent division that reports administratively to the Deputy Administrator for Accountability and Compliance and directly to the Executive Director of the Division of Medicaid. Established in response to State law (Mississippi Code Annotated, 1972; Section 25-65-1, et al.), the Internal Audit Division is designed to assist in improving agency operations, to verify the existence of assets and to identify opportunities for cost savings and revenue enhancement.

The staff uses standard audit procedures to plan and direct risk-based audits of various program areas throughout the agency and to train and monitor internal audit staff as required under MISS CODE ANN. Sections 25-65-1 et. Seq. The key function of this support area is to improve agency operations by preparing and implementing an annual, risk-based audit plan to assess ways of improving DOM's key operational and financial activities and internal controls. Additionally, Internal Audit is responsible for

- identifying and assisting in the documentation of existing internal finance and disclosure controls;
- implementing and documenting new internal controls, policies, and procedures; and
- establishing an internal monitoring function to audit the agency's compliance with such internal controls

Internal Audit staff examine issues related to agency business practices and risk, with audits conducted throughout the year to improve administrative operational efficiency. The area works constantly with Accountability and Compliance and all other units of the Division of Medicaid to improve policies, procedures, operations, and controls.

Office of Financial Administration

(Finance, Procurement, Reimbursement and Pricing Strategy, Healthcare Pricing, Managed Care Financial Oversight, Third Party Recovery, Property Management, Imaging/Document Management, and Office of Hospital Programs and Services)

The **Office of Financial Administration (OFA)** is responsible for effective fiscal management of agency funds for DOM. The Office of Financial Administration is also responsible for ensuring there are adequate internal controls in place to provide for accurate financial reporting both from the perspective of financial statements which are included in the State's Comprehensive Annual Financial Report (CAFR) and from the perspective of fulfilling all financial reporting requirements to the federal grantor agency. Sub-offices within OFA include:

- The **Comptroller**, which consists of **Financial Reporting, Accounting, Buy In/Medicare, and Third-Party Recovery**
- **Property Management**
- **Reimbursement**
- **Imaging and Document Management**

The **Comptroller** is responsible for overseeing the activities and functions of Financial Reporting and Accounting. Other added responsibilities include oversight of the operations of the Buy In/Medicare functions for Medicare premiums paid by DOM for eligible Medicaid beneficiaries and oversight of the Monthly Financial Comparison Reporting functions.

Financial Reporting prepares major financial reports required for submission to oversight authorities including required federal financial reports that detail DOM's medical services and administrative expenses and the agency's financial statements and grant schedules included in the state's CAFR. Responsibility for preparing DOM's annual operating budget for the forthcoming fiscal year is also included within the Office of Financial Reporting.

Accounting is responsible for four different units: **Purchasing**, **Accounts Payable**, **Payroll**, and **Accounts Receivable**. These units oversee the day-to-day responsibilities of purchasing and payment of the goods and services provided to the agency, receipt of all funds, payroll for all employees and contract workers, travel for employees, and payment to providers among a vast variety of other duties.

The **Purchasing Unit** is responsible for acquisition of goods and services needed by the central office and regional offices. Purchases are made by purchase orders or by a procurement card to ensure the most efficient and cost-effective means of delivery. The purchases are done in accordance with the State Procurement Manual, Mississippi Agency Accounting Policy and Procedures (MAAPP) Manual and State Contracts that are governed by Department of Finance and Administration (DFA). All DOM employees are required to submit a request for commodities or services through a software system application known as *eRequisition*.

The **Accounts Payable Unit** is responsible for processing all invoices for goods and/or services received by DOM and processing vouchers for reimbursement of employee travel expenses and for the accurate and timely processing of paychecks for all of the agency's State Service and contractual employees.

Accounts Receivable is responsible for receiving, reviewing, maintaining, and depositing all monetary transactions payable to DOM in a timely manner and in accordance with the MAAPP Manual. This area processes the weekly transfer of funds to the DOM's fiscal agent for claim payments to Medicaid providers and draw federal grant funds. Accounts receivable is also responsible for agency operations involving the collection, processing, recording and reconciling all cash receipts including checks, wire transfers, and inter-governmental transfers into the correct funds with the correct revenue source codes within the State of Mississippi's MAGIC Accounting

System. Other duties include the weekly funds report; the invoice for hospital and nursing homes for bed tax assessments; and the budget with any assistance needed to input.

Payroll is responsible for preparing, managing, and reconciling monthly, supplemental, and contractual payrolls in accordance with a schedule authorized by DFA. It involves computing and recording deductions, collecting forms for changes to federal/state tax exemptions along with handling insurance, miscellaneous deductions, name/address changes and various other duties in order to ensure the accuracy of employee payroll in compliance with the policies and procedures set forth by DFA. Payroll is processed in the Statewide Payroll and Human Resources System (SPAHRS).

The **Office of Procurement** is responsible for managing the selection of contracts that are awarded on a competitive basis through the Request for Proposal (RFP) Process. They are responsible for ensuring that the competitive bidding process follows the rules and regulations set forth by the Public Procurement Review Board (PPRB). Procurement has at least one attorney dedicated to the drafting and construction of all DOM contracts.

The **Office of Third Party Recovery** ensures that Medicaid is the payor of last resort and recovers money due Medicaid from any third party responsible for paying medical expenses of beneficiaries. The office is tasked with identifying liable third-party sources to prevent Medicaid payments, recovering medical payments made on behalf of beneficiaries after discovering a liable source, and assisting providers and others in complying with federal and state regulations governing Medicaid. The office's objective is to protect the beneficiary who has a third-party resource from being billed by the provider or being refused service because of the existence of a third-party source. Within the Office of Third-Party Recovery, there are several units with various responsibilities: File Maintenance Unit, Bookkeeping Unit, Beneficiary Recoupment Unit, Estate Recovery Unit, Health Unit and Casualty Unit.

Property Management is responsible for scheduling and conducting internal agency property audits, recording inventory of all new property acquisitions, facilities maintenance liaison, agency fleet management, iTECH warehouse management, parking assignments, office renovations and maintaining the vehicle policy manual.

Reimbursement and Pricing Strategies computes institutional provider reimbursement rates and manages payment methodology for certain medical care services including nursing facilities, intermediate care facilities for individuals with intellectual disabilities, psychiatric residential treatment facilities, home health agencies, hospitals (both inpatient and outpatient), rural health clinics, federally qualified health centers, hospices and the Mississippi State Department of Health clinics in accordance with the State Plan. Reimbursement also analyzes cost and statistical data to suggest changes in reimbursement methodology and amendments to the State Plan.

The **Office of Imaging and Document Management** is responsible for analyzing and executing the document scanning requirements for the agency, shredding scanned documents, and serving as a liaison between DOM and Archives and History.

The **Office of Hospital Programs and Services** is responsible for managing the policies governing prior authorization, the rendering of prior authorized services, and validating the adjudication or coordination of the federally mandated auditing programs associated with these claim types. This Office is also responsible for analyzing trends in claims processing, assisting in identifying and quantifying issues, conducting ongoing assessments, and investigating claim payments and operations and monitoring coordinated care plans to assure contracting and regulatory obligations are met.

Office of Information Technology Management (iTECH)

The **Office of Information Technology Management (iTECH)** is responsible for overseeing the operation of Medicaid's eligibility and claims processing and payment systems. **iTECH** provides data analysis to support state health policy changes and health care reform and is responsible for the design, implementation, operation, and security of DOM's networks. This office also manages software, equipment, and technical support services, provides staff with access to data in a secure environment and manages CMS funding requests for system modifications. The **Offices of Clinical Support Services, Technology Operations and MRP** fall under iTECH.

The Office of iTECH takes on responsibility for the design, implementation, and operation of the agency's Wide and Local Area Networks which connect DOM's central and regional offices located throughout the state and for maintaining the agency's *All Hazards Continuity of Operations Plan (COOP).*

Office of Human Resources

The **Office of Human Resources** is responsible for coordinating all personnel policies and procedures originated by the Mississippi State Legislature, Mississippi State Personnel Board, the Department of Labor, and DOM. The office's obligations include, but are not limited to, the following:

- Recruiting personnel
- Classifying positions with fair compensation
- Ensuring all disciplinary actions are carried out in a fair and legal manner
- Validating the agency complies with relevant federal and state laws
- Overseeing leave and benefit matters
- Facilitating training of current employees and employee development
- Maintaining personnel files

Special Assistant to the Executive Director

The Special Assistant to the Executive Director lays the groundwork to define agency project expectations and goals, ensuring clear communication and creating efficient ways to work together. The Special Assistant to the Executive Director oversees disaster management and serves as the agency's Emergency Coordination Officer overseeing preparation and implementation of the agency's Disaster Management Plan, as well as coordinating disaster, emergency, and inclement weather messages to staff.

Components of Internal Control

Internal control is defined as a process involving those charged with governance, management, and other personnel designed to provide reasonable assurance about the achievement of the entity's objectives with regard to the reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations. Internal control includes designing, implementing, and managing system, operational, organizational, and employee controls relating to financial reporting and operations for safeguarding assets against unauthorized acquisition, use, or disposition. Internal control encompasses everything that controls risk for fraud, waste, and abuse at DOM.

A comprehensive framework of internal controls consists of five interrelated components and 17 principles. In an effective internal control system, these components support DOM's mission, objectives, and strategies:

1. **Control Environment:** The organization's culture, philosophy, and ethical values. It is the set of standards, processes, and structures that underpin internal control across the organization.
2. **Risk Assessment:** The identification and analysis of potential risks that could hinder or prevent DOM from achieving its objectives and mission.
3. **Control Activities:** The structure, policies, and procedures needed to address the risks identified that could prevent management from achieving its objectives and mission.
4. **Information System and Communication:** Data and information that is reliable to determine their risks and communicate the policies and other information internally and externally. Information is necessary for the entity to carry out internal control responsibilities. The Information System includes the related business processes relevant to financial reporting.
5. **Monitoring**: Control activities are monitored to continuously manage their effectiveness.

Each of these components will be addressed in this Internal Control Plan.

Section 1. Control Environment

The control environment sets the tone of an organization, influencing the control consciousness of its people and is the foundation for all other components of internal control, providing discipline and structure. It comprises the integrity and ethical values of the organization. A weakness in the control environment may result in the ability to rely on the effectiveness of the other components of internal control. Five principles make up the control environment:

1. Demonstrates commitment to enforcement of integrity and ethical values
2. Exercises oversight responsibility
3. Establishes organizational structure, assignment of authority and responsibility, and human resources policies and practices
4. Demonstrates commitment to competence
5. Enforces accountability

The control environment consists of the actions, policies, and procedures that reflect the attitudes of top management and directors about control and its importance to the agency. The overall goal of an effective control environment is to promote teamwork among competent cost-conscious employees with integrity and shared organizational values, with management reinforcing expectations at the various levels of the organization. The resulting control environment has a universal impact on the overall system of internal control.

Employee Hiring and Expectations

After an applicant interviews and is selected for an open job position, the candidate is required to sign a Background Authorization Form for the Division to conduct a criminal background investigation. No offer of employment is extended until the results of the background check have been reviewed and approved by the Human Resources office.

Once the employee is hired and begins work, he or she is given a packet of information, which includes a written statement from the Executive Director expressing commitment under his leadership and guidance with the expectation of conducting operations with accountability, consistency, and respect as stated in the DOM's Strategic Plan Document and Mission Statement. Also, the new employee must review, watch, read, and successfully complete tests at a passing level in a system known as E-orientation. Employees access the E-orientation system via DOM's intranet, and it involves a series of questions about the entity. Additionally, employees are required to acknowledge through the completion of a DOM Employee Manual Acknowledgement Form and the Mississippi State Employee Handbook Acknowledgement Form that they are responsible for reading and understanding the policies and procedures included in both manuals. Since DOM is a state agency, the agency also follows the rules and regulations outlined in the Mississippi State Employee Handbook, and the Mississippi State Personnel Board Policy and Procedures Manual.

The agency has a Division of Medicaid Employee Manual that is more specific to internal operations and expectations. This manual is currently undergoing a review and update process, which began in 2021. In the Employee Manual under the section titled Ethical Policies, it states that employees are required to comply with the agency's Internal Control Plan.

The DOM Employee Manual details what actions can be considered offenses, which could result in disciplinary action taken when the policies and procedures are not followed. Also, upon being hired, employees are required to complete a Nepotism Questionnaire under their signature asserting that they have disclosed that there are either no nepotism issues or have provided information that can be used to determine if facts indicate a potential ethics issue.

Due to the sensitivity of information handled by DOM employees, there are requirements that employees must read and understand, as evidenced through the passing of a written examination, various rules and regulations related to the Health Insurance Portability and Accountability Act (HIPAA). The employee is required to continue reviewing the HIPAA policies and taking the HIPAA test until he or she receives a passing score.

Another requirement for employees is to sign a Confidentiality Agreement Form wherein they acknowledge the importance of confidentiality related to Medicaid records; the responsibility of public trust and confidence placed upon them in conjunction with performance of their job duties; and the expectation that they will adhere to the confidentiality policy referenced in the DOM Employee Manual as well as the consequences for failure to follow the requirements of the policy.

The Division Office of Information Technology Management (iTECH) has adopted Security Policies and Procedures as reflected in the DOM Employee Manual to ensure confidentiality and security of Protected Health Information (PHI). The Division also has adopted specific Information Technology Policies referred to as the Division of Medicaid Security Policies for Protecting Confidential Information. These policies are incorporated into the DOM Employee Manual.

Both the DOM Employee Manual and the State Employee Manual are available at all times to DOM employees via electronic access through the DOM intranet. As such, all employees are always expected to follow these policies.

All employees are issued a Division of Medicaid Security ID Card (SmartCard) by iTECH. One way this smart card is used to protect the confidentiality and resources accessed by DOM employees is used to access printers. With the increased number of employees who are teleworking during the past two years related to the COVID-19 pandemic, there has been some data security risks related to working from home. Employees are required to complete an attestation if working from home that includes a series of questions that covers these risks and concerns. A two-factor authorization is used to log into the DOM network from an outside network. Two-factor authentication gives a higher level of security than single-factor authentication, where only one factor is used

such as a password. The second factor gives additional security such as a phone call, text, or an approval notification via an app with all using the cellular phone number set up for the employee.

Employee job performance is rated every six months for new employees and at least annually for permanent status employees under the Performance Development System (PDS). DOM's executive management has mandated that all employee performance evaluation reports include a performance standard requiring the employee to adhere to the agency's ethical policies and that the employee be evaluated on compliance with this standard.

Communication

Weekly, the Executive Director sends an email newsletter called the Medicaid Snapshot to all employees with up-to-date information on activities within the agency and to reinforce the importance of their job responsibilities. The agency has a department dedicated to employee training and access to training opportunities, which are located on the agency's intranet for easy access by employees. Specific job duty technical training is generally accomplished through "one on one" individualized training. Management is committed to ensuring all employees possess the required professional and technical competence to perform their jobs at a highly successful level.

Internal and External Audits

DOM has implemented a formal Internal Audit Function, which adheres to both the Mississippi Internal Audit Act and the professional standards of the International Internal Audit Standards Board (IIASB). The Office of Internal Audit annually plans and conducts risk-based audits that are independently designed and discussed with the DOM Executive Director. The Internal Audit Director operates independently of all other program areas at DOM, although it does provide support to audit results.

Findings and the program area responses and corrective action plans are presented to senior level leadership staff of the areas being audited and the Executive Director for consideration and implementation of the auditor's recommendations.

Additionally, DOM participates in numerous external audits of the agency from federal and state agencies such as the Mississippi Office of the State Auditor, the Joint Legislative Committee on Performance Evaluation and Expenditure Review, the federal Health and Human Services (HHS), the Centers of Medicare and Medicaid Services (CMS), the Social Security Administration, and other federal entities.

DOM continuously conducts audits, desk reviews, and general and project specific oversight of external providers and contractors through several divisions throughout the agency. DOM audits are conducted by the Office of Program Integrity and the Office of Financial and Performance Audit as well as the Finance, Medical Services, Pharmacy, Compliance, and several other program areas. This work also includes audits of medical service claims which make up roughly 97% of total agency expenditures and some of the Division's larger contracts.

Each of these program areas also collaborate interagency to ensure that all relevant program areas are included in the agency-wide oversight responsibilities.

Control Environment Conclusion: The control environment objectives have been properly addressed through a good organizational structure and policies and procedures, which have been put in place by the management of the Division of Medicaid. Management has effectively communicated the policies and procedures to the staff.

Section 2. Risk Assessment

An entity's risk assessment process for financial reporting purposes is concerned with its identification, analysis, and response of risks relevant to the preparation of the financial statements that are presented fairly in conformity with generally accepted accounting principles. The focus is on the objectives of the agency and the risks to achieving those objectives. It is important to emphasize stating operations, reporting and compliance objectives clearly, so that any risks to those objectives can be identified and assessed. Four principles are associated with the risk assessment component:

1. Specifies suitable objectives
2. Identifies and analyzes risk
3. Assesses fraud risk
4. Identifies and analyzes significant change

DOM considers risks both external and internal that could occur and have an adverse effect on its ability to initiate, authorize, record, process, and report financial data consistent with the assertions of management in the financial statements. Risk can arise or change due to circumstances such as changes in the operating environment, personnel changes, and new business models or technology.

Risk assessment begins with the identification of the agency's primary responsibilities and functions through the development of DOM's Mission Statement and Strategic Plan. The Mission Statement and the Strategic Plan serve to ensure that the agency's priorities are clear and communicated to all levels of staff.

DOM has initiated a strategic business planning process to establish a sound foundation for the agency's success moving forward. Known as the Division of Medicaid Strategic Plan, it includes objectives that the agency has adopted to address both the overall issues of ongoing risk and the continuity of the operations. Several objectives are outlined in the original document:

- Improving human resources management by decreasing turnover and burnout
- Strengthening succession planning and improving customer service relations
- Improving staff development opportunities
- Reviewing the current agency structure towards making changes necessary to enhance the agency's success

Within each of these objectives are sub-objectives which provide the Division of Medicaid's staff with specific areas for focus to ensure the objective is met. Each of these areas drives the effort to minimize risk associated with the operations of the agency. The Strategic Plan has been undergoing review and revision beginning in July 2021. This on-going effort is expected to be completed by July 1, 2022.

Risks prevalent in the operations of the Medicaid program that management has had to consider include external risks and internal risks:

1. External risks include economic and social conditions, external regulation, rapid growth, natural events, political conditions including budgeting of funds and technology changes. These risks can include individuals and contractors, vendors, providers, and beneficiaries and other outside entities, such as the State Legislature that sets appropriation and activity levels and requirements, and that can have an impact on Medicaid's efficient and effective operations and compliance with federal rules, regulations, and laws. External influences also include national emergencies, such as the COVID-19 pandemic, which had wide-ranging state and national impacts in 2020 and 2021.

2. Internal influences that contribute to Medicaid operational and financial risks include changes and turnover in personnel, changes in staffing duties and responsibilities, new or modified technology, software, hardware, information systems, data processing, cash management activities, and asset

protection and preservation. Loss of key, experienced personnel, staffing shortages, changes in the availability of technology to complete job functions, changes in required financial applications and operations, lack of training, and similar internal operational issues can all have an impact on DOM's ability to function at its peak capacity.

The Division of Medicaid's response to the identified risks are addressed by management by:

1. Avoiding Risk – continuously evaluating operations to identify and reduce, modify, or end those activities that give rise to risk.
2. Reducing Risk – implementing management decisions daily to drive the risk down; including staff in understanding operational risk issues to help mitigate risk at all levels.
3. Sharing Risk – transferring a portion of the risk to another party by means of outsourcing an activity, while retaining oversight of the activity to determine if risk may be lower or eliminated.
4. Identifying, through root cause analysis, the underlying causes of the risk to DOM so that the agency can create and implement strategies to further mitigate risk.
5. Accepting Risk – represents management's decision to accept an identified level of risk because the cost to address the risk exceeds the potential threat or cost of the risk.

In conjunction with risk assessment, an Agency-Level Internal Control Assessment document is completed under the direction of the State of Mississippi's Department of Finance and Administration (DFA) and is updated annually to ensure controls are documented and in place. A copy of the most recently completed DFA Agency-Level Internal Control Assessment document is available upon request from the Comptroller. Along with updating the Agency-Level Internal Control Assessment, a certification letter is sent annually to the State of Mississippi's Department of Finance and Administration making the assertion that the evaluations of internal controls within the significant areas of processing and reporting of financial and compliance data have been completed and weaknesses, if any, have been addressed.

Operational Risk

To address operational risks associated with continuity of operations, DOM has developed an All-Hazards Continuity of Operations Plan which applies to the functions, operations and resources necessary to ensure continuation of all essential functions in the event normal operations at its central office are disrupted or threatened with disruption. This Operations Plan addresses areas of operation within DOM related to Readiness and Preparedness, Activation and Relocation, Continuity of Operations and Reconstitution Operations. This document ensures that DOM can conduct its essential missions and functions under all threats and conditions, with or without warning. Periodic updates are made to the document to ensure it includes the most current information available in the event it is required to be put into action.

Fraud Risk

The agency considers a potential for fraud in assessing risks to the achievement of objectives. The fraud risk triangle is made up of three sides: incentives/pressure, opportunity, and rationalization. Fraud risk is addressed by DOM through the performance of procedures by the **Office of Program Integrity**, the **Office of Accountability and Compliance**, the **Office of Financial and Performance Audit**, and other program areas, such as Medical Services and the Office of Financial Administration that either directly or through contracts, continuously review claims data, financial reports, and other relevant data. The Office of Program Integrity investigates cases of provider fraud or abuse by analyzing provider records, medical charts, eligibility records and payment histories. Also, the Office of Program Integrity, as a part of its audit and investigative function, conducts field audits which include interviews with provider staff and medical beneficiaries to help make determinations of potential fraud. In addition, a member of the public or a DOM related person or entity can also report suspected fraud or abuse via

the internet. The following link to the Division's public facing website allows individuals to report suspected fraud or abuse in the Medicaid program: https://medicaid.ms.gov/contact/report-fraud-and-abuse.

The **Office of Medicaid Eligibility Quality Control (MEQC)** within the Office of Program Integrity determines the accuracy of eligibility decisions and investigates complaints alleging improper receipt of medical benefits. MEQC verifies that persons receiving Medicaid benefits are eligible and ensures that no one is refused benefits for which they are entitled. DOM employees are specifically prohibited from processing initial applications, redeterminations, or changes for Medicaid benefits of their own, their immediate family members, or members of their household as detailed in Section 101.12 of the Mississippi Division of Medicaid's Eligibility Policy and Procedures Manual. Within the manual, specific guidelines detail how the applications for Medicaid benefits involving a DOM employee, household member, or immediate family member are to be processed and by whom. Employees who fail to follow these procedures outlined in the policy manual are subject to disciplinary action. Normally, the process of all applications is to be reviewed a level above and at other levels. See the link to the Eligibility Policy and Procedures Manual at https://medicaid.ms.gov/eligibility-policy-and-procedures-manual/

The **Data Analysis Unit** within the Office of Program Integrity creates algorithms that uncover potential areas of fraud and abuse in the Medicaid program. Staff develops analysis reports for use in investigations, collects data for analysis reports and documents recovery and recoupment of funds in cases worked by the Office of Program Integrity. Program Integrity will be adding on a spatial analysis unit that will allow for the use of GIS as an analytical took to identify potential for fraud. This opportunity will help to streamline certain manual processes, making the Division's operations more efficient and effective and allowing the staff to focus on higher risk areas.

The **External Audit Contract Management Unit** within the Office of Program Integrity oversees the activities of external auditors including the Recovery Audit Contractor (RAC) and the Unified Program Integrity Contractor (UPIC) and their efforts to identify and remediate potential fraud, waste, and abuse. This unit also reviews various reporting requirements on CCOs related to fraud, waste, and abuse and provides oversight for the Program Integrity related efforts of the current Non-Emergency Transportation (NET) Broker. See the Monitoring Section of this document for additional information.

The **Medical Review Unit** within the Office of Program Integrity utilizes registered nurses to review claims of both providers and beneficiaries to determine the medical necessity and appropriateness of services rendered to ensure quality to meet professionally recognized standards of health care.

Each of these areas provide support and assistance to other DOM program areas that also do audits and desk reviews. These other program areas consult with and feed projects into the PI unit. This overlapping communications between the direct project areas and the Program Integrity support unit helps to lower overall risk levels as well.

Management has identified the following areas of operation that have risk associated with them impacting the overall objectives of accurate processing of the transactions for financial reporting and compliance. Inherent risks in these areas of operation are considered to range from medium to high. As such, control procedures have been implemented to mitigate the risks in these areas. Documentation of the assessed risk and the control procedures identified to reduce the assessed levels of risk is available upon request from the Comptroller.

Areas of Risk Related to Medicaid Claims Processing and Reporting Related Costs of Medicaid Claims

Provider enrollment functions

- Medicaid eligibility determination
- Fiscal Agent Medicaid Management Information Systems (MMIS) claims processing functions (this system is still in transition to a new one that has a current expected "go-live" date in 2022.)
- Managed care claims processing and data transfer
- CHIP eligibility determination processes and billing and payment processes
- Claims reimbursement processes
- Matching requirements
- Federal funds drawdown processes and revenue recognition

- Activities allowed or unallowed
- Allowable costs/cost principles
- Rate setting procedures
- Federal reporting requirements for the CMS 21 federal report and the CMS 64 federal report
- Special tests and provisions

Areas of Risk Related to the Administrative Cost Functions of Medicaid Programs:

- Statewide accounting system (MAGIC) transaction processing and approvals
- GAAP reporting packages preparation
- Journal entries/correcting entries
- Human Resources (including payroll functions)
- Receipt/Revenue recording functions
- Procurement functions
- Disbursement functions
- Travel functions
- Budget limitations/spending authority levels

External Network Security Risk Assessment

DOM has a network risk assessment performed by an external vendor every three years with the most recent external security assessment performed in April 2021. This vulnerability assessment was designed to help the Division perform due diligence in maintaining reasonably secure internal network environment. This evaluation consisted of using industry standard commercial and open-source scanning software to scan the DOM environment. Network security procedures are performed according to the Network Systems Manual, the Mississippi Department of Information Technology Services (ITS) Enterprise Security Policy dated October 1, 2013, and IRS Publication 1075 dated September 2016 (revised November 2021).

The objectives agreed upon between DOM and the external vendor included the following:

1. Perform an automated vulnerability scan of internal devices including an analysis of identified systems to determine the reasonableness of security levels.
2. Perform penetration testing needed to validate vulnerabilities found during scanning.
3. Create a consistent and complete report summarizing the vulnerabilities in the Division of Medicaid's internal and external environment, including an executive overview with separate supporting detailed technical documentation.
4. Provide security expertise to assist with understanding and identifying remediation of any identified control weaknesses and provide recommendations needed to bolster the environment security posture.

Recommendations, if any, for improvement identified because of the performance of this risk assessment are considered by iTECH for implementation of corrective action plans. The most recent copy of the Executive Summary of the Network Security Risk Assessment is available for review upon written request to the iTECH Security Officer.

Risk Assessment Conclusion: Management has effectively identified areas of risk for ongoing risk-assessment management and the internal-control activities necessary to mitigate risks to meet the internal control objectives of efficient and effective operations, reliable financial reporting, and compliance with laws and regulations.

Section 3. Control Activities

Control activities are the actions established through policies and procedures to help ensure that management's directives to mitigate risks that are identified during the risk assessment process are carried out. The necessary actions are taken to address risks that threaten the achievement of the entity's objectives and are applied at the various organizational and functional levels. Control activities may be preventive or detective in nature and may cover both manual and automated activities.

Control Activities help ensure that the management directives are carried out. These directives can be carried out by performance and secondary supervisory reviews, include those relating to authorization, safeguarding of assets, asset accountability, information processing and various reconcilement procedures and processes, and segregation of duties, which is to be designed to reduce opportunities for an individual to perpetrate and conceal errors in frauds while performing normal duties.

The control activities principles consist of the following three items:

1. Selects and develops control activities
2. Selects and develops general controls over technology
3. Deploys through policies and procedures

Medicaid staff prepare narratives addressing specific control procedures that have been designed, tested, and implemented to address each area of risk in an effort to ensure that the risk of a material misstatement or the risk of a material instance of noncompliance can be reduced or mitigated to an acceptable level. Cost-benefit considerations are considered unless the potential negative effect of the risk is greater than management is willing to tolerate in its system of processes. Procedure narratives within these major categories of operations are currently being reviewed for any updates required to effectively manage risks and address changes in various processes. See the Risk Assessment Section for areas of risk DOM has identified and for which control procedures have been implemented.

Additionally, the Agency-Level Internal Control Assessment document is prepared using the guidance and rules set forth by the State of Mississippi's Department of Finance and Administration and includes documentation and responses from DOM staff to pre-established questions pertaining to certain control activities applicable to the fiscal processes of the agency. This documentation is updated annually and includes control activity assessments in the following areas:

- Control Environment
- Risk Assessment
- Control Activities
- Information and Communication
- Monitoring
- Procurement and Accounts Payable
- Cash Disbursements
- Accounts Receivable
- Travel
- Grants Administration
- Fixed Assets
- SPAHRS
- MAGIC Security
- Fraud, Waste and Abuse

During 2020 and 2021, DOM established an Office of Internal Audit. This department is responsible for independently evaluating operations within the agency, reporting to the Executive Director and related division

directors and executive leadership on any deficiencies or weaknesses in operations, systems, personnel, etc., that could lead to increased risk. Operating under the Mississippi Internal Audit Act and within the established standards of the International Internal Audit Standards Board (IIASB). Annually, the Office of Internal Audit creates risk-based audit plans that evaluate operations within the agency with the aim of improving operations, strengthening controls, and mitigating risks of fraud, waste, and abuse. Internal Audit has an approved operating manual that defines and describes its operations, independence, standards, and goals.

To fulfill the agency's statutorily required responsibilities, DOM contracts with an external service organization known as the fiscal agent – currently Conduent – to process Medicaid claims payments. These processes are part of a separate control environment and have separate control functions involved with the daily processing of Medicaid claims.

Fiscal Agent Operations

By far the largest expenditure at Medicaid are the funds disbursements related Medicaid claims payments to providers and capitation payments to the Coordinated Care Organizations (CCOs) under the managed care program. Both of these are managed through a DOM contract with an external fiscal agent or service organization. The Division currently contracts with Conduent as the Fiscal Agent for the purpose of making all payments of medically related claims to approved providers for eligible services rendered to Medicaid eligible beneficiaries and for capitation payments made to the CCO on behalf of their claims paid.

The Envision System

The Fiscal Agent Conduent uses a system referred to as Envision, and which was developed over many years from a base system. The system type is a Medicaid Management Information System or MMIS. The **Envision System** has specific system documentation that has been put into a document called the System Documentation Document or (SysDoc). Information in this document is based upon what was included in the approved Detail System Design within the DOM's Advance Planning Document approved by the Centers for Medicare and Medicaid Services (CMS), the federal grantor agency for the Medicaid program. The following link provides documentation for the Envision System: http://intranet.ms.acs-shc.com/.

Within the Envision System, many control edits or tools have been created to help ensure that the most accurate and correct data is maintained in relation to medical claims processing. The "General" subsystem of Envision includes support components of the MMIS such as security group and user administration and password maintenance. Envision has system parameters and systems lists that control processing functions performed by subsystems and data locking, which provides a mechanism to ensure data integrity across the system by ensuring that only one user will update a record at any given time.

Envision includes a Claims Processing Assessment System (CPAS) which is a Medicaid Quality Control management tool used to assist the DOM in monitoring the integrity of claims processing and payment within the system. CPAS selects sample claims based on various user defined parameters and selection criteria. The System also includes Electronic Data Interchange which provides connectivity for the flow of health information and data between providers, facilities, vendors, claims payment agencies, and other clearinghouses. Numerous interfaces are completed as cross checks for duplicate payments, issues, or invalid claims. Also, the system provides for two specific eligibility interfaces that are outside DOM and the Medicaid Eligibility Determination System to help determine a beneficiary's eligibility for Medicaid or CHIP. Online user login security for the Envision System consists of two basic services:

- Authentication validates the identity of a user when they initially log into the system and provide that information to the system applications as required.
- Authorization enables or disables functions and data access needed for an individual user.

The Envision System uses an IBM Database 2 (DB2) to provide a secure and flexible data storage environment. Envision also has many processes that use secure file transfers between systems and produce several reports that can be used by DOM and other authorized entities to analyze provider data in the system.

Each subsystem Envision maintains its own security profile information for its own functions. Envision System security is implemented independently of network security and does not depend on the functionality of network security. This feature is designed to ensure that Envision System security rules are enforced above and beyond any safeguards such as firewalls, Windows, domains, or Netware which may be applied to the network connection.

The Envision System also includes audit trails and logging which refers to information that the system stores in the production database to identify changes that system users make online. Logging refers to MMIS functions that capture and retain data that users newly add, replace, or delete from the database. Information on the identification and date and time of any changes made by the user is stored in the system for future reference. Envision is made up of 10 standard subsystems, of which three of the subsystems are described below in more detail:

- The Envision System Provider Subsystem supports the entry, maintenance, and reporting of current and historical information for all providers who participate in the Medicaid program as administered by the Division and is designed to be fully HIPAA compliant. The Provider Enrollment subsystem includes enrollment tracking, completion edits, and final edits to ensure accuracy and integrity of the data processed.
- The Reference Subsystem provides a reliable, flexible means to maintain information required by the Envision System for claims administration. The primary function of the reference database is to serve as a repository of data required for claims processing, prior authorizations, and third-party liability processing.
- The Claims subsystem within the Envision System is divided into four general areas: Claims Entry, Claims Pricing and Adjudication, Claims Payment and Reporting and Claims Financial, which the details of specific edits and other controls for each area are addressed in specific sections within the Mississippi Envision Systems Documentation Manual.

As part of DOM's efforts to ensure that the fiscal agent maintains adequate internal controls over the processing of medical claims payments, the fiscal agent is required under its contract with the Division to have an external audit of its controls including an opinion on the effectiveness of those controls performed annually. See additional information in Section 5. Monitoring under Fiscal Agent Claims and Other Controls Processing Report related to this requirement.

Managed Care Program Information

DOM implemented a managed care program called the Mississippi Coordinated Access Network (MississippiCAN) January 1, 2011, in all 82 counties. This program has continued to grow since its implementation and has developed into becoming a very significant part of the health care costs paid through the Medicaid program. Additionally, DOM has a supplemental program called the Mississippi Children's Health Insurance Program (CHIP), which is administered by two CCOs. Both MississippiCAN/CHIP are designed to help the State of Mississippi receive a better return on Mississippi's health care investment by providing low-to-no-cost health care coverage to eligible Mississippians.

MississippiCAN/CHIP are statewide coordinated care programs designed to meet the following goals:

1. Improve beneficiary access to needed medical services.
2. Improve quality of care and population health.
3. Improve program efficiencies and cost effectiveness as well as cost predictability.

DOM has contracted with three CCOs – Magnolia Health, Molina HealthCare, and UnitedHealthcare Community Plan – to aid in carrying out MississippiCAN. Two mange the Mississippi CHIP program. These organizations are private organizations that have entered into risk-based contractual agreements with DOM to obtain and finance health care for enrolled Medicaid members or beneficiaries who participate in the MississippiCAN/CHIP programs. Certain beneficiaries qualify for this program, both mandatory and optional beneficiary populations. There are some Medicaid eligible beneficiaries that cannot be a part of MississippiCAN for various reasons and are part of a direct pay, fee-for-service Medicaid program. Those eligible members deemed mandatory are required to be in MississippiCAN.

Currently, these mandatory members or beneficiaries can choose Magnolia Health, Molina HealthCare, or United Healthcare Community Plan. Choosing to be in the fee-for-service Medicaid program is not an option for mandatory members. Only those beneficiaries in the optional populations will have the choice of fee-for-service Medicaid or MississippiCAN. Effective November 1, 2019, CHIP beneficiaries are administered by two of the three CCOs: Molina Healthcare and UnitedHealthcare Community Plan. Any CHIP beneficiary who was enrolled in the outgoing CHIP CCO, Magnolia Health Plan, received a letter giving them the choice between the other two CCOs plans. If no response was received, the CHIP beneficiary was assigned to Molina Healthcare.

To ensure that the calculation, documentation, and certification of the capitation rates paid to the coordinated care organizations are actuarially sound and comply with CMS regulations, DOM has retained the services of an actuarial firm, Milliman, Inc. Capitation rates are actuarially determined rates that the CCOs will be paid on a per member per month basis for providing services to eligible Medicaid beneficiaries through its network of medical providers. Each CCO is paid an amount based upon the distribution of members they have in each contractually approved rate cell at the predetermined actuarial rate approved by CMS.

Annually, with review, approval, and input by DOM, Milliman develops a rate-tracking document and prepares a rate setting letter which addresses all of the categories of eligibility (COEs) split between three regions of the State (North, Central and South) where there are separate capitation rates defined for each region, for each beneficiary Category of Eligibility (COE) and age. This rate setting letter identifying the actuarially determined rates and supporting information is submitted to CMS for approval.

As part of the contractual arrangement and to comply with federal regulations, DOM does not allow the CCOs to directly market to beneficiaries. DOM provides beneficiaries with information about choosing a coordinated care organization and enrolls the beneficiary into the program of the beneficiary's choice. Beneficiaries who are automatically assigned do not choose a CCO.

The Mississippi Envision MMIS System includes a Managed Care subsystem which generates capitation claims, produces enrollment rosters, and reports for the managed care plans and handles capitation processing. DOM provides the fiscal agent with changes to the system and the fiscal agent modifies the system "rules" to accommodate necessary changes that ensure the accuracy of payments. Each of the coordinated care organizations are assigned a Medicaid provider number and report encounter claims data to the Division's fiscal agent, Conduent, for inclusion in the Envision System. See **Section 5. Monitoring Efforts Over the Managed Care Program** for additional information related to this requirement.

Control Activities Conclusion: The Division of Medicaid has documented its control procedures to help mitigate the risks of material misstatements or instances of material noncompliance with federal and state laws and regulations.

Section 4. Information Systems

(Includes related business processes relevant to financial reporting and communication)

The control structure should provide secure access to both the agency and external parties for the identification, capture, and exchange of information. The information system includes the related business processes relevant to financial reporting objectives, which contains the accounting system, consisting of the procedures and records designed and established to initiate, authorize, record, process, and report entity transactions. The technology captures the information relevant to financial reporting and ensures information required to be disclosed by the applicable financial reporting framework is accumulated, recorded, processed, summarized, and appropriately reported in the financial statements in a secure environment. The framework for this component stresses the significance of the quality of information where it should be of a certain quality and relevance.

The three principles making up the Information Systems and Communication component are the following:

1. Uses relevant information
2. Communicates internally
3. Communicates externally

The Office of iTECH

The Office of Information Technology (iTECH) is responsible for purchasing, installing, and supporting all technology resources and technology security policies within DOM. iTECH supports DOM by:

- Providing oversight and support for agency-wide applications and vendors contracted to provide systems and services
- Ensuring the agency's Fiscal Agent operates the Envision System Medicaid Management Information System (MMIS) and the new MEDS Eligibility system in compliance with key performance indicators, as well as Federal, State, and Agency Guidelines. See **Section 3. Control Activities** Section within this document related to the *Envision System*
- Managing CMS funding requests for system implementations and modifications.
- Assisting with requests for data and reports needed for agency health and policy decisions.

The different areas of iTECH are represented below:

The Chief Information Systems Officer (CISO) is responsible for Legacy Enterprise, Technology Services, Information Technology Planning, Help Desk Services, and the Security Officer.

The Legacy Enterprise Division of iTECH oversees systems operated by the fiscal agent (Conduent) which include Medicaid Management Information System (MMIS), Decision Support System/Data Warehouse (DSS/DW), and Pharmacy Benefit Management/Point of Sale (PBM/POS). Additionally, the Legacy Enterprise staff work in conjunction with the CSIO and the Deputy Administrator to manage and provide oversight for Conduent' s fiscal agent services.

The Technology Services Division of iTECH maintains and supports DOM's network infrastructure, email and file systems, data repository, and databases. Additionally, this division administers the Citrix and RDS environment which provides access to applications for DOM's 30 regional offices and remote access for the central office and third-party contractors. This division of iTECH is also responsible for backing up data stored on DOM's network systems.

The Information Technology Planning Division of iTECH is responsible for hardware and software procurements and for coordinating technology procurements in accordance with Information Technology Services (ITS) rules and regulations.

The Help Desk Services Division of iTECH provides daily support for hardware, software, telephone, and mobile device issues and requests. The Help Desk troubleshoots Citrix issues and works in conjunction with the Technology Services Division of iTECH to resolve technical Citrix issues.

The Security Officer is responsible for oversight of security audits, security training, security policies, and coordination of any efforts necessary to respond to reported security incidents. The Security Officer works closely with iTECH, Legal, and the Privacy Officer in maintaining a secure environment. During FY 2020, the Security Officer position was vacant, but the plan was to fill the position during FY 2021. Currently, the Security Officer duties are split among other members in the iTECH department.

MRP Team is in the process of replacing the legacy MMIS system (MMIS/PBM & DSS/DW) and fiscal agent services with a new system and services provided by DXC. The MMIS Replacement Project (MRP) team is responsible for overseeing the design, development, and implementation of the DXC solution. The plan for replacement is set for CY 2022.

The Eligibility team is responsible for the project management and testing of maintenance releases for the Eligibility System (New MEDS) which is provided by Conduent. Additionally, this team is responsible for managing the multiple vendors responsible for the development, implementation and enhancements of the Health and Human Services Transformation Project (HHSTP). The goal of the HHSTP is to develop an interoperable health and human services model that provides coordinated client services, reduces fraud and abuse, achieves greater administration efficiency, promotes self-sufficiency, and introduces innovation to improve the lives of all Mississippians server by both DOM and the Mississippi Department of Human Services. HHSTP modules include a Common Web Portal, Enterprise Service Bus, and a Fraud and Abuse Module.

The Office of Innovations is under the direction of the Chief Innovations Officer, and the office consists of the Health Information Technology, Population Health, and Provider Incentive Program (PIP) teams. The responsibilities associated with these teams include: facilitation of EHR Meaningful Use attestations and payments; external clinical and claims data exchanges; Population Health solutions; system development; beneficiary identity management; transforming large data sets into usable information (dashboards, charts, geo-mapping, etc.).

Network Security Risk Assessments

As described in the Risk Assessment section, DOM has a network security risk assessment performed by an external vendor every three years, with the last one completed in 2021. This vulnerability assessment is designed to help DOM perform due diligence in maintaining a reasonably secure internal network environment. Network security procedures are performed according to the Network Systems Manual and the Mississippi Department of Information Technology Services (ITS) Enterprise Security Policy dated October 1, 2013, and IRS Publication 1075 dated September 2016, and recently revised in November of 2021. Recommendations, if any, for improvement identified because of the performance of this assessment are considered by iTECH for implementation of corrective action plans.

In 2021, DOM completed its required CMS Security and Privacy Control Assessment (SCA) of New Medicaid Eligibility Determination System. The assessment was conducted in accordance with the approved Security and Privacy Assessment Plan (SAP), dated April 16, 2021. This security and risk assessment provided DOM's Information System Security Officer (ISSO), Senior Official for Privacy (SOP), and the Authorizing Officials (AOs) with information about any associated vulnerabilities identified during the New MEDS independent security and privacy assessment and served as the risk summary report as referenced in the Framework for Independent Assessment of Security and Privacy Controls and the Information Security and Privacy Continuous Monitoring (ISCM) Guide for Administering Entity (AE) Systems, developed using guidance from Minimum Acceptable Risk and Standards (MARS-E) Document Suite 2.0.

Health Insurance Portability and Accountability Act (HIPAA)

Due to the fact that some of DOM's responsibilities involve access to beneficiaries' Protected Health Information (PHI) or Personally Identifiable Information (PII) and medical information under the Health Insurance Portability and Accountability Act (HIPAA), it is extremely important that extra care and caution and controls related to this information be maintained within DOM. When processes involve the activities associated with this level of protected information, control processes have been designed and implemented to address these risks.

The Division uses extra care and caution to ensure that to the highest degree possible, information is not leaked or handled in an inappropriate manner. Control systems are in place that effectively limit an employee's access to only that type of data that is considered necessary for the individual to complete his/her job duties. Physical access is controlled by employees having to swipe their issued ID cards to gain access to various areas of offices and equipment such as printers. Additionally, DOM's iTECH has put in place security features to access desktop/laptop computers while inside or outside their agency facilities.

DOM uses a fiscal agent to process the Medicaid claims for payments to be made to the providers or CCOs who provide the services to eligible beneficiaries. The Division uses email encryption procedures for instances in which protected information is being included to ensure privacy under the HIPAA laws and regulations. See additional information related to HIPAA controls under Section 1. Control Environment within this document.

DOM employs a Privacy Officer, an attorney in the Legal department who is HIPAA certified and who reviews requests for information, employee activities, vendor/contractor activities, and others to help ensure that HIPAA data is protected and handled properly internally and externally (by DOM contractors and subcontractors).

Communication

Communication by the entity of the financial reporting roles and responsibilities and significant matters relating to the financial reporting involves providing an understanding of individual roles and responsibilities pertaining to internal control over financial reporting. It includes such matters as the extent to which personnel understand how their activities in the financial reporting information system relate to the work of others and the means for reporting exceptions to an appropriate higher level within the entity. Communication may take such forms as policy manuals and financial reporting manuals, as well as in-person training, briefs, email notices, etc. (AICPA Auditing Standards AU-C §315.A97.)

DOM has several policy and procedural manuals in place to provide information and expectations to staff regarding the control environment that management desires to maintain. DOM's most recent Internal Control Plan, along with its Mission Statement and Strategic Plan is available to all staff through the Division's intra-agency employee website.

Within the DOM's Strategic Plan, four specific objectives are outlined with the strategy being to enhance internal and external communication. Within each of these communication objectives, DOM has developed specific goals or duty statements that will help the leadership management accomplish these objectives. Some of these duty statements include the following:

1. **Improving internal communication among the executive leadership team:**
   Require deputies and office directors to submit concise bullet points of topics to recap their areas after meetings. Provide cross training of the leadership staff on the responsibilities of each office.

2. **Improving internal communications between management at all levels and their employees:**
   Focus on interpersonal skills and training and other targeted leadership training to be more effective communicators. Require deputies to have monthly meetings with each of their office directors at least every two weeks and quarterly office meetings with their entire staff. Provide training for staff on the aspects of the Strategic Plan. Require each office director to develop standard operating procedures

(SOPs) using a standard template across the agency and to regularly review and update the SOPs to ensure they are always current and accurate. Implement an agency-wide performance review process.

3. **Ensure that policies and procedures and the State Plan are more accessible, accurate and user friendly.**

Establish a process for continuous review and updating of policies and procedures to ensure that the Administrative Code and State Plan are consistent and in compliance with state and federal laws and regulations.

4. **Improve external communications to enhance the public's perception of the Division of Medicaid.**

Information System and Communication Conclusion: The Division of Medicaid has developed information system processes and communication procedures that allow for safe, timely and effective communication providing accurate information for management of the program.

Section 5. Monitoring of Controls

Monitoring of controls is a process to assess the effectiveness of internal control performance, which involves assessing the effectiveness of controls on a timely basis and taking necessary remedial actions to ensure that the findings of audits and other internal or external reviews are resolved promptly. Ongoing monitoring occurs during the entity's normal recurring operations and includes regular management and supervisory activities, comparisons, reconciliations, and other review actions occurring during the performance of their regular duties.

DOM has created and implemented an Office of Internal Audit that has full authority to independently assess and report to the Executive Director and appropriate management any control deficiencies and other findings that may impair the agency's ability to be effective and efficient in its operations.

The two following principles make up the DOM Internal Audit Monitoring component:

1. Conducts ongoing and/or separate evaluations
2. Evaluates and communicates deficiencies

Management periodically considers the appropriateness of the agency's internal control monitoring and the degree to which it helps them accomplish their objectives. Reconciliations of amounts reported in the state's financial system are performed at least quarterly and often continuously because the agency and CMS require them. Computer assisted techniques are used through MAGIC and the Envision System (Conduent) to accumulate transactions into certain reporting categories for completion of these reports.

General Monitoring Functions

External Audits and Reviews

The agency is subject to numerous annual external financial and compliance audits performed by federal and state auditors and/or their contractors. These audits, in addition to the Internal Audits provide independent and objective monitoring information for management. Findings noted by the external parties are reported to upper management for consideration of resolution. Management is responsible for ensuring that the appropriate corrective action is taken timely. DOM responses are centralized to ensure that agency-wide impacts are considered in all responses.

Utilization Management and Quality Improvement

Under the purview of the Office of Medical Services, the Division contracts with a Utilization Management and Quality Improvement Organization (UM/QIO), currently Alliant Health Solutions, to provide review procedures including prior authorization requests from providers related to fee-for-services beneficiaries and to safeguard against unnecessary utilization of care and services under the Medicaid program.

Office of Program Integrity Functions

The Office of Program Integrity is constantly monitoring payments to Medicaid providers for evidence of fraud or abuse. The Office of Program Integrity also works with the Medicaid Fraud Control Unit (MFCU) within the Mississippi Attorney General's Office to pursue recovery of fraudulent and/or unallowable costs. Monitoring functions overseen by the Office of Program Integrity include the Medicaid Eligibility Quality Control (MEQC) Program, the Recovery Audit Contractor (RAC), the Unified Program Integrity Contractor (UPIC), Data Analysis, and specific assignments involving the Managed Care Program and other claims and provider related issues. Each area is described below.

Medicaid Eligibility Quality Control Program (MEQC)

All non-SSI Medicaid eligibility determinations performed by DOM staff in the 30 regional offices throughout the state are subject to a secondary review "in addition to" and "outside of" the purview of the immediate supervisor who performed the initial eligibility determination. The Medicaid Eligibility Quality Control (MEQC) program is within the Office of Program Integrity and is a federally required program that ensures the Division monitors the accuracy of the Medicaid eligibility process and helps determine the state Medicaid payment error rate. On a monthly basis, eligibility files are selected for review by the MEQC Division. Sampled cases are selected from the MMIS recipient file using an approved sampling plan and are sent to the central office where an independent redetermination is made of the decision made at the regional office as to the correctness of the eligibility status of the individual selected. At the conclusion of each review, an MEQC Memorandum is issued to the bureau director of the regional office from where the files were selected and the Deputy Administrator for Enrollment. Any disagreements with the findings identified during the redetermination of eligibility are reviewed by the Director of the Bureau of Enrollment and forwarded to the MEQC Supervisor for further consideration.

External Audit Contract Management staff within the Office of Program Integrity oversee the activities of external auditors including the **Recovery Audit Contractor (RAC)** and the **Unified Program Integrity Contractor (UPIC)** and their efforts in identification of potential fraud. (See below for a description of each of these.)

Recovery Auditor Contractor (RAC)

Section 6411 of the Affordable Care Act requires states to contract with RACs to identify overpayments and underpayments and to recoup overpayments, create processes for entities to appeal adverse determinations made by RACs, and coordinate recovery with other governmental entities. The RAC reviews claims on a post-payment basis to detect improper payments, so the Division can implement actions to prevent future improper payments. These reviews are federally required to be supplemental and in addition to existing Program Integrity efforts already underway and are not to duplicate or interfere with processes being conducted by DOM.

Unified Program Integrity Contractor (UPIC)

To improve efficiency and coordination of federal data analysis and audit investigation work, CMS developed a Unified Program Integrity Contractor (UPIC) strategy. Under this strategy, Medicare and Medicaid Program Integrity audit and investigation work at the federal level is consolidated into a single contractor within a defined multi-state area, which will complement audit and investigation efforts by states. This contractor performs Medicare, Medicaid, and Medi-Medi investigations and audits within designated geographic jurisdictions. This work is accomplished through a Joint Operating Agreement between DOM and the Unified Program Integrity Contractor selected by CMS-MIG. It is also required to be complementary and not duplicative or in place of existing Program Integrity work.

Data Analysis

The Data Analysis Unit within the Office of Program Integrity creates algorithms that uncover potential areas of fraud and abuse in the Medicaid Program. This unit develops analysis reports for use in investigations, collects data for analysis reports and documents the recovery and recoupment of funds from Program Integrity cases.

iTECH Functions

External Network Security Risk Assessment

As previously discussed in the Risk Assessment section and the Information Systems and Communication section of this document, the Division has a network security risk assessment performed by an external vendor every three years to ensure that network security procedures are operating in accordance with the Network Systems Manual and the Mississippi Department of Information Technology Services (ITS) Enterprise Security Policy dated October 1, 2013, and IRS Publication 1075 dated September 2016 (revised in 2021). Any recommendations that are needed and identified are considered by iTECH for implementation of corrective action plans.

Fiscal Agent Claims and Other Controls Processing Report (Service Organization Report)

As part of its contract with its fiscal agent, DOM requires that the fiscal agent have an Electronic Data Processing (EDP) Examination performed each year on its functions of processing Medicaid claims. An EDP audit analyzes an organization's computer and information system to evaluate the integrity of its own productions systems and any potential security cracks. For the calendar year ending December 31, 2020, the current fiscal agent, Conduent, had an examination performed for the period January 1, 2020, through December 31, 2020. The examination was performed in accordance with Statements on Standards for Attestation Engagements Number 16 (SSAE 16). The report on the fiscal agent performed by Ernst and Young, LLP, which is a Big 4 Accounting Firm, is a Service Organization Control report, which there are three types: SOC1, SOC2, and SOC3. A SOC1 report is concerned with examining controls over financial reporting. The fiscal agent has provided this to DOM in February of each year.

The SOC1 report includes a description of the service organization's system and the suitability of the design of its internal control to achieve the related control objectives and an opinion on the operating effectiveness of the controls to achieve the related control objectives. A copy of this report is submitted to the Director of iTECH for review and oversight purposes to ensure that follow up procedures are performed for any noted deficiencies and that appropriate corrective action is taken to resolve any deficiencies noted, which one deviation was noted during and has been resolved. A copy of this report is available upon request from the Chief Systems Information Officer.

Monitoring Efforts over the Managed Care Program

Monitoring efforts over the transactions and activities of the managed care program involve almost all program areas and subdivisions of DOM. Various offices within DOM oversee multiple aspects of the managed care programs – MississippiCAN and Mississippi CHIP – as well as analyzing and overseeing comparison date of the fee-for-service program to which managed care is often compared. The many DOM offices have designated assignments for review of contractually required deliverable reports that the contracted CCOs are required to submit to DOM.

The oversight and data review through these electronic reports is most often referred to as "the reporting manual," although it is a collection of data spreadsheets rather than a manual. This manual is primarily coordinated by the Office of Compliance. In addition, the Office of Coordinated Care has its own review requirements for contract related submissions (not duplicative of the reporting manual) that they work with other program areas to complete in a timely manner. Their work, like the Compliance work, allows DOM to have coordinated oversight of the many parts of managed care.

Processes are in place to ensure designated DOM reviewers are reminded to electronically access the CCOs' deliverable reports and complete their assigned reviews. When the reviews are finished, staff members complete a "Program Area Monthly Deliverable Review/Approval Tracking Form" for each CCO, and it is sent to their supervisor for review and approval signature. Supervisors within the different DOM offices then submit the signed "Deliverable Tracking Form" to a single staff person who logs potential compliance issues and comments into the designated CCO Deliverable Compliance Tool (DCT). The office director reviews and approves each completed CCO DCT prior to each CCO DCT being uploaded to the designated ShareFile folders as instructed by the Office of Compliance and the Office of Coordinated Care. Designated staff members also participate in monthly meetings with the Office of Compliance and the Office of Coordinated Care to review any potential compliance issues and comments noted on each CCO DCT.

Office of Coordinated Care

The Office of Coordinated Care directly oversees contracts associated with the operation and performance of the managed care program. This office oversees all contractual responsibilities of the CCOs. The Director of the Office of Coordinated Care is in charge of monthly status meetings with the CCOs and oversees the following contracts related to monitoring and oversight of the managed care program: Milliman, Inc. (Actuarial Services/ Calculation of Capitation Rates) and The Carolinas Center for Medical Excellence (External Quality Review Organization). The following is a description of the responsibilities for both contractors in relation to the operation of the managed care program:

Milliman, Inc. (Actuaries Mississippi CAN/CHIP Contract)

Milliman Inc. provides actuarial services to assist DOM with the procurement of vendors to provide care coordination services for certain targeted DOM beneficiaries with the goal of improving access to services, improving quality of services, saving the state dollars, and assisting the state in the implementation of the managed care program. Milliman Inc. calculates, documents, and certifies to its capitation rate development.

The firm's role is to certify that the capitation rates are actuarially sound and follow CMS regulations. Once determined, the annual capitation rates are submitted to CMS for their approval. CCOs that have agreed to become managed care plans for DOM are required, under their contractual agreement, to accept the CMS-approved actuarially determined capitation rates for which they will be reimbursed on a per member/per month basis. Annually, Milliman develops a rate tracking document and prepares a Rate Setting Letter which addresses all the Categories of Eligibility (COE) split between three regions of the state (north, central and south). The capitation rates for which payments will be made are typically established on a state fiscal year (July-June) basis. As such, DOM makes every effort to have the reimbursement rates developed, approved by CMS, and established with its fiscal agent before the start of the new fiscal year.

The Carolinas Center for Medical Excellence

To comply with the federal regulations cited above, DOM has contracted with a private, not-for-profit company called The Carolinas Center for Medical Excellence (CCME) to function as its external quality review organization (EQRO). An external quality review (EQR) is the analysis and evaluation by an independent EQRO of aggregated information on quality, timeliness, and access to the health care services that a CCO or their contractors furnish to Medicaid recipients. Each state contracting with a CCO must have an external EQR of each CCO performed annually. Federal regulations at 42 CFR Part 438, subpart E (External Quality Review) relate to quality measurement and improvement and set forth the parameters that the U.S. states must follow when conducting an EQR of its CCOs.

The reports prepared by CCME for each CCO are submitted to DOM's Office of Coordinated Care for further review and then submitted to CMS in accordance with the federal requirements. The CCME also performs quarterly follow-ups with each CCO and develops corrective action plans for the CCO's response with details of the CCO's intentions to correct any deficiencies noted during the review by the EQRO. The EQRO is also available to DOM staff members as a consultant to assist on any other issues or concerns related to the federal requirements involving the managed care program.

The Office of Coordinated Care, in conjunction with the Office of Clinical Support Services, oversees the development of the Managed Care Quality Strategy Report. This document serves as a road map to monitor and implement quality improvement and allows necessary revisions to strengthen the effectiveness and reporting of the managed care program. The Managed Care Quality Strategy Report details the standards and mechanisms for holding the CCOs accountable for desired outcomes. It also articulates compliance requirements from the federal managed care rule.

A copy of this report is available from the Division's website at: MS-DOM-Comprehensive-Quality-Strategy-2021.pdf

Office of Accountability and Compliance

In addition to numerous other oversight and compliance activities related to contracts and interagency agreements, the Office of Accountability and Compliance is designated as the primary office at the Division to track reporting, monitoring and oversight activity of the CCOs. The Office of Compliance is tasked with ensuring that DOM contractors and other vendors, including the CCOs, are complying with the terms of their contracts. The office employs attorneys and auditors to manage the responsibilities. They have created procedures for contract monitoring by the various offices throughout the agency.

Specifically, the Office of Compliance has developed and maintains a MississippiCAN Reporting Manual which serves to organize and standardize the thousands of reports submitted by the managed care plans over the course of a reporting year. Also, the Office of Compliance develops and maintains a Deliverables Compliance Tool (DCT), which assists each DOM program area involved in these data/information reviews by providing a timeframe for review and a mechanism for reporting noncompliance. Upon a report of noncompliance or noncompliance, whether through the DCT or other avenue, the Office of Accountability and Compliance assists the program area with resolution of the issue, whether through requests for clarification, corrective action plans, or assessment of damages.

The Office of Accountability and Compliance works closely with program area contract managers to review documents and deliverables submitted by contractors in relation to implementation of their contract, as well as to determine steps to be taken in cases of breach or non-compliance of a contract. Steps may include assessment of liquidated damages, imposition of a corrective action plan, or enforcement of other contractual remedies.

Additionally, the Office of Compliance also reviews and recommends appropriate language to be included in the Division's competitive solicitations prior to contract procurement or execution.

The External Audit Contract Management staff within the Office of Program Integrity has responsibility to review various reporting requirements of the CCOs related to the identification of fraud, waste, or abuse. Reports

required to be submitted by the CCOs are reviewed and forwarded with comments, if any, to the Office of Accountability and Compliance for resolution. Staff members attend regular meetings with the CCOs and other oversight contractors involved in the managed care program to ensure oversight of compliance.

Office of Financial Administration

Myers and Stauffer, LC (CPA Firm)

DOM seeks a confidence level that the CCOs are adhering to their contractual obligations from a financial standpoint. To accomplish this objective, DOM has contracted with a public accounting firm named Myers and Stauffer, LC (CPAs) to perform some additional monitoring procedures related to operations of the managed care program. The Office of Financial Administration is designated with oversight responsibility related to the performance of the scope of work responsibilities as spelled out in the contract with Myers and Stauffer. The scope of work as identified in the contract with the firm requires the firm to perform some additional External Quality Review (EQR) functions that will be conducted bi-monthly in accordance with CMS' EQR Protocol 4 Validation of Encounter Data as reported by the CCOs. The most current EQR Protocol 4 Reports are available here: https://medicaid.ms.gov/programs/managed-care/.

The complete listing of the agreed upon procedures and analytical activities to be performed by Myers and Stauffer include:

1. Encounter Data Validation and Reconciliation (CMS EQR Protocol 4)
2. Contract Compliance / Medical Loss Ratio / Administrative Ratio
3. Capitation Rate Reviews. Managed Care Organization Financial Integrity / Reporting
4. Provider Payments Coverage of Services to Beneficiaries
5. Other Services

The results of the agreed upon procedures performed by Myers and Stauffer are provided to DOM staff members for further review and consideration. Deficiencies are reviewed and followed up on to ensure timely corrective action is taken to address the matters noted.

Additional Monitoring Efforts over the Managed Care Organizations

The Division has also contracted with several additional independent certified public accountants to aid in monitoring the activities of the CCOs, one of which is a contract DOM staff member, and the others include Cornerstone Healthcare Financial Consulting, Inc., White Collar, LLC, and WR Solutions, LLC. These contractors, along with the assistance of a DOM staff, review reports assigned to the Office of Financial Administration required to be submitted periodically by the CCOs and review the work product of Myers and Stauffer. White Collar, LLC and WR Solutions are tasked with conducting the independent audits of the CCOs set forth in §43-13-117(H)(3)(b) & (c), Mississippi Code, Annotated.

Oversight of the activities of Cornerstone Healthcare Financial Consulting, Inc. falls primarily within the purview of the Office of Financial Administration. These individuals meet periodically with Myers and Stauffer to review and gather evidence on the performance level of the managed care programs and ensure the reconciliations of Encounter Submissions to Cash Disbursement Journals are completed and accurate. The contractors' main responsibilities involve overseeing (on behalf of the Office of Financial Administration) issues related to managed care (both MississippiCAN and CHIP) from the beginning of the establishment of the Request for Proposal/Qualifications documents received from the prospective contractors, to reviews of the submitted proposals and the reviews of contracts.

In addition, Office of Financial Administration staff have responsibility for tracking and monitoring all of the assigned managed care contract reports and then, reporting any compliance issues to the Office of Accountability and Compliance. They attend monthly meetings with Milliman, Inc., the external contractor actuary, for updates

on capitation rate development and must work with other DOM staff members and the managed care contractors concerning costs reported, encounter validation, and other payment reconciliations.

In 2021, DOM was given a statutory mandate to hire independent auditors to conduct specified audits under §43-13-117(H)(3)(b) & (c), Mississippi Code, Annotated. To complete that task, DOM has hired two companies to design and conduct those audits.

Monitoring of Controls Conclusion: The Division has procedures in place to provide for continuous monitoring of control activities related to the operations of the Medicaid program.

DOM Organizational Chart

The DOM organization Chart is in the process of being updated and is currently unavailable for this document. Once it becomes available, this document will be updated to include it.