MISSISSIPPI DIVISION OF MEDICAID

# DOM Internal Control Plan 2022-23

DOM Internal Control Components and Statement on Internal Controls

***The Mississippi Division of Medicaid responsibly provides access to quality healthcare for vulnerable Mississippians.***

*Division of Medicaid (DOM) Values and Principles:*
*Accountability*
*Consistency*
*Respect*
*Excellent Customer Service*
*Fiscal Prudence*
*High Integrity*

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# Executive Director's Statement on Internal Controls

*To the Staff of the Mississippi Division of Medicaid:*

*I would like to express my continued support for the need to establish and maintain effective internal controls through the Mississippi Division of Medicaid's (DOM) Internal Control Plan. As an agency of state government, we must remember that our internal control policies and procedures, guided by our mission statement and workplace values, position us to strive toward operational excellence.*

*Internal Controls are an essential component in the structuring of an organization to be able to reach its full potential and accomplish its objectives. Controls provide foundational support for the agency as we work to responsibly provide access to quality health coverage for vulnerable Mississippians.*

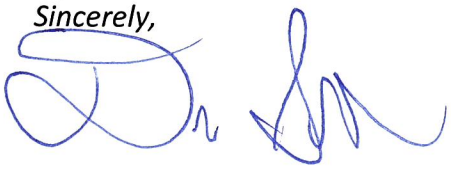
*Please review DOM's Internal Control Structure in the following pages. It details the five essential components of internal control: Control Environment, Risk Assessment, Control Activities, Information and Communication, and Monitoring.*

*The principles outlined in the Internal Control Structure have been tested in organizations, companies, and agencies around the world, and they align with and support DOM's focus on on providing excellent customer service, acting with fiscal prudence, and operating with high integrity.*

*The Mississippi Division of Medicaid has worked, and will continue to work, to become a high-functioning government agency that aims to improve the health and the life outcomes of people it serves, and in turn the state on whole, while optimally managing public funding and public trust to ensure the Medicaid program remains stable and sustainable.*

*The DOM Internal Control Plan 2022 explains the concepts of Internal Control and provides examples of actual Internal Controls already in place at the agency and plans for others going forward. This document represents the adopted Internal Control Plan for the DOM. Each year management will review the information included here and revise it to reflect the most recent activities of their offices. I encourage each of you to become familiar with the components and principles of Internal Control and use them to carry out your responsibilities.*

*Sincerely,*



*Drew Snyder*
*Executive Director*

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## Division of Medicaid (DOM) Internal Control Plan

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# Summary of DOM's Five Components of Internal Control

**1. Control Environment**

*To promote an atmosphere of strong internal control, DOM management:*

- *demonstrates commitment to integrity and ethical values*
- *oversees the agency's system of internal controls*
  *(e.g., Internal Control Plan and Assessments and detailed procedures)*
- *establishes organizational structures, assigns responsibility, and delegates authority to achieve DOM objectives*
- *commits to recruiting, developing, and retaining competent individuals*
- *holds individuals accountable for their internal control responsibilities.*

**2. Risk Assessment**

*DOM management should, with the support and assistance of staff:*

- *define objectives clearly to enable identification of risks*
- *identify, analyze and respond to risks related to achieving the objectives*
- *understand and address the potential for fraud*
- *identify, analyze, and respond to significant changes that could affect internal control.*

**3. Control Activities**

*DOM management should, with the support and assistance of staff:*

- *design control activities to achieve objectives and respond to risks*
  *(e.g., Segregation of financial duties, supervisory and management approvals, assurance of accurate and timely records, rules for safekeeping of assets)*
- *design DOM's information system to achieve objectives and respond to risks*
  *(e.g., Information processing rules, security, edits for accuracy, capacity)*
- *implement control activities through policies and procedures*
  *(e.g., for programs, personnel, technology).*

**4. Information and Communication**

*DOM management should, with the support and assistance of staff:*

- *use relevant, quality information to achieve agency objectives*
- *internally communicate quality information to achieve DOM objectives*
- *externally communicate quality information to achieve DOM objectives.*

**5. Monitoring**

*DOM management and staff should:*

- *conduct internal control monitoring activities and evaluate results*
- *communicate and remediate identified internal control deficiencies.*

Note: This summary of internal control principles is based on work initially developed by The Committee of Sponsoring Organizations (see COSO Framework) and the federal standards created in response to COSO. According to the Department of Finance and Administration (DFA), the State adheres to the policies found in the Standards for Internal Control in the Federal Government developed by the U.S. Government Accountability Office. (See the internal control section of the DFA MAAPP manual for additional information on internal controls.)

# DOM Mission Statement and Workplace Values

## Mission Statement

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

## Agency Philosophy / Values and Principles

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.

## DOM Internal Control Structure

Control Environment
Risk Assessment
Control Activities
Information and Communication
Monitoring

# Division of Medicaid Responsibilities and the Importance of Internal Control

Internal Control principles and strategies are routine and continuous in the operations of the Mississippi Division of Medicaid. Not only do federal and state government form an overall authority structure for the Division (DOM), but the agency's Executive Director stresses the importance of our mission statement and values and the principles of Accountability, Consistency, Respect, Excellent Customer Service, Fiscal Prudence, and High Integrity.

Internal Control is important for all organizations, companies, and agencies, forming the basis for successful achievement of objectives and goals. DOM's ability to meet its goals affects many stakeholders. The DOM Internal Control Structure presented in this document outlines the agency's current activities and plans for internal control and their importance to the state. The agency's primary purpose and responsibilities are outlined below.

## Purpose and Scope of Services

The Mississippi Division of Medicaid (DOM) pays for health coverage for eligible, low-income Mississippians funded by the federal/state program. Populations receiving care under the programs are primarily children, the aged and disabled, low-income parents/caretakers, and pregnant women. As eligible members do not directly receive money from Medicaid for health benefits, payments are made directly to health care providers on a reimbursement basis. The state's providers must be qualified and enrolled by DOM to be reimbursed for services they provide to members.

DOM also administers the Children's Health Insurance Program as described on the next page.

DOM has over 900 employees located throughout the state, including the Central Office in Jackson, 30 regional offices, and nearly 70 outstations. DOM serves approximately 800,000 Medicaid and CHIP enrollees across the state, or over one quarter of Mississippi's population of nearly three million. During state fiscal year 2022, 45,119 healthcare providers located within Mississippi had either delivered services to Medicaid or CHIP beneficiaries, or ordered, referred, or prescribed items or services for these beneficiaries. An additional 34,420 healthcare providers for Mississippi beneficiaries were located out of state during the same year.

## Medicaid

The Mississippi Legislature established the state's Medicaid program in 1969 to provide health coverage for eligible, low-income populations in Mississippi. Medicaid is a state and federal program created by the Social Security Amendments of 1965 (PL 89-97), authorized by Title XIX of the Social Security Act. All 50 states, five territories, and the District of Columbia participate in the voluntary matching program which is administered by the U.S. Centers for Medicare and Medicaid Services.

Each state runs its own Medicaid program within federal guidelines. The Mississippi Division of Medicaid (DOM) within the Office of the Governor is the managing agency for the state's program. Beneficiary eligibility is determined by federal requirements for household income based on the Federal Poverty Level and family size, and by Supplemental Security Income status (the disabled, and those 65 and older who meet low-income financial qualifications). As the program is jointly funded by state and federal dollars, the Federal Medical

Assistance Percentage is used to calculate the amount of federal matching funds for the state's medical services expenditures. Mississippi has the highest assistance percentage in the country (78% federal matching prior to the Covid-19 pandemic, and currently near 84% in response to the pandemic). Roughly one in four Mississippians receive health benefits through the Medicaid program or the Children's Health Insurance Program (CHIP).

## Children's Health Insurance Program (CHIP)

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. CHIP was created as part of the federal Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). By the year 2000, every state, territory, and the District of Columbia had children enrolled in CHIP-financed coverage. CHIP provides health coverage for children up to age 19 whose family income does not exceed 209 percent of the federal poverty level. To be eligible for CHIP, a child cannot be eligible for Medicaid and cannot be covered by another form of major medical insurance to qualify for CHIP. As noted below, all federal/state CHIP services in Mississippi are provided under a managed care contract.

## Managed Care (MississippiCAN/Medicaid and CHIP)

While Medicaid was developed under a fee-for-service structure (reimbursing providers separately for each individual service provided to a beneficiary), in recent decades states have increasingly turned to administering health benefits through managed care programs. Managed care is paid through contractual arrangements with coordinated/managed care organizations, based on actuarially determined fees on a per-member, per-month basis (i.e., capitation rates).

The Mississippi Legislature authorized DOM's managed care program in 2009 with goals to increase beneficiary access to needed medical services and to improve both the quality of care and cost predictability. Typically, about two-thirds of Mississippi's Medicaid beneficiaries have been enrolled with one of the three managed care organizations contracted by the state. The Mississippi Coordinated Access Network (MississippiCAN) is administered by three different managed care organizations. In addition, since 2015 the Children's Health Insurance Program (CHIP) has been provided solely through two managed coordinated care organizations.

# Components of Internal Control

Internal control is a process of providing reasonable assurance that the objectives of an entity will be achieved. Internal control is set by an entity's management and personnel to help ensure (1) effective and efficient operations, (2) reliable reporting, and (3) compliance with applicable laws and regulations. Internal control includes designing, implementing, and managing system, operations, organizational, and employee controls for accurate financial reporting and safeguarding of assets.

A comprehensive framework of internal controls consists of five interrelated components.* In an effective internal control system, these five components will support the organization's mission, objectives, and strategies:

1. **Control Environment:** The organization's culture, philosophy, and ethical values that serve as the foundation for an internal control system. 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 the organization from achieving its objectives and mission. Risk assessment provides the basis for developing appropriate risk responses.

3. **Control Activities:** The actions management establishes through policies and procedures to achieve objectives and respond to risks in the internal control system, which includes the entity's information system.

4. **Information and Communication:** Data and information that management and personnel use to communicate policies and support the internal control system. Quality information and communication are necessary for the entity to carry out its activities and its internal control responsibilities.

5. **Monitoring**: Activities that management establishes and operates to assess the quality of performance over time and to promptly resolve the findings of audits and other reviews.

Each of these components is described below, followed by examples of ways in which Division of Medicaid structures and activities form a good internal control structure. In addition to the description of internal control principles summarized below, also see *Appendix E* for the *DOM Internal Control Structure: Five Components of Internal Control and Supporting Internal Control Principles.*

* NOTE: These descriptions of internal control include ideas and language developed over three decades by entities such as the Committee of Sponsoring Organizations of the Treadway Commission (COSO); the U.S. Government Accountability Office (GAO) as outlined in the *Standards for Internal Control in the Federal Government* (known as the *Green Book*); and the Mississippi Department of Finance and Administration as outlined in the *Mississippi Accounting and Auditing Policies and Procedures* (*MAAPP Manual*).

# Component 1: Control Environment

## What is the "Control Environment" in an Organization?

The control environment consists of the actions, policies, and procedures that represent the commitment of top management to the value of effective internal control. In a strong internal control environment, employees recognize their executive leadership as having integrity and strong ethical values. At the same time, management provides the discipline and structure that promotes control consciousness and ethical values among staff, and reinforces and promotes teamwork and shared organizational values at various levels of the organization.

The Control Environment of an organization serves as the foundation for the overall system of internal control. A weakness in the organization's Control Environment generally results in an inability to rely on the effectiveness of the other components of internal control (i.e., Risk Assessment, Control Activities, Information and Communication, and Monitoring).

## Methods Maintained by DOM to Affect a Strong Internal Control Environment

*The first component of Internal Control is the **Control Environment**.*
*To promote an atmosphere of strong internal control, DOM management:*

- *demonstrates commitment to integrity and ethical values;*
- *oversees the agency's system of internal controls (e.g., the Internal Control Plan and Assessments);*
- *establishes organizational structures, assigns responsibility, and delegates authority to achieve DOM objectives;*
- *commits to recruiting, developing, and retaining competent individuals; and,*
- *holds individuals accountable for their internal control responsibilities.*

The Division of Medicaid maintains a dynamic control environment through high expectations for accountability and integrity being set and communicated by the Executive Director and passed down through his Deputies and Directors to all staff; the emphasis placed upon communication and training; and an organizational structure that allows statewide oversight and monitoring of all programs and operations. (The agency organization chart is shown in *Appendix D* of this document).

### Executive Leadership

The DOM Executive Director has established a structure for strong internal controls across the organization. For instance, the Mission Statement clearly expresses the need for internal controls by stating that services will be delivered in a responsible manner and that the organization strives for quality delivery. The Values Statement is also clear in citing the importance of accountability, consistency, excellence, fiscal prudence, and high integrity.

The Executive Director is ultimately responsible for the implementation of the appropriate levels of internal control for DOM's operation. That responsibility is delegated to the individuals who report directly to the Executive Director. This core group of senior leadership assists the Executive Director in ensuring proper direction is communicated and provided to the staff. In addition, each DOM manager and officer is responsible for enlisting all staff members in the ongoing monitoring of operations for the achievement of agency objectives.

## Employee Recruiting, Hiring, and Expectations

The Human Resources unit provides documentation and orientation to new employees concerning agency control procedures and has a continued role in setting an effective control environment.

Initially, after an applicant interviews and is selected for an open job position, Human Resources requires the candidate to sign a Background Authorization Form for the Division of Medicaid to conduct a criminal background investigation. No offer of employment is extended until the results of the background check has been reviewed and approved by the Human Resources division.

**Orientation on DOM Values and Ethics**
Each new employee is given a packet of information providing an overview of DOM operations. Included is a written statement from the Executive Director emphasizing the DOM Mission Statement (i.e., to "responsibly provide access to quality health coverage for vulnerable Mississippians") and outlining the agency's commitment to the Values of Accountability, Consistency, and Respect.

Each employee is required to complete and sign a Nepotism Questionnaire, which discloses any potential nepotism issues. The new employee must either confirm in writing that no nepotism issues exist or provide relevant facts that can be used to determine a potential ethics issue.

New employees are also required to complete online training and orientation at the DOM Office of Human Resources SharePoint website (employee intranet). Employees must review, watch, read, and successfully complete tests at a passing level in a system known as the DOM HR Connection. The orientation system involves a series of questions on Active Shooter Situations, Workplace Discriminatory Harassment Awareness & Prevention, and federal regulations for confidentiality of information as described in the following section.

**Confidentiality and HIPAA**
Employees must sign a Confidentiality Agreement Form acknowledging they understand the confidentiality of the sensitive personal records handled by Medicaid and the public trust and confidence placed upon them in performing their job duties. In signing the form, they agree to adhere to the confidentiality policy in the DOM Employee Manual and acknowledge the consequences for failure to follow the policy.

In addition, employees must follow the rules and regulations outlined in the federal Health Insurance Portability and Accountability Act (HIPAA), which are enforceable by law. To ensure the understanding that personal information must be maintained in a confidential manner, employees must pass a written examination on the HIPAA requirements. Each employee is required to continue reviewing the HIPAA Policies and taking the HIPAA test until he or she receives a passing score.

**Employee Evaluations**
DOM employee job performance is rated every six months for new employees and at least annually for permanent status employees under the Performance Review Assessment (PRA). During 2022, Human Resources has provided training on the new PRA system and required each employee to sign a statement that they have completed the training.

**Employee Performance Awards**
The DOM Human Resources office sponsors an employee awards program as a way to honor outstanding agency employees, including for Employee of the Month and Supervisor of the Quarter. Awards are based on a nominee's dedication to the DOM mission and values, positive attitude and productivity, and demonstration of

excellent customer service. Along with agency recognition, award winners receive incentives such as alternative work site hours, a casual day for their office area, and an invitation to the Employee of the Year Awards Banquet.

## Training

The agency's objective is to ensure all employees possess the required professional and technical competence to perform their job duties. DOM works to assist employees with various types of training needs, including obtaining certifications related to job performance. For DOM employees with professional certifications such as JD and CPA, DOM allows time away from the office for external training to allow them to maintain their licenses.

In addition to ongoing training, DOM develops significant resources to train employees for new agency initiatives and systems. Examples include training available to all of the nearly 1,000 agency employees on the Gainwell MESA (Medicaid Enterprise System Assistance) management information system that was implemented in the fall of 2022. In addition to training classes for key personnel, MESA training is presented online in a user-friendly way with various course levels and subjects quickly available in 30-minute sessions.

The Accountability and Compliance office is also dedicated to training DOM personnel. For instance, its Program Integrity unit is currently providing fraud training and courses to assist auditors in obtaining the Certified Fraud Examiner designation. See additional descriptions and references to training under the "Control Environment" and the "Information and Communications" sections of this document.

## Communication

The Executive Director has established a regular schedule of meeting and communicating with employees at various levels of the organization. At weekly senior leadership group meetings, biweekly meetings with Deputy Directors, and monthly meetings with Central Office directors, the Executive Director presents progress towards goals and explains important activities and aspirations of the department.

The Executive Director's agency-wide communications to the staff reinforce the Division of Medicaid Mission statement. The Executive Office reinforces relevant policies and procedures by emailing fact sheets to employees. See additional descriptions of communications in the "Information and Communications" section of this document.

## Quality Initiatives

DOM's Medical Services office includes a Quality Initiatives unit. The unit coordinates with internal and external stakeholders to focus on healthcare quality issues and make suggestions for improvement; advances strategies for reducing gaps in access to care; develops ways to improve preventative healthcare education; facilitates multiple quality focused work groups and meetings with external stakeholders; collects, organizes and submits annual quality measures; and provides assistance with legislative performance measures.

This unit coordinated the preparation of a Comprehensive Quality Strategy for the agency dated September 10, 2021. The Quality Initiatives unit also facilitates the Quality Leadership Committee (QLC). The QLC is tasked with developing and implementing a strategy to improve the health outcomes of the Medicaid population in Mississippi.

## Internal and External Audits

Executive leadership created an independent Internal Audit function in 2020, adding another dimension to the agency's internal control structure. Internal Audit adheres to the Institute of Internal Auditor's (IIA) *International Standards for the Professional Practice of Internal Auditing*. To ensure independence and objectivity of the office, the Director of Internal Audit reports directly to the Executive Director for the functions of the office, and reports administratively to the Deputy Administrator for Accountability and Compliance. Internal Audit annually plans and conducts risk-based audits that are strategically designed and discussed with the DOM Executive Director. After considering auditee responses to the audits, Internal Audit presents conclusions and recommendations to the Executive Director for consideration and to add another layer of oversight to implementation of corrective action plans.

In 2021, the agency also created an audit function within Accountability and Compliance to fulfill two functions. First, the Deputy Administrator of Accountability and Compliance oversees independent consultant-led audits of DOM's managed care contractors, as required by the Legislature in 2021 via MS CODE ANN §43-13-117(H)(3)(b) & (c). Second, the Deputy hired staff auditors into the Compliance unit to conduct ad hoc state agency, managed care-related, and other types of audits and analysis as needed. These auditors also function as support to Program Integrity, Internal Audit, and other DOM program areas and assist with the root cause analysis needed to understand why internal control issues occur.

In addition, independent external audits of DOM operations play a significant role in the agency Control Environment. Numerous state and federal agencies conduct annual audits and other ad hoc or scheduled reviews and evaluations throughout each year. Audits are routinely conducted by the Mississippi Office of the State Auditor, the Mississippi Joint Legislative Committee on Performance Evaluation and Expenditure Review, the U.S. Department of Health and Human Services, the U.S. Centers for Medicare and Medicaid Services (CMS), HHS Office of the Inspector General, the Government Accountability Office, and the Social Security Administration, as well as various other external regulatory and oversight agencies. Internally, DOM Accountability and Compliance oversees and coordinates these audits and assists with agency audit responses. When necessary, they conduct root cause analysis and assist in the development of corrective action plans. Various program areas participate based on the scope of the audit.

# Component 2: Risk Assessment

## What is Risk Assessment?

Risk assessment begins with a clear identification of an organization's objectives, so that the risks that threaten these objectives can also be clearly identified and addressed. Risks are the potential factors that could impede the organization's ability to achieve its objectives for operations, reporting, and compliance. Risk assessment also includes identifying types of potential risks that an organization could face from both internal and external sources; studying the likelihood of those risks; and understanding possible responses to those risks (such as choosing strategies to accept, avoid, reduce, or share the risk). In addition, risk assessment includes being alert and responding to significant changes that could impact the internal control system. See specific risk assessment responses and strategies included in *Appendix B*. A sound internal control structure relies on the ongoing assessment of risks that an organization faces from both internal and external sources.

## Risk Assessment at the Division of Medicaid

*The second component of Internal Control is **Risk Assessment**.*

*DOM management should, with the support and assistance of staff:*

- *define objectives clearly to enable identification of risks;*
- *identify, analyze and respond to risks related to achieving the defined objectives;*
- *understand and address the potential for fraud; and,*
- *identify, analyze, and respond to significant changes that could affect internal control.*

DOM defines and assesses the risks facing the agency through a variety of methods including the 5-Year Strategic Plan. See the following discussion of current DOM risk assessment processes and planning. In addition, DOM personnel are considering other risk assessment processes for the agency.

### Defining Objectives to Respond to Risk

**Strategic Plan**

DOM's executive leadership has developed a ***5-Year Strategic Plan for Fiscal Years 2024-2028***, dated July 15, 2022. The major plan goals are improving the quality of Medicaid and CHIP services for adults and children, while simultaneously reducing costs, and to improving the health and care of beneficiaries enrolled in the Home and Community Based Services program (which moves residents from institutional settings to home or community-based care). A representative list of other objectives and strategies in the ***5-Year Strategic Plan*** are:

- Promoting effective prevention and treatment of chronic diseases;
- Promoting effective coordination of care;
- Maintaining and enhancing a robust network of high-quality providers;
- Implementing payment incentives or disincentives to providers to promote quality and value;
- Discouraging low-value provider practices and swiftly addressing abuse, fraud, and improper payments;
- Ensuring fees, charges, and rates for medical services are kept at a minimal but reasonable level;
- Increasing the percentage of long-term care recipients receiving home care versus institutional care; and,
- Improving data analytics to improve decision-making capacity, inform the public of program performance, and promote continuous improvement.

## Identifying Risks

For its ongoing process of assessing and managing risks, DOM assesses threats that impair efficient and effective agency operations and the provision of quality healthcare, while also assuring compliance with laws and regulations and reliable financial reporting. DOM's risk assessment begins with the identification of primary responsibilities and functions through development of the Mission Statement, Values and Principles, and the Strategic Plan. The Mission Statement is clearly communicated to all levels of staff through internal media and distributed documents.

In 2021 planning sessions, DOM senior leadership identified four key areas of focus to address its risks and needs: technology solutions and infrastructure; workforce training, development and recruitment; vendor selection and oversight; and data analysis for improved outcomes. Senior Leadership has pursued each of these strategies and continues to gather data about agency needs at all levels for these initiatives. In choosing the four key areas of focus, DOM management identified the following external and internal risks to the agency:

**External Risks**
DOM management determined that external risks include economic and social conditions, external regulations, rapid growth of programs, natural events, political conditions including budgeting of funds, and technology changes. External influences on legal and regulatory compliance and efficient and effective operations include actions of contractors, vendors, providers, beneficiaries. State Legislative risks include changes to appropriations, activity levels, and requirements. External threats include local or national emergencies, such as the 2020 COVID-19 pandemic that has negatively affected the economy and increased beneficiary rolls.

**Internal Risks**
Medicaid operational and financial risks include staff turnover, changes in staffing duties and responsibilities, new or modified technology (software, hardware, information systems, data processing), and challenges to cash management and asset protection and preservation. DOM's ability to function at its peak capacity can be impacted by loss of experienced personnel, staffing shortages, changes in the availability of technology to complete job functions, changes in requirements for financial systems and operations, and lack of training.

In previous planning sessions, DOM management identified the specific risks that would impact accurate processing of transactions for financial reporting and compliance. See *Appendix C* for descriptions.

## Analysis and Response to Risks and Changes in the Environment

DOM employs various methods to define and analyze its risks and respond to changes in the external environment, as discussed below. (Also see *Appendix B* for Risk Assessment Responses and Strategies.)

**Assessment of Health Outcomes and Healthcare Indicators for Quality Improvement**
A primary risk for the Division of Medicaid is continued poor health indicators among the state's population, particularly Medicaid beneficiaries who are the most vulnerable in the state. DOM management monitors the state's health outcomes and the outcomes for Medicaid beneficiaries specifically. To address this overarching risk, DOM has developed a Comprehensive Quality Strategy and created a Quality Leadership Committee to study indicators, address planning and strategies, and collaborate among state agencies for improved health outcomes.

Managed Care Financial Oversight personnel also monitor indicators such as potentially preventable hospital readmissions, which are used in provider-incentive healthcare improvement efforts. See additional discussion in the *Component 5: Monitoring* section of this document.

**Review of Laws and Regulatory Requirements**
Various program areas continuously review notices, legislation, court cases, and other information sources that can impact DOM operations. The agency closely monitors for activity that might affect the agency and analyzes changes to federal regulations that could affect the operations of the agency.

**Operational Risk and Disaster Management**
To address operational risks associated with continuity of operations, the DOM has developed a *Disaster Management Plan* available to all employees on the DOM employee online intranet site. The plan is a basic overview of the roles, responsibilities, and procedures in place for employees in the event of disaster, emergency, or inclement weather. The plan offers guidelines to prepare for and respond to these types of situations, stressing that each employee should be familiar with the plan and that preparedness is the key to employee safety. (Per the link above, the Disaster Management Plan can be accessed under the "Manuals/DOM Employee Manual" and "Training & Resources" sections on the intranet site.)

In addition, DOM is currently contracting for the development of a Business Continuity and Disaster Recovery plan. This plan is expected to be fully implemented in 2023.

**Financial Management and Reporting**
DOM personnel consider internal and external risks that could have an adverse effect on the agency's ability to initiate, authorize, record, process, and report financial data. Poor internal controls over transactions could pose a threat to accurate financial reporting and to the security of agency funds and assets. Circumstances that affect risk can include changes in the operating environment, personnel changes, and new business models or technology. Specific risks identified by Finance staff are included in *Appendix C* of this document.

**Network Security Risk Assessments**
Agency information systems store sensitive personal information on current and former Medicaid beneficiaries and applicants, as well as staff and contractors. To reduce threats to information systems and the unauthorized release of data, DOM's Information Technology Management (iTECH) staff maintain network security procedures according to the Mississippi Department of Information Technology Services security policies and standards and the *IRS Publication 1075*. Some elements of DOM's technology infrastructure are considered within the system boundary of the New Medicaid Eligibility Determination System (New MEDS) system and are subject to additional controls of the MARS-E 2.2 framework of the federal Centers for Medicare and Medicaid Services.

DOM's ongoing risk assessments include contracting for a network vulnerability audit at least every three years. These types of confidential evaluations assist DOM in assessing any vulnerabilities in its internal and external information systems. Any findings or recommendations that may arise from the audits are considered by iTECH for implementation of corrective action plans.

The most recent audit was completed in 2021. Audit steps included an automated vulnerability scan of devices, penetration testing to determine susceptibility to network attacks, a manual review of primary systems, technical documentation of results, and security expertise to assist with control procedures. A copy of the 2021 *Information Risk Assessment Executive Summary* is available for review upon written request to the iTECH Security Officer.

**Assessments of Eligibility Systems Security and Privacy**
In 2022, DOM completed its required CMS Security and Privacy Control Assessment of the New MEDS system. The assessment was conducted in accordance with the approved Security and Privacy Assessment Plan, dated April 16, 2021, and completed in October of 2022. This security and risk assessment provided the information about any associated vulnerabilities identified during the New MEDS independent security and privacy assessment.

**DFA Internal Control Assessments**
The Mississippi Department of Finance and Administration (DFA) requires annual assessments of agency risks and internal controls, as outlined in the *Mississippi Agency Accounting Policy and Procedures* (MAAPP) Manual, Sub-section 30.50.00. Each agency is required to complete and/or update fifteen questionnaires to discuss how it addresses the Five Components of Internal Control (see p. 3 for a summary of the five Components), as well as specific operational issues such as procurement and accounts payable, cash disbursements, accounts receivable, travel, grant information, fixed assets, personnel and financial systems, and fraud, waste and abuse.

Along with the completed assessment questionnaires, agencies send DFA a required Certification Letter affirming that its internal controls "provide reasonable assurance that the assets of the agency have been preserved, the duties have been segregated by function, and the transactions executed are in accordance with laws of the State of Mississippi." (See the *Component 3: Control Activities* section of this document for the definition of segregation of duties and references to the activities cited in DFA's Certification Letter.)

**Internal Audit**
Internal Audit plans and directs risk-based audits of various programs and offices throughout the agency. Internal Audit has used several techniques to perform risk assessments, including management questionnaires regarding personnel, oversight, technology, and other issues; preparation of lists of emerging internal and external issues and concerns; and creation of a risk matrix (or heat map) that visualizes important threats and opportunities for the agency. Internal Audit rates potential audit areas based on the related financial, strategic, reputational, organizational, and compliance risks that might affect the agency. Based upon the results of the most recent risk assessments and in consultation with the Executive Director, each year Internal Audit establishes or revises an audit schedule that addresses three years of forward planning. When audit work reveals deficiencies in agency operations, program areas are required to devise corrective action plans to help mitigate the risks associated with the deficiencies cited. Internal Audit follows up to ensure program areas have implemented their corrective action plans and controls are implemented to help avoid recurring problems.

## Assessing Fraud Risk

In assessing risks that would affect achievement of agency objectives, DOM considers the potential for fraud. Fraud risk is addressed by various agency offices, including Accountability and Compliance (Program Integrity/Financial and Performance Audit), Internal Audit, Medical Services, and Finance (including Managed Care Financial Oversight).

Either directly or through contracts, various DOM offices continuously review claims data, financial reports, and other relevant data. The offices share internal information and alerts from federal and state agencies and other healthcare partners and stakeholders. By sharing support and assistance and taking referrals from other offices, DOM staff address risks with the objective of lowering overall risk levels. See *Appendix A* for a detailed description of the operations of these DOM offices and their methods of addressing fraud risks.

# Component 3: Control Activities

## What are Control Activities?

Control Activities are the actions management establishes through policies and procedures to achieve objectives and respond to risks in an organization's internal control system. The risk of failures in internal control affects all aspects of an organization's operations, including its information systems. Other risks are inherent to particular types of organizations (for instance, Medicaid faces the risks of maintaining control over a huge volume of transactions and overseeing consistency of quality and pricing of medical treatment by thousands of providers.) Of particular concern, any organization's information systems face ongoing internal control risks, as well as ever-changing external threats.

Control Activities can be developed to prevent problems or to detect problems occurring at an organization, and they are implemented at the various organizational and functional levels within the entity. Examples of Control Activities include supervisory authorization of transactions, safeguarding of assets and asset accountability, reconciliation of transactions and reports, information processing edits, performance reviews, training of personnel, root cause analysis of identified weaknesses or system failures, and segregation of duties related to any operation that could lead to fraud or theft within an organization. Segregation of duties ensures that more than one person completes the various tasks required to complete a business process, e.g., preventing one individual from handling both receipt and disbursement of funds; it reduces opportunities for fraud or error concealment during routine performance of duties.

Control activities help to ensure that an entity realizes efficient and effective operations, reliable financial reporting, and compliance with laws and regulations.

## Control Activities at the Division of Medicaid

*The third component of Internal Control is **Control Activities**.*

*DOM management should, with the support and assistance of staff:*

- *design control activities to achieve objectives and respond to risks*
  *(e.g., Segregation of financial duties, supervisory and management approvals, assurance of accurate and timely records, rules for safekeeping of assets);*
- *design DOM's information system to achieve objectives and respond to risks*
  *(e.g., Information processing rules, security, edits for accuracy, capacity); and,*
- *implement control activities through policies and procedures*
  *(e.g., for programs, personnel, technology).*

To affect strong internal controls over activities, DOM has developed (1) policies and procedures to ensure consistency in operations management and (2) oversight mechanisms to help avoid opportunities for fraud and loss of control over data and programs. Control activities include information systems controls, financial controls, and reviews of claims decisions and claims data to help ensure responsibilities are carried out as intended and agency objectives are met.

## Policies and Procedures

**Policies for Medicaid Service Delivery**
The Policy unit within Health Policy and Services is responsible for the development and maintenance of policies for Medicaid programs. The Policy unit oversees and manages the State Plan Amendments and the Mississippi Administrative Code (which serve as the baseline for managed care policy and service delivery) and the Provider Reference Guide; develops all fee-for-service policy (for reimbursement of providers for individual health services); and collaborates in the maintenance of policy for DOM's managed care contractors. To create new policies, Policy works with internal and external stakeholders and conducts research on the health and financial and implications of new policy. The office manages internal communications and feedback regarding policy development, acts as interpreter of State and Federal guidelines and policies, and serves as the primary contact with federal regulators for policy communication, questions, and updates.

**Personnel Policies**
Since the Division of Medicaid (DOM) is a state agency, DOM follows the rules and regulations outlined in the Mississippi State Personnel Board (MSPB) Policy and Procedures Manual and the Mississippi State Employee Handbook. New state employees are required to acknowledge through the completion of a Mississippi State Employee Handbook Acknowledgement Form that they are responsible for reading and understanding the state employee policies and procedures established by MSPB according to relevant state law.

In addition, employees must be familiar with the Division of Medicaid Employee Manual that is more specific to DOM operations and expectations. Employees must also complete the DOM Employee Manual Acknowledgement Form confirming their responsibility for reading and understanding the agency's internal policies and procedures. The DOM Employee Manual details the actions considered to be offenses and the disciplinary actions that can result when the agency policies and procedures are not followed.

**Standard Operating Procedures**
Office Directors are required to develop standard operating procedures (SOP's) using a standard template across the agency and to regularly review and update the SOPs to ensure they are current and accurate. The agency's Standard Operating Procedures for all units are located on the DOM network K: drive, accessible to DOM managers. In addition, DOM procured a new system in 2022 to house agency SOPs that will be available to all employees in 2023.

**Financial Management Policies**
Finance staff are responsible for acquisition of goods and services needed by the Central Office and Regional Offices. Finance conducts purchasing and service procurement in accordance with state and federal laws and regulations as outlined below.

> **State Policies—**State procurement policies and procedures are overseen by the Mississippi Department of Finance and Administration (DFA), the Public Procurement Review Board, and the Mississippi Department of Information Technology Services (Mississippi ITS). State regulations include DFA's Mississippi Agency Accounting Policy and Procedures (MAAPP) Manual and Mississippi Procurement Manual; the Public Procurement Review Board Rules and Regulations, as administered by DFA's Office of Personal Services Contract Review; various fleet and procurement manuals and purchasing card and travel guidelines managed by the DFA Office of Purchasing, Travel and Fleet; and the ITS Procurement Handbook published by Mississippi ITS, which includes guidelines for purchase of computer systems and other information technology using state general funds.

DFA draws its statewide authority from legislation set forth in Chapter 104 (*State Fiscal Affairs*) of the annotated Mississippi Code of 1972, especially Sections 27-104-1 to 27-104-167. The state's Public Purchasing Law is contained in MS Code Sections 31-7-1 to 31-7-423, and the data processing and telecommunications procurement laws are included in Sections 25-53-1 to 25-53-201.

In addition to the financial-related policies above, DOM has created a State Plan which is a detailed agreement between the State of Mississippi and the Federal Government that describes the nature and scope of Mississippi's Medicaid Program. The State Plan is based on the federal requirements and regulations found in Title XIX of the Social Security Act. DOM's Administrative Code is a set of rules that dictate how the agency is administered. The Code is divided into parts, chapters and rules which outlines policy and procedures. Changes to the Administrative Code must be filed with the Secretary of State's Office in accordance with the Mississippi Administrative Procedures Act.

**Federal Rules—**DOM also must abide by various federal laws and regulations in the U.S. Code of Federal Regulations, which are administered by the Centers for Medicare and Medicaid services (CMS) and the Office of Management and Budget (OMB). Financial-related federal regulations include 45 CFR 75 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 2 CFR 200 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. State procurement standards set forth by the U.S. Department of Health and Human Services is located in sections 45 CFR §§ 75.326 to 340. Specific guidance on many types of allowable and unallowable costs under federal grants to states is included at 2 CFR §§ 200.420 to 200.476.)

Other specific financial-related rules are included within the overall Medicaid and CHIP statutes in Title 42 of the Code of Federal Regulations. See 42 CFR § 430-456 for Grants to States for Medical Assistance Programs (Medicaid) and 42 CFR 457 for State Children's Health Insurance Programs. For instance, 42 CFR 447 relates to Payments for Services under the Medicaid program.

## Financial Management

The Finance unit supports state Medicaid strategy by seeking to incorporate innovative payment methodologies and the use of quality metrics. Finance also leads, coordinates, or supports cross-agency projects to improve effectiveness and efficiency.

Finance is responsible for ensuring financial control-related activities are in place within the agency to safeguard assets and ensure accurate financial reporting. These activities include:

- supervisory review and approval, including assignment of duties within the MAGIC accounting system to ensure proper segregation of duties among personnel;
- physical control over vulnerable assets through the property office;
- establishment and review of performance measures and indicators; and,
- proper execution of transactions, including accurate and timely recording.

Finance establishes control procedures to mitigate the risks of material misstatements in the DOM financial statements or instances of material noncompliance with federal and state laws and regulations. The cost and benefits of internal controls are also considered. The agency seeks to avoid instituting controls that do not result in benefits that outweigh the associated costs.

## Program Integrity, Accountability, and Compliance

The Division of Medicaid (DOM) Accountability and Compliance office serves as an oversight mechanism for DOM, overseeing a variety of programs to help ensure strong internal controls within the agency. E.g., the operations of the Program Integrity and the Financial and Performance Audit units serve as an overall deterrent to protect federal and state funds from fraud, waste, and abuse. In addition, the Compliance unit function serves as a preventive control to ensure fairness in competition among managed care organizations and compliance with all contractual and regulatory requirements by outside vendors. Specifically, as an example, a Compliance unit specialist reviews all marketing materials that DOM's managed care contractors send to potential Medicaid enrollees for recruitment purposes. The specialist reviews the language against federal requirements and contract language to ensure that the managed care contractors comply with regulations. The programs of Accountability and Compliance, including these units, are described in more detail in *Appendix A* and throughout the Internal Control Plan.

To assist the statewide Eligibility staff in avoiding the appearance of impropriety and personal conflicts of interest, the following ethical control was established: 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. This rule is detailed in Section 101.12 of the *Mississippi Division of Medicaid's Eligibility Policy and Procedures Manual.* The manual describes specific guidelines for the way 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 the procedures outlined in the policy manual are subject to disciplinary action. Normally, the processing of all applications is to be reviewed by managers at a level above the staff member and at other levels. See the link to the *Eligibility Policy and Procedures Manual* at https://medicaid.ms.gov/eligibility-policy-and-procedures-manual/.

## Legal Counsel - HIPAA Precautions

Because agency responsibilities involve access to beneficiaries' Protected Health Information, Personally Identifiable Information, and medical information under the federal Health Insurance Portability and Accountability Act (HIPAA), DOM maintains continuous controls over its data to address security risks. e.g., the DOM Legal Counsel office employs a Privacy Officer. This HIPAA-certified attorney reviews requests for information and requires that employees, vendors, contractors, and subcontractors certify they will protect DOM information from improper disclosure.

Control systems are in place that limit an employee's access to only the types of data considered necessary for individuals to complete their job duties. See the following section for discussion of DOM's information technology controls over DOM's fiscal agent processes and over other information systems and equipment.

## Information Systems/Processing Controls

DOM information systems contain many control processes over the volumes of personnel, beneficiary, and financial data maintained. DOM's Information Technology Management (iTECH) staff responsibilities include oversight of security audits, security training, security policies, and backup of stored data and cloud systems. ITECH has implemented security features to control access to computers while inside or outside of agency facilities and to limit employee access to only the data considered necessary for completion of job duties. iTECH also uses email encryption procedures when necessary to ensure privacy under the HIPAA laws and regulations.

iTECH and Legal Counsel coordinate efforts as necessary to respond to reported security incidents. In addition, DOM systems users must complete and sign attestation forms that cover related risks and concerns.

**Security Card**
The iTECH division issues security ID cards to all employees to control physical access to various offices areas and equipment. DOM manages an access control system in conjunction with these security cards that permit employees to gain access to both central offices and regional offices. Logs of all card swipes are maintained for review in case of a security incident. The security cards are also required to utilize the agency's printers and copiers. Confidentiality is safeguarded and paper is conserved because, after initiating a print job from a computer, an employee must use an ID at the printer to complete the process. The paper is not released until the ID is swiped by the employee; therefore, printed items are not left unattended.

**Information Processing Policies and Procedures**
iTECH has adopted security and privacy Policies and Procedures as reflected in Sections 6 and 7 of the DOM Employee Manual accessible on the DOM employee intranet. The policies address confidentiality and security of data in information systems, including Protected Health Information under the federal HIPAA law. In addition, the standard operating procedures (SOPs) for iTECH personnel are located on the network K-drive along with other agency SOPs.

**Remote Security**
To address data security risks when central office employees are required to work from home and to handle operations for the agency's 30 regional offices and third-party contractors, iTECH operates RDS (a remote data access environment). RDS is DOM's way to access on-premises technology resources remotely. Employees must set up a multi-factor authentication process to log into the DOM network from a remote location, including typing of a password and an approval notification via a phone call, text, or cell phone app. Email and other collaboration tools are available remotely without the use of RDS and are also subject to these types of controls (i.e., multi-factor authentication and conditional access policies).

**Eligibility Systems**
DOM uses a vendor (currently Conduent) to maintain and operate the agency's New Medicaid Eligibility Deterministic System (New MEDS). DOM eligibility case workers use New MEDS to assess Medicaid applications for eligibility. Each year an independent audit firm conducts security assessments of New MEDS, using the Minimum Acceptable Risk Standards for Exchanges required by CMS. After review and approval DOM sends the completed audit reports to CMS for final approval.

Conduent maintains and operates the New MEDS system in a secure data center. The system is subject to all security and privacy controls established by DOM's federal grantor (the Centers for Medicare and Medicaid Services/CMS). CMS must approve Conduent's planning and controls for New MEDS maintenance and operation.

New MEDS is connected to a variety of outside data systems to help DOM eligibility workers verify accuracy and completeness of data provided by applicants, including the (1) Federal Data Services Hub for income (i.e., HUB, which provides a secure connection to federal data to enhance security of private information); the federal Public Assistance Reporting Information System (PARIS) which matches data to determine if an applicant is receiving assistance in another state; and the agency's Fraud and Abuse Module (FAM) as a source of applicant information for liquid and real assets. Once a DOM case worker verifies all data for an application is acceptable and correct, New MEDS processes it through an IBM rules engine (BLAZE Advisor) for an initial eligibility determination. After the DOM case worker finishes processing the application, a supervisor verifies key elements and makes a final determination for approval or denial of benefits.

Access to New MEDS is controlled through the DOM Active Directory system to ensure security group and user administration and password maintenance. Online user login security consists of: (1) authentication which validates the identity of each user when they initially log into the system and provides identity information to the system applications, and (2) authorization which enables or disables functions and data access needed by an individual user.

## Managed Care Program Activities

DOM has retained the services of an actuarial firm, Milliman, Inc., to calculate managed care capitation rates and certify they are correct and comply with federal regulations. The capitation rates are actuarially determined fees that the managed care organizations (MCO) will be paid on a per-member, per-month basis for providing services to eligible Medicaid beneficiaries. With DOM's review, approval, and input, each year Milliman prepares an annual rate setting letter which includes the actuarially determined rates, and the letter and supporting information are submitted to CMS for approval. Supporting documentation includes exhibits which define separate capitation rates by age, region of the state, and other categories of eligibility. A separate rate tracking document has been developed for DOM internal use for the entire period of the program.

As part of the contractual arrangement and to comply with federal regulations, DOM does not allow the MCOs to directly market to individual beneficiaries. DOM and its Fiscal Agent are responsible for the member enrollment process, and they provide beneficiaries with information about choosing an MCO and assist them with enrolling with their MCO of choice.

The fiscal agent's management information systems include a Managed Care subsystem which assigns members to MCOs, produces enrollment rosters and reports, and generates capitation payments. DOM provides the fiscal agent with changes to the program and required system changes, and the fiscal agent modifies the system "rules" to accommodate necessary changes that ensure the accuracy of member assignment and payments. Each of the managed care organizations is assigned a Medicaid provider number. Each MCO reports claims data to DOM's fiscal agent for inclusion in the Medicaid management information system (MMIS).

# Component 4: Information and Communication

## What is the "Information and Communication" Component of Internal Control?

An agency's internal control structure should ensure that information generated for distribution to internal and external stakeholders is accurate. The information that is communicated to describe operations should be of high quality so that stakeholders can rely upon it for good decision making.

The information system includes the business processes relevant to operational and financial reporting and objectives. An entity should provide secure access for the identification, capture, and exchange of information. Financial statements depend upon an accounting system designed to properly initiate, authorize, record, accumulate, process, summarize and report entity transactions.

A good internal control system also requires ease of communication among the staff who need quality information to support internal operations.

## Information and Communication Processes at DOM

*The fourth component of Internal Control is **Information and Communication**.*

*DOM management should, with the support and assistance of staff:*

- *use relevant, quality information to achieve agency objectives;*
- *internally communicate quality information to achieve DOM objectives; and,*
- *externally communicate quality information to achieve DOM objectives.*

DOM works to maintain information system processes and procedures that secure timely and effective communications among staff and accurate information for program management.

### Executive Communication

The **Executive Director** has established a regular schedule of meeting and communicating with employees at various levels of the organization. At weekly senior leadership group meetings, biweekly meetings with Deputy Directors, and monthly meetings with Central Office directors, the Executive Director presents progress towards goals and explains important activities and aspirations of the department.

For all employees, the Executive Director emails a monthly ***Medicaid Snapshot*** memo with up-to-date information on activities within the agency. The memo includes a message from the director, announcements of employee award winners, health tips, and a banner that reinforces the agency Mission Statement. The office of the Executive Director also reinforces relevant policies and procedures and important job responsibilities by emailing fact sheets and reminders to employees.

### Communication

**Communications** staff produce internal newsletters, maintain the agency's external website and social media channels, and prepare news notices and press release for external audiences. An important priority during the previous year has been communicating with all employees regarding the implementation of a new agency-wide

eligibility and information system. (A staff and contractor team known as the MMIS Replacement Project or MRP team has logged many hours towards the replacement of the current information system.) As a part of the transition, the Communications Officer has emailed an ***MRP One-Minute Message*** on a regular basis to provide high-level updates to employees and other stakeholders.

The Communication Director also emails a frequent ***News Bulletin*** to DOM Office Directors. The News Bulletin alerts personnel to agency-related news which has been published by print and online media outlets during the week.

## Information Technology

The responsibility for ensuring agency personnel use relevant, quality information is born by various DOM offices. For instance, Information Technology Management (iTECH) plays a major role in ensuring that DOM information is not compromised by external sources and remains secure so that quality data can be maintained. iTECH oversight of systems for determining eligibility of service recipients and system security is discussed in the Control Activities section of this document. iTECH is also responsible for procuring vendors to handle eligibility and other technical systems.

The Procurement unit within Finance, other relevant program areas, and senior leadership are involved in procuring contracts for the major systems which deliver Medicaid and CHIP services. For instance, in October 2022 DOM was in the process of requesting and reviewing proposals for a contractor to take over its eligibility systems from a prior vendor. The successful vendor will be required to implement quality control and audit processes, employ a quality assurance engineer, and provide an updated bi-weekly plan that includes Quality Management and Communications Management Plans. The vendor is expected to provide a continual improvement process that will minimize software code flaws and provide ease of maintenance. In particular, the vendor will be responsible for generating daily reports of potential data integrity issues from worker portal data entry; extracting random electronic data base samples to check for accuracy; generating reports of in-process applications that have aged beyond a set maximum number of days; and generating reports of individuals without case numbers that are created by improper merging of interface records. These types of detailed quality control procedures serve to increase the quality of agency information by catching errors that can be corrected and that could point to more extensive systems problems.

Another example is DOM's Clinical Data Interoperability Program (CDIP) which has multiple built-in checks and balances to assure data accuracy and quality. CDIP allows for DOM's agency-approved healthcare providers to send and receive information on Medicaid Beneficiaries at the point of care. To enhance security, the providers and DOM use an industry-accepted format for health information exchange (Consolidated Clinical Document Architecture) which adheres to certain data systems standards. Before clinical data is added to a DOM beneficiary record during the exchange process, the patient is verified as an active Medicaid beneficiary via the CDIP master person index. Additionally, processes within the CDIP infrastructure ensure that no incoming clinical data will duplicate records that already exist in CDIP. The CDIP team uses these types of checks and balances to ensure the data in CDIP (including the data used by the associated Analytics system) are accurate, timely, and appropriate.

## DOM's Statewide Eligibility Workforce

The office of Eligibility conducts intensive training for recruits to the workforce of 650 frontline workers and maintains regular communications on other policies and updates.

Newly hired Benefit Program Specialists participate in a 7-day course to learn the fundamentals of policy, the methodology of reviewing applicant financials to determine eligibility, and the application of these new skills in everyday scenarios. Through the TEAMS online platform, statewide classes are presented to newly hired staff in the conference rooms of their own regional offices. Regional supervisors work with the Central Office training team to ensure trainees have completed pre-training materials and are able to function in the training software. During the classes, trainees are engaged in a variety of discussions, illustrations, homework and in-class assignments. The training is geared to equip the workforce with a firm foundation on tools and software, present the material in a user-friendly manner, and encourage and assure trainees that support is available to them as they transition into their new roles.

The director of Eligibility in the Central Office maintains regular communications with all 650 eligibility workers. In a monthly TEAMS meeting, the director gives updates, goes over software changes to the eligibility information systems, and answers questions from offices. In addition, the eligibility director sends memos explaining policy changes.

## Human Resources Communications

To complement the monthly ***Snapshot*** communication from the Executive Director, the ***Around Mississippi*** newsletter from DOM Human Resources is published quarterly within the agency to feature news of interest in both central and regional offices. The communication includes updates on employee activities and office events. The newsletter aims to foster a sense of community within the agency and to encourage employee engagement by celebrating employee achievements and individuality.

In addition, the Human Resources director reinforces the need for various types of training. For instance, the director has required that all employees sign statements that they have watched a training webinar on the scoring process for the new Performance Review System for employee evaluations.

## Managed Care Financial Oversight

Managed Care Financial Oversight coordinates the financial analysis of managed care claims data and communicates issues and findings to DOM management, including for categories of costs, validation of claims counts, claims payment reconciliations, the managed care rate setting process, and the reconciliation of enrollment counts. To alert senior leadership and DOM managed care, program, finance, and compliance staff, the unit sends emails, data and reports of numerous ongoing analyses being conducted internally and by agency contractors.

The unit meets weekly and monthly with Milliman, the agency's actuary, and monthly with the agency's primary managed care auditors, Myers and Stauffer, LC. By inviting other DOM personnel to these meetings, Information and Communication is shared with other offices to assist with understanding the financial and data reporting issues of the three MCOs. The unit's personnel also participate in meetings arranged by the office of Coordinated Care.

## Other Examples of Information and Communication (Internal and External)

**Finance**
In addition to the *Information and Communications* role of the Managed Care Financial Oversight unit within the Finance, numerous other budgeting, accounting, purchasing and transaction oversight personnel communicate with all agency units to disseminate information needed to oversee operations. To safeguard assets and promote accurate financial reporting, Finance is responsible for ensuring that relevant financial control information is communicated agency wide.

Finance is also responsible for the proper segregation of duties among staff within the MAGIC state-wide accounting information system, i.e., frontline staff who enter transactions are given supervisory oversight through transaction-approval hierarchies, or levels of approval. Communication tools include policy and procedures manuals (e.g., Mississippi Department of Finance and Administration regulations on its website), the Finance staff's standard operating procedures found on DOM's K-drive, and other methods such as training, briefs, and email notices.

**Coordinated Care**
DOM Coordinated Care facilitates the communication of information among each of the managed care organizations (MCOs) and DOM personnel from managed care financial oversight, medical services, pharmacy, compliance, and finance offices and other program areas.

In a monthly meeting with each of the three MCOs, attendees hear about the status of requested information and activities and view agendas and reports on the most recent MCO performance, plans, and goals. The variety of topics may include healthcare trends, system updates, Quality Improvement efforts, enrollment, call center statistics, member events and outreach, provider education and credentialing (the process of ensuring that healthcare providers have the proper credentials), subcontractors, and required state and federal reporting. The office of Coordinated Care identifies areas of improvement needed by CCOs and directs improvement via various remedies, such as corrective action items, website improvements, document corrections and clarifications, work group meetings, etc.

**Health Policy and Services**
The Policy unit within DOM's Health Policy and Services office oversees all fee-for-service policy in the Agency, including the State Plan and the agency Administrative Code, and assists with managed care policy. The Policy unit manages internal communications and feedback regarding agency policy development, acts as interpreter of State and Federal guidelines and policies, and serves as the primary contact with federal regulators for policy communication, questions, and updates. Communications activities of Health Policy and Services include ensuring internal and external stakeholder engagement, circulating internal and external policies and updates, managing internal discussions and feedback in interpreting State and Federal guidelines for the agency, and serving as the primary contact with the federal Centers for Medicare and Medicaid Services.

**Long-Term Services and Support**
DOM contracts with Myers & Stauffer, LC, a healthcare oversight contractor, to assist in administration of the Case Mix program. (See the discussion of case mix reimbursement in *Appendix A* under the description of the DOM's Long-Term Services and Supports office.) As part of its contract, Myers & Stauffer, LC publishes the Mississippi Messenger newsletter to address Mississippi Case Mix Reimbursement issues. The newsletter notifies stakeholders, such as long-term care providers and Medicaid personnel, of the most recent official clarifications and changes to the federal documentation requirements, upcoming training, and other major case mix-related issues.

**External and Legislative Affairs**
The External and Legislative Affairs Liaison reports to the Executive Director and serves as the primary point of contact for elected officials and legislative staff. The Liaison is responsible for developing, refining, and communicating agency policy positions with external constituencies, including the governor's office, the Mississippi Legislature, Congressional staff, provider associations, advocacy groups, other state agencies, and other third parties. The liaison works to ensure transparency and optimize stakeholder relationships; coordinates and responds to external legislative and congressional requests for information, including assistance with inquiries from their constituents; and advises the Executive Director on matters of policy and strategy.

**Information Technology Management (iTECH)**
The Help Desk Services Division of iTECH provides daily support for hardware, software, telephone, and mobile device issues and requests. The Help Desk troubleshoots end user technical issues and works in conjunction with other iTECH staff as needed to resolve technical issues. The director of iTECH notifies all DOM staff by email regarding any technical disruptions that have occurred and keeps the staff updated until issues have been resolved.

**Accountability and Compliance**
The Accountability and Compliance office oversees legislatively required independent audits of MCO topics and communicates with external consultants and contract auditors who perform the audits. The Deputy Administrator of Accountability and Compliance works to ensure all response to audits, reports, or other questions related to DOM operations are easily read and accessible through coordination with various program areas and the Director of Communications.

The Program integrity unit within Accountability and Compliance regularly communicates with the Mississippi Medicaid Fraud Control Unit in the Mississippi Attorney General's office and the National Medicaid Fraud Control Unit, referring their research and investigations into apparent frauds perpetrated by providers and beneficiaries. Program Integrity also routinely communicates with other federal or state law enforcement or fraud prevention regulatory and oversight agencies.

**Internal Audit**
The Director of Internal Audit provides a copy of each completed audit report to the department director of the program that has been audited, the Deputy Administrator over that program area, the Deputy Administrator of Accountability and Compliance, and the Executive Director. During the process of each project, Internal Audit and the program auditee hold meetings to discuss draft copies of the reports, feedback, clarifications, program responses, and recommendations for improvement.

**Weekly Communication Updates**
Each week, the DOM Deputy Administrators receive updates from their officers and various staff on weekly activities and upcoming plans. The Deputies use staff reports and information obtained from staff meetings to prepare their own Weekly Program Updates. Reports are submitted to the Executive Director in concise bullet points on topics that recap their office's accomplishments and priorities.

**Written Reports, Manuals, and Documentation**
All DOM areas have developed detailed policy and procedures manuals to assist in maintaining consistency of operations, training new staff, and providing information on DOM control activities. DOM maintains its Standard Operating Procedures manuals (SOPs) in the K-drive folders available to all staff. In addition, the DOM employee manual, the state employee handbook, the Internal Control Plan and other documents for staff can be accessed on the DOM intra-agency employee website.

# Component 5: Monitoring

## What is Monitoring of Controls?

Monitoring occurs during an entity's routine operations and includes regular management and supervisory activities, comparisons, reconciliations, and other review actions.

Internal control monitoring assesses the quality of performance over time and promptly resolves the findings of various reviews and audits. Corrective actions are a necessary complement to control activities in order to achieve objectives. Monitoring of controls is essential in helping internal control remain aligned with changing objectives and changes in the environment. External pressures include changes in risks, resources, and laws.

## Monitoring Functions at the Division of Medicaid

*The fifth component of Internal Control is **Monitoring**.*

*DOM management and staff should:*

- *conduct internal control monitoring activities and evaluate results, and,*
- *communicate and remediate identified internal control deficiencies.*

The Division of Medicaid (DOM) carries out a variety of procedures for continuous monitoring of program operations. Internal and external audits provide independent and objective monitoring information for management. Throughout the year, DOM undergoes numerous financial and compliance audits performed by federal and state auditors and/or their contractors. 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. In addition, DOM's various other program areas conduct audits and desk reviews and oversee external providers and contractors.

Management periodically considers the appropriateness of the agency's internal control monitoring and the degree to which it helps to accomplish agency objectives. As summarized in the section below, monitoring helps to ensure that information and data developed and communicated by DOM is of high quality.

## Monitoring for Quality of Healthcare

**Utilization Management and Quality Improvement**

The DOM Medical Services unit oversees contracts with two separate Utilization Management and Quality Improvement Organizations, as required by the Centers for Medicare and Medicaid Services, to review prior authorization requests for fee-for-service beneficiaries and providers to determine medical necessity. Through their review procedures, the two vendors assist in safeguarding against unnecessary utilization of care and services under the fee-for-service delivery system of the Medicaid program.

**Managed Care Quality Strategy Report**

The office of Coordinated Care and the office of Medical Services have collaborated in the development of the Managed Care Quality Strategy Report. The report 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 report also details the standards and mechanisms for holding the MCOs accountable for desired

outcomes and articulates federal compliance requirements. The report is available on the Division of Medicaid's website at: MS-DOM-Comprehensive-Quality-Strategy-2021.pdf.

**External Quality Review Organization**
Federal Medicaid managed care regulations require states to have a written strategy for assessing and improving the quality of health care services offered by managed care entities. Each year, the External Quality Review Organization (EQRO) performs an overall external quality review of Mississippi's coordinated care system. See a detailed discussion of the EQRO contractor under the office of Coordinated Care monitoring activities below.

## Monitoring of 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 DOM offices within the Division of Medicaid oversee multiple aspects of the managed care programs for Medicaid and the Children's Health Insurance Program. Oversight among the various offices includes comparing fee-for-service program data to managed care data and review of contractually required deliverable reports that the MCOs are required to submit to DOM.

**Coordinated Care**
The Coordinated Care office directly oversees contracts associated with the operation and performance of the Managed Care Program. The unit monitors the operation and performance of the three MCOs on an ongoing basis, reviewing policies, communications, data, and reports required by the contracts. This unit collaborates with other DOM units such as Managed Care Financial Oversight, Pharmacy, and Medical Services. Coordinated Care is also in charge of the monthly status meetings with MCOs.

To comply with federal regulations DOM has contracted with a private, not-for-profit company called **The Carolinas Center for Medical Excellence**, which functions as DOM's External Quality Review Organization (EQRO). Coordinated Care oversees the EQRO contract. Each state contracting with an MCO must obtain an external quality review of each MCO annually. An external quality review is an independent analysis and evaluation of an MCO's information on quality and timeliness of the healthcare services that they provide to their Medicaid beneficiary members, and the ease of access provided to those beneficiaries. The EQRO review aggregates data from the MCO and any of the MCO's subcontractors. (The federal regulations at *42 CFR Part 438, subpart E,* for External Quality Review relate to quality measurement and improvement and set forth the parameters that states must follow for an external quality review).

The reports prepared by The Carolinas Center for each MCO are submitted to Coordinated Care for further review and then submitted to CMS in accordance with the federal requirements. The company also performs quarterly follow-ups with each MCO and develops and submits corrective action steps to the MCO for their review and response. The company is also available to staff members of the Division of Medicaid as a consultant to assist on any other issues or concerns related to the federal, state, or agency requirements involving the Managed Care Program.

Coordinated Care communicates various types of information and findings to DOM management, including EQRO review results and corrective actions, enrollment reports and trends, capitation reports and trends, and encounter data issues.

**Managed Care Financial Oversight**
DOM established this unit to serve as a further control over the three managed care organizations which serve two thirds of the state's Medicaid beneficiaries. In addition to information and communications roles, this unit

performs numerous monitoring activities and various types of financial and data analyses. This unit has the responsibility for tracking and monitoring the financial-related reports received from managed care contractors and reporting any of those compliance issues to DOM Accountability and Compliance. Managed Care Financial Oversight also assists DOM with healthcare Quality Improvement initiatives.

To assist in maintaining a confidence level that the MCOs are adhering to their contractual obligations from a financial standpoint, DOM has contracted with accounting firm Myers and Stauffer, LC, which specializes in oversight of states' managed care Medicaid programs. The Managed Care Financial Oversight unit oversees, analyzes, and interprets the various work done by Myers and Stauffer, LC, which is outlined below.

**Myers and Stauffer, LC**—Myers and Stauffer, LC employs CPAs, systems analysts, and other professionals to provide many services for DOM, including:

- validation of claims data and patient visit counts (Encounter Data) submitted to DOM by the managed care organizations (MCOs);
- reconciliation of MCOs' Encounter Data with the cash disbursement journals (CDJs) submitted by the MCOs (note that CDJs record both the MCOs' direct payments to healthcare providers for the claims processed by the MCOs and the claims paid by MCOs' subcontractors for services such as pharmacy, dental, and vision);
- independent calculation of the Medical Loss Ratio (MLR) to ensure contract compliance (i.e., a managed care organization's reported calculation of the amount it has spent on medical claims compared to a contractually required Minimum MLR ratio, administrative expenses, and other required reporting information);
- audits to determine if payments to providers were made in return for actual services to beneficiaries; and,
- analysis and correction/resolution of duplicate members in the enrollment data.

In coordination with Coordinated Care staff, Managed Care Financial Oversight unit staff follow up on deficiencies noted by Myers and Stauffer, LC to ensure timely corrective action is taken. In developing insights on managed care claims data, the unit may also gain insights on improving fee-for-service transactions and reporting. The unit also oversees the contract with **Milliman, Inc**., the actuarial firm which sets rates charged by the state's managed care organizations.

**Milliman, Inc.**—Milliman provides actuarial services to certify that the fees (capitation rates) paid to MCOs are actuarially sound and follow Centers for Medicare and Medicaid (CMS) regulations. Once determined and approved by Managed Care Financial Oversight personnel, the annual capitation rates are submitted to CMS for their approval. The MCOs agreed under their contracts 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 an MCO rate tracking document and prepares a Rate Setting Letter for the MississippiCAN and CHIP managed care program. The MCO Rate Setting Letter outlines the rate categories within northern, central, and southern regions of the state. Milliman, Inc. calculates, documents, and certifies to its capitation rate development. Because Milliman meets monthly with Managed Care Financial Oversight and other DOM offices to discuss ongoing analysis of claims, Milliman serves a valuable role in DOM monitoring processes.

**Compliance**

The Compliance unit within Accountability and Compliance serves an important role in program areas' ongoing monitoring of legally required reports and other documents. When program staff believe that a managed care organization (MCO) or other vendor is out of compliance with contract reporting requirements or other contract requirements, they first request assistance from the Compliance unit attorney for review and resolution. To

begin the process of resolution, a program area will complete a Referral Form describing the instance of non-compliance and submit it to the Compliance attorney. At that point the attorney will research the applicable legal and contract issues and reach out to the MCO as necessary. The Compliance attorney then takes applicable actions for resolution of the non-compliance issue, including meeting with applicable parties for understanding of issues, sending notices or warnings, offering MCOs an opportunity to cure the non-compliance, sending a liquidated damages letter and/or requiring a correction action plan, and placing monetary or other sanctions upon the MCO.

Leading up to the crucial resolution process, the Compliance unit coordinates the receipt, tracking and oversight of MCO reporting for participating DOM offices. The three MCOs submit documents to DOM and place them in the Reporting Manual folders set up by Compliance. (The Reporting Manual actually consists of various reports in spreadsheet format.) After reviewing the reports received, various DOM offices will complete approval tracking forms (known as Deliverable Compliance Tools) set up by Compliance for each MCO. Program staff members communicate with Compliance as necessary to review any potential compliance issues and comments noted on their Deliverable Compliance Tools. When program staff believe that an MCO is out of compliance with the contract reporting requirements, they refer the issues to Compliance as described in the previous paragraph. Note that the Coordinated Care unit also requires additional contract-related submissions not included in the reporting manual.

## Finance

The Finance unit monitors agency funding and spending from federal and state sources. As required by the Centers for Medicare and Medicaid Services (CMS), Finance ensures reconciliations of amounts reported in the state's financial system are performed at least quarterly and often monthly. Computer assisted techniques have been used through MAGIC and the *Envision System* (Conduent) to accumulate transactions into required reporting categories for completion of these reports.

Among other monitoring duties, Finance oversees the activities of Cornerstone Healthcare Financial Consulting, Inc. Cornerstone personnel meet periodically with Myers and Stauffer, LC to review and gather evidence on the performance of managed care contractors and to ensure the accuracy of reconciliation of claims (encounter) reports to Cash Disbursement Journals. A primary Cornerstone responsibility in 2021 and 2022 has been to assist with the procurement of new Managed Care contracts for MSCAN and CHIP, including preparing Requests for Proposal and Qualifications documents, reviewing prospective contractors' submitted proposals, and reviewing final contract drafts.

## Accountability and Compliance

The Deputy Administrator of Accountability and Compliance is responsible for several program areas including Program Integrity, Compliance, Financial and Performance Audit, and Internal Audit (administratively). These areas operate internally and externally providing both oversight and support functions to DOM by reviewing operations and contracts, as well as conducting audits of DOM contracts and interagency agreements. The Deputy also tracks reporting, monitoring and oversight activity of the MCOs. To manage numerous oversight, monitoring, and compliance responsibilities, the Deputy Administrator employs attorneys, auditors, investigators, and registered nurses, and also contracts with independent certified public accountants and auditors to aid in its responsibilities to the agency.

Accountability and Compliance also works closely with program area managers to review documents required to be delivered by contractors and to determine steps to be taken in cases of breach or non-compliance of a

contract. Responses may include assessment of liquidated damages, imposition of a corrective action plan, or enforcement of other contractual remedies. Staff within Accountability and Compliance conduct the following types of compliance reviews, audits and reviews.

**Compliance**
The attorney serving in this unit is tasked with ensuring that MCOs or other DOM contractors and vendors comply with the terms of their contracts. This unit has created procedures for contract monitoring by various offices throughout the agency. Specifically, Compliance has developed and maintains Medicaid and CHIP Reporting Manuals to organize and standardize the hundreds of reports submitted by the MCOs over the course of a reporting year. To assist program areas with monitoring the data reports assigned to them, Compliance has developed and continues to maintain a Deliverables Compliance Tool (DCT). The DCT provides a timeframe for review and a mechanism for reporting noncompliance.

If a program area reports an issue of noncompliance to the Compliance unit, the Compliance attorney assists the program area with resolution of the issue, whether through requests for clarification, corrective action plans, or assessment of damages. The unit also reviews and recommends appropriate language to be included in the Division of Medicaid's competitive solicitations prior to contract procurement or execution and works with all agency areas to update the agency's Annual Internal Control Plan and Internal Control Assessments.

**Financial and Performance Audit**
The staff in this unit monitor the compliance and operational integrity of certain types of healthcare providers and federal waiver programs. Auditing responsibilities include reviewing claims reimbursements to providers; inspecting facilities; reviewing qualifications of providers; auditing reimbursement-related costs reported by nursing facilities and the hospital costs allocated to nursing facilities through the Medicare cost report or other allocation methodology; and auditing technology grants to providers. Monitoring includes desk reviews and on-site audits of individuals, long-term care institutions, contractors, and other healthcare entities. See a more detailed description of the three units within the Financial and Performance Audit section in *Appendix A*.

**Legislative Audits of Managed Care Contractors**
The Mississippi Legislature passed a law in 2021 (under §43-13-117(H)(3)(b) & (c), Mississippi Code, Annotated) requiring the DOM to hire independent auditors to conduct specified audits of DOM's managed care contractors. To complete that task, DOM has hired White Collar, LLC, and WR Solutions to conduct these audits, which are in various stages of completion. The assessments under this statute contribute to agency Monitoring functions as they require at least two different audits each year, among 11 topics addressed in the statute. Topics to be reviewed include administrative expenses, performance measures, and reasonableness of corporate allocations.

**Program Integrity Functions**
The Program Integrity unit continuously monitors payments to Medicaid providers for evidence of fraud or abuse. The unit also works with the Medicaid Fraud Control Unit within the Mississippi Attorney General's Office to pursue recovery of fraudulent and/or unallowable costs. Monitoring functions and consultants overseen by Program Integrity are as follows.

> **Medicaid Eligibility Quality Control Program (MEQC)--**All non-SSI Medicaid eligibility determinations performed by staff of the Division of Medicaid 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. 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 to 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--**This unit reviews various reporting requirements of the Managed Care Organizations related to the identification of fraud, waste, or abuse. Reports required to be submitted by the Managed Care Organizations are reviewed and forwarded with comments, if any, to the Compliance attorney for resolution. Staff members attend regular meetings with the Coordinated Care Organizations and other oversight contractors involved in the Managed Care Program to ensure oversight of compliance. When applicable, this unit oversees the contract for a Recovery Audit Contractor (RAC) which is tasked with identifying and remediating potential fraud, waste, and abuse. This unit also participates in meetings with the Unified Program Integrity Contractor, as discussed below.

**Unified Program Integrity Contractor (UPIC)--**To improve efficiency and coordination of federal data analysis and audit investigation work, the federal Centers for Medicare and Medicaid Services (CMS) developed a Unified Program Integrity Contractor strategy. Under UPIC, federal Program Integrity audit and investigation work for a given region is consolidated into a single multi-state contract. The UPIC contractor, selected by CMS and its Inspector General, performs Medicare and Medicaid investigations and audits within the designated geographic jurisdiction. In order to complement state efforts, UPIC's work is accomplished through a Joint Operating Agreement between the Division of Medicaid and the UPIC.

## Internal Audit

DOM's office of Internal Audit independently assesses internal operations and control deficiencies that may impair the agency's ability to be effective and efficient in its operations. Internal Audit findings and program area corrective action plans are included in audit reports, along with target completion dates for the corrective actions. Upon the target completion date of each finding, Internal Audit evaluates the remediation efforts the program has undertaken. If found satisfactory and aligned with the agreed upon corrective action plan, the related finding is closed. In addition, Internal Audit ensures that all findings issued by external auditors are addressed by the audited DOM office and remediated in a timely manner. Also see the descriptions of internal audit functions related to other components of internal control and in *Appendix A* of this document.

## Other Program Monitoring and Audits

The 2022 Internal Control Plan does not include a description of the monitoring efforts of every program or office. Only two additional examples are noted below.

**External Audits of Management Care Organizations**
DOM obtains and reviews copies of the statutory audits that the Mississippi Department of Insurance requires that MCOs submit each year and quarter. The statutory audits are meant to shed light on the financial capacity of managed care organizations to ensure that they are sufficiently capitalized to continue operations for the foreseeable future. DOM also obtains copies of the MCOs' annual financial audit reports which present similar financial information.

**Information Technology Security (iTECH) Audits**
The iTECH Security Officer is responsible for oversight of information technology security audits and security training for the agency. In addition, as part of the Division of Medicaid's efforts to ensure that its fiscal agent Conduent has maintained adequate internal controls over the processing of medical claims payments, Conduent has undergone independent examinations of controls over financial reporting. The results are submitted to the

Director of iTECH for review and oversight purposes, to ensure that follow up procedures are performed for any noted deficiencies, and to ensure that appropriate corrective action is taken to resolve any deficiencies noted. Similar audits will be conducted of the new fiscal agent, Gainwell.

As part of DOM's contract with Conduent, for calendar year 2020 the accounting firm Ernst and Young, LLP, examined Conduent's records and issued an SOC1 (Service Organization Controls) audit. The SOC1 report included (1) a description of the service organization's information system, (2) a description of the suitability of the design of its internal control to achieve the related control objectives, and (3) an opinion on the operating effectiveness of the controls to achieve the objectives. In August 2022, Conduent issued a follow-up to the 2020 report and cited no additional problems.

## *Appendix A:*

# Description of Division of Medicaid Offices and Programs

## Leadership

The **Executive Director** is responsible for the overall administration of the Mississippi Division of Medicaid (DOM), providing access to quality health coverage for vulnerable Mississippians. Executive duties include managing federal and state resources, directing staff towards effective and efficient operations and innovative solutions, working with staff from the Centers for Medicare and Medicaid Services, monitoring state and federal legislative and regulatory activity regarding Medicaid, presenting budget information to the Governor and to the Legislature, and networking with other agencies and organizations for improved healthcare delivery.

The Executive Director's senior leadership (or direct reports) include the following positions:

- **Executive Assistant** (Assistant to the Executive Director, Emergency Coordination)
- **Communications Officer**
- **Deputy for Eligibility** (Regional Office Administration, State Eligibility Operations and Systems, Eligibility Policy and Training)
- **Senior Director, Managed Care Operations** – (Contracts for MississippiCAN and CHIP)
- **Deputy for Health Policy and Services** (Long-Term Services and Supports, Medical Services, Mental Health, Pharmacy, Policy)
- **Attorney for Special Initiatives** (Special Projects and Policy)
- **Supervising Attorney, Business Operations and Solutions** (Provider and Beneficiary Solutions, Provider Enrollment, Innovations, Data and Analytics, Federal Systems Funding, Business System Solutions)
- **Chief Information Officer** (iTECH Network & Infrastructure Support, Service Desk, Cybersecurity)
- **Chief Legal Counsel** (Legal Services, Privacy and Civil Rights)
- **Director of Appeals**
- **Chief Human Resources Officers**
- **Senior Director, External Affairs** (External and Legislative Affairs Liaison)
- **Deputy for Finance** (Financial Administration, Accounting, Budgeting, Reporting, Healthcare Pricing Services and Supports, Managed Care Financial Oversight, Procurement and Contracts, Provider Reimbursement and Payment Methodology, Third Party Recovery, Imaging/Document Management, Property Management)
- **Deputy for Accountability and Compliance** (Compliance, Financial and Performance Audit, Program Integrity)
- **Director of Internal Audit**

The agency includes the following areas:

## Communications

**Communications** is responsible for messaging to DOM's internal and external audiences, which includes the design, writing, layout, editing and distribution process for the external DOM website and for other digital media and publications. Communications handles public relations, issues official statements, ensures that DOM management is aware of current DOM-related news, and serves as the contact for requests for information from news media.

## Eligibility

**Eligibility** is responsible for determining eligibility status of applicants, assisting beneficiaries, and maintaining federal and state policy for the Division of Medicaid (DOM). Representatives in the 30 regional offices and nearly 70 part-time outstations bear much of the responsibility for carrying out the DOM mission of accountability, consistency and respect. The Eligibility unit houses two-thirds of DOM's workforce, employing 26 in the **Central Office** who provide oversight and direction, nine regional managers, and nearly 650 employees located across the state, as described below.

The **Regional Offices** consists of two in Central Office administration, the nine regional managers, and the state-wide frontline staff. Working directly with the vulnerable population, DOM frontline staff determine whether applicants are eligible to receive various types of Medicaid and CHIP health coverage (especially family or child insurance and services for aged, blind, and disabled groups). In addition to initially approving or denying coverage according to federal and state regulations, processing redeterminations of beneficiary eligibility is also a major staff responsibility.

**State Operations and Systems** supports regional and Central office staff in their use of the various online eligibility information systems, troubleshooting errors and difficult processing issues. The unit handles inventory and user access to all verification systems; creates and submits federally required processing and productivity reports; and assists with auditor requests for information. This unit coordinates with DOM **Information Technology Management** (iTECH) staff, who are together responsible for various stages of maintenance and development of current and replacement Eligibility information systems.

**Eligibility Policy and Training** (EPT) maintains policy and operational procedures for regional offices to use in making eligibility decisions and develops new policy in response to changing federal and state guidance. EPT develops training to orient new staff and provides both ongoing training programs for the regional offices and continuing education for eligibility workers. The unit also administers eligibility programs not processed by the regional offices: the Newborn waiver program, aliens' immigration status, institutionalized individuals, Hospital Presumptive Eligibility (HPE), HPE full application (approving hospitals' initial admissions of patients), and emergency certifications of SSI (Social Security disability Supplemental Security Income).

## Coordinated Care

(Managed Care Programs for Medicaid and Children's Health Insurance)

**Coordinated Care (OCC)** directly oversees contracts associated with the operation and performance of the Division of Medicaid (DOM) Managed Care program. Also known as Coordinated Care, Managed Care includes the Mississippi Coordinated Access Network (MississippiCAN or MSCAN) for Medicaid services and the Children's Health Insurance Program (CHIP).

OCC monitors the operation and performance of the three Managed Care organizations (MCOs), reviewing policies, communications, data, and reports required by the contracts. OCC also coordinates oversight by other DOM offices such as Managed Care Financial Oversight (consisting of accountants within Finance), Pharmacy, and Medical Services. Through an extensive request for proposal and evaluation process conducted in 2021 and 2022, OCC also assisted in the procurement of new managed care contracts. The contracts are expected to be executed in 2023.

Because of the relative risk associated with such large contracts ($3 billion of the $5.2 billion spent for beneficiary services in SFY 2021), OCC conducts extensive monitoring and control activities to help ensure that DOM goals are met through the contracts. See the Internal Controls Sections 3 through 5 of this Document for descriptions of ongoing internal control procedures.

OCC monitors operations and systems processing of the fiscal agent that performs certain managed care operations. The fiscal agent is responsible for systematically assigning members to MCOs, producing enrollment and capitation reports and adjustments, generating MSCAN member enrollment notifications, processing encounter data, and transferring data files to MCOs.

## Health Policy and Services

(Communications, Medical Services, Long-Term Services & Supports, Mental Health, Pharmacy, State Medicaid Policy)

### Long-Term Services and Support

**Long-Term Services and Support (LTSS)** oversees institutional long-term care programs and administers Home and Community-Based Services (HCBS). HCBS programs support older adults and people with disabilities to live at home or in their community. LTSS administers four HCBS Waivers from the U.S. Centers for Medicaid and Medicare Services/CMS: the Elderly and Disabled (includes Adult Day Care, Personal Care Services and In-Home Respite services), Traumatic Brain Injury/Spinal Cord Injury, Independent Living, and Assisted Living programs. LTSS also oversees and maintains the electronic case management and Electronic Visit Verification (EVV) platforms and data systems (in coordination with iTECH), and collaborates with DOM Finance on nursing facility health coverage.

LTSS administers and operates the following programs and services, as outlined below:

**Prior Authorization of HCBS waiver services and Case Management** - Registered nurses approve and recertify beneficiary applications for the four HCBS waiver programs, both to confirm that clinical eligibility requirements have been met and that appropriate levels of services have been requested for the beneficiary. The RNs also coordinate patient transitions from institutions to the home or community. To develop quality improvement strategies, the RNs conduct ongoing reviews and survey individuals receiving HCBS services.

**LTSS Program Operations** - Operational staff provide administrative and business support including coordination of Legislative Services inquiries. The staff in this unit also oversee, review, and approve the enrollment of providers for Elderly and Disabled (E&D) services and administer training to the E&D providers.

**Assisted Living (AL) Waiver Case Management** - A team of professional social workers oversee the services provided to AL waiver beneficiaries and also oversee the entities that provide the services. The social workers coordinate the care and services provided, enroll providers, and help ensure the quality of services provided to the program's participants.

**Institutional Dataset Compliance** - Registered nurses conduct remote and on-site reviews of the Minimum Data Set assessment completed in nursing facilities. During this process, the RNs also review the related statistics which the facilities have coded and entered into a federal system of metrics. These audits update the Case Mix Index used in calculating reimbursement rates paid to nursing facilities. (The Case Mix reflects the level of care needed by the residents in a facility, based on complexity and severity of conditions being treated. The higher the Case Mix weight, the greater the resources the resident will require.)

**Civil Money Penalty (CMP) Reinvestment Grant Program** - LTSS staff oversee and coordinate the review and approval of all federal CMP Reinvestment Grant applications, monitor the institutional grant recipients, and review and approve grantee invoices.

**LTSS Solutions Management** – Staff in this area are responsible for defining and overseeing the implementation of sustainable business solutions to support the provision and coordination of LTSS. This involves management of several external vendor contracts including, but not limited to, those to support the eLTSS/EVV systems, the Relias Learning system, the Person-Centered Practices Institute at the University of Mississippi, and the MS Access to Care Centers in collaboration with the MS Department of Human Services. Additionally, this area coordinates and monitors the agency's dual integration efforts and dual special needs plan contracts as well as the state's American Rescue Plan Section 9817 Spending Plan.

## Medical Services

**Medical Services** is responsible for program management, contract management, and quality initiatives for DOM. Medical Services oversees the delivery of healthcare over more than 30 medical program areas, for both the fee-for-service and the MississippiCAN delivery systems.

**Program Management** activities include, but are not limited to, data analysis of provider claims; review of contractors' reports on their delivery of care to Medicaid beneficiaries; monitoring utilization data (e.g., visits and expenditures per type of service); and directing providers, beneficiaries, and other stakeholders to the appropriate policies and fee schedules. Additionally, onsite clinic reviews and desk audits are conducted for the following programs: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Early Intervention, Family Planning Waiver (FPW), and the Perinatal High-Risk Management and Infant Services System (PHRM/ISS).

**Contract Management** activities include, but are not limited to, facilitating routine meetings with the contractor, review of deliverables reports, monitoring for contract compliance, working with DOM's Contract Compliance attorney when deficiencies are identified, reviewing and approving invoices for payment, monitoring total contract amounts, and submission of contract renewal documents. The following contracts are managed by the Medical Services staff:

- The contract for Utilization Management and Quality Improvement Organization (UM/QIO) with Advanced Imaging;
- UM/QIO for all other medical services (separate contract from Advanced Imaging);
- A Non-Emergency Transportation Broker;
- Several Interagency Agreements with the Mississippi State Department of Health, Early Intervention, Family Planning Waiver (FPW), Lead Data Exchange, and PHRM/ISS); and,
- The Independent Evaluator for the Healthier MS Waiver (HMW).

The team is divided into four service divisions for the purpose of providing oversight of assigned programs, contracts, and quality initiatives. Medical Services conducts oversight for:

- **Preventive Health**, including Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) services for children up to age 21; EPSDT provider enrollment, Early Intervention, Family Planning Waiver, Healthier MS Waiver, Hospice, Perinatal High-Risk Management and Infant Service System (PHRM/ISS); and vaccines and the Vaccines for Children (VFC) program, VFC provider enrollment, and transplants;
- **Professional and Ancillary Services**, including ambulatory surgical centers, dental/dental surgery and orthodontics, dialysis, hearing and vision services, occupational, physical, and speech therapy, federally qualified health centers (FQHCs)/rural health clinics (RHCs), private duty nurses (PDN), prescribed pediatric extended care (PPEC) center services, telehealth, laboratory and radiology/advanced imaging services, durable medical equipment (DME)/medical supplies/appliances, and physician services (MD, NP, PA, chiropractor & podiatry);
- **Transportation**, non-emergency transportation (NET) services and emergency transportation services; and,
- **Quality Initiatives**, which coordinates teams to analyze specific healthcare quality issues and make suggestions for improvement; advances strategies for reducing gaps in access to care; develops ways to improve preventative healthcare education; facilitates multiple quality focused work groups and meetings with external stakeholders; collects, organizes and submits annual quality measures; and provides assistance with legislative performance measures.

## Pharmacy

**Pharmacy** is responsible for administering the pharmacy drug coverage benefit to the state's eligible beneficiaries, in accordance with state and federal laws. To provide for quality and cost-effective pharmacy benefits, oversees the Universal Preferred Drug List (PDL); the federal and supplemental drug rebate programs, such as the 340B Drug Pricing Program; and all pharmacy and drug-related contracts. Pharmacy also maintains the criteria for which Prior Authorization Requests for drug prescriptions are to be assessed. These criteria are provided to DOM's Utilization Management and Quality Improvement contractors, as discussed in the *Monitoring for Quality of Healthcare* section of this document.

Pharmacy oversees and manages the following:

- the fiscal agent's pharmacy claims processing/payment system to ensure compliance with all clinical and reimbursement methodology found in the State Plan and Administrative Code (the fiscal agent collects data used by DOM to manage, analyze, and review compliance with state and federal laws);
- the contract for the rate setting vendor which assists DOM in analysis, reimbursement policy, drug ingredient cost determination and cost of dispensing surveys for all outpatient covered drugs;
- the contract with the drug prior authorization vendor that reviews requests submitted by prescribers for drugs which require prior authorization;
- the pharmacy-related contract provisions of the DOM managed care organizations;

- the contract with the Drug Utilization Review (DUR) vendor (note that Federal law mandates states to conduct quarterly meetings of the DUR Board, which consists of 12 Mississippi doctors and pharmacists appointed by the governor; the Board is tasked with engaging a vendor to perform in-depth studies of MS Medicaid fee-for-service and MSCAN claims data, which are presented for consideration; promoting the appropriate use of drug therapies to improve health outcomes of beneficiaries and the appropriate education for providers and beneficiaries; helping to prevent waste, fraud, and abuse of drugs; and advising DOM of actions and initiatives to ensure optimal health outcomes of all Medicaid beneficiaries); and,
- the contract with the vendor responsible for managing the PDL and presenting drug class reviews and cost analyses to the Pharmacy and Therapeutics Committee. The Committee consists of 12 Mississippi doctors and pharmacists who are appointed by the governor to conduct in-depth clinical evaluations and advise DOM of appropriate drugs for preferred status on DOM's Preferred Drug List (PDL) and/or drugs for prior authorization

Pharmacy staff also assists Mississippi healthcare providers and beneficiaries with resolving problems related to drug coverage.

## Mental Health

**Mental Health** oversees providers of healthcare that offer mental health, substance use disorder, and intellectual and development disability (ID/DD) services to Division of Medicaid (DOM) beneficiaries. (For ease of description, these three categories of services related to mental health will be referred to below as MHR services.) Mental Health also works to ensure beneficiaries with MHR issues receive appropriate access to either traditional fee-for-service health coverage or coordinated case program services. This includes reviewing and approving the amounts that MHR providers can be reimbursed, in accordance with state and federal law.

For the oversight of mental health, substance use, and intellectual and development disability (MHR) services, Mental Health:

- Assists the Healthcare Services and Supports unit in approving amounts to be included on fee schedules for MHR services--

  MHR services on the schedule can include numerous serious mental illness and emotional disturbance issues, including for depression, ADHD, substance use disorders, opioid treatment, autism spectrum disorder, intellectual and developmental disorders. Services can also include targeted case management for specific individuals.

- Approves enrollment of MHR service providers (in coordination with Provider Enrollment staff), ensuring providers meet state and federal certification requirements--

  MHR providers include licensed professionals, agencies, and other providers and institutions. Independent licensed providers include psychiatrists, mental health nurse practitioners, and licensed counselors. Other types of providers include community mental health centers, private mental health centers and mental health clinics, federally qualified health centers, rural health clinics, psychiatric residential treatment centers, psychiatric hospitals, and hospital psychiatric units.

- Oversees contracts for MHR services, including the Home and Community Based Services Waiver Administration with the Department of Mental Health, and the Mississippi Wraparound Institute with the University of Southern Mississippi.

## State Medicaid Policy

**Policy** staff are responsible for the development and maintenance of policies for Medicaid programs. The unit handles amendments and revisions to the State Medicaid Plan and the State Child Health Plan, the Mississippi Administrative Code, and the Provider Reference Guide. Policy develops all fee-for-service policy (for reimbursement of providers for individual health services) and collaborates in the maintenance of policy for DOM's managed care contractors. To create new policies, the staff works with internal and external stakeholders and conducts research on the health and financial implications of new policy. The unit manages internal communications and feedback regarding policy development; acts as interpreter of State and Federal guidelines and policies; and serves as the primary contact with federal regulators for policy communication, questions, and updates.

## Provider and Beneficiary Solutions

(Provider Enrollment, Beneficiary Relations, Provider Relations)

**Provider and Beneficiary Solutions** oversees the day-to-day operations for the Provider Enrollment Team**,** the Provider Relations Team**,** and the Beneficiary Relations Team**.**

The **Beneficiary Relations Team** operates the switchboard that receives calls to the agency and transfers them to the appropriate office areas. Beneficiary Relations representatives take the calls from beneficiaries and answer questions on beneficiary health benefits and billing issues. The team's outreach coordinator represents the agency in outreach and educational events.

The **Provider Relations Team** takes calls from the switchboard and call center to respond to healthcare provider requests. The team serves as a point of contact for providers, assisting providers with claims-related issues and conducting administrative reviews when necessary. The team also conducts outreach events and provides education on Medicaid programs and services.

The **Provider Enrollment Team** is responsible for the enrollment of healthcare providers to ensure they qualify to provide Medicaid services, through DOM managed care organizations and/or traditional reimbursement for individual services. The team screens providers to ensure their enrollment will comply with state and federal regulations and makes final determinations on all provider applications. The team also monitors the fiscal agent's enrollment and updating of provider information in its system. In addition, the team works with DOM's policy and program areas to streamline the provider enrollment process.

## Information Technology Management (iTECH)

Business System Solutions, Eligibility Systems, Medicaid Management Information Systems (MMIS), MMIS Replacement Project (MRP), Mississippi Enterprise Systems Assistance (MESA), Innovations, Network Infrastructure, Customer Support, Cybersecurity)

**Information Technology Management** is responsible for (1) oversight of the operation of Medicaid's eligibility and claims processing and payment systems, (2) data analysis to support state health policy changes and innovations, (3) operation of DOM's statewide information system networks, (4) maintaining a secure environment and protocols for staff use of the systems, (5) management and procurement of software, equipment, and technical support services, and (6) managing CMS funding requests for system modifications.

With a change in fiscal agent in charge of processing all beneficiary claims (from Conduent Solutions to Gainwell Technologies), DOM systems have undergone major changes. As part of the transition, information technology at DOM is currently administered through two units, **Business System Solutions** and **Infrastructure, Support, Management, and Cybersecurity**.

## Business System Solutions

**Business System Solutions** oversees the eligibility, fiscal agent, clinic data interoperability, and data analytics systems for the Medicaid agency. The unit has oversight of the CMS funding received to develop eligibility and business systems. The unit also conducts research and analyzes data with the goal of improving healthcare systems in the state.

The **Eligibility Systems** unit provides technical expertise to support the DOM Eligibility office staff and serves as the primary point of contact for managing the agency's current eligibility enrollment IT projects. The primary eligibility components include New MEDS (operated by Conduent), the Fraud and Abuse Module (operated by Softheon Technologies), the Common Web Portal (operated currently by Mississippi Interactive, to be replaced by the Conduent Self Service Portal by 2023), and the Master Patient Index (a SaaS MPI through Verato). New MEDS is the eligibility and enrollment system used by the 30 regional offices to intake, process and review cases for Medicaid eligibility; to access beneficiary data from the Central Office; and to enroll eligible beneficiaries for administered coverage. The New MEDS system is now in procurement to be taken over, in a Request for Proposal process for takeover by an awarded vendor.

The **Medicaid Management Information Systems (MMIS)** unit provides technical expertise to support various business areas within DOM and serves as the primary point of contact for managing the agency's **Fiscal Agent** operations. The Fiscal Agent (on contract with DOM) maintains the healthcare provider billing and claims data, and accounts for receipt of Medicaid funds from DOM and the disbursements to healthcare providers to pay claims. The MMIS systems, previously provided by Conduent, has been replaced by the Gainwell system, MESA, in October 2022. MESA (Mississippi Enterprise Systems Assistance) modules include Financial Management (FM), Member Management (MM), Claims Management (CM), Pharmacy Point of Sale (POS), Third Party Liability (TPL), Managed Care Enrollment (ME), Program Integrity (PI), Provider Management (PM), Electronic Document Management System (EDMS), Customer Relations Management System (CRMS), Automated Voice Response System (AVRS), Automatic Letter Generation (ALG), and the Learning Management System.

Other Business System Solutions units, including **MRP** (Medicaid MMIS Replacement Project), **CMS Funding** (federal Centers for Medicare and Medicaid Services Funding), and **MES/DSS** (CMS Medicaid Enterprise System and Decision Support Systems), have collaborated with DOM program managers, senior leadership and various subject matter experts to design, develop, and implement MESA. These units will be combined into other units after full implementation of MESA.

The **Innovations** unit provides project management and technical expertise and data analytics to support the agency. Innovations promotes and improves data utilization to increase data-driven decision-making for health and policy decisions as well as operational improvements. Innovations also oversees the Clinic Data Interoperability Solution, which allows for healthcare providers to send and receive information on Medicaid beneficiaries at the point of care, using the Consolidated Clinical Document Architecture format.

### Infrastructure, Support, Management, and Cybersecurity

**Infrastructure, Support, Management, and Cybersecurity** is responsible for oversight of DOM's Service Desk team, Network & Infrastructure team, and Cybersecurity operations. These groups are collectively responsible for the various aspects of information technology service delivery, including providing and maintaining technical infrastructure, back-office applications, and technical support services.

## Legal Counsel

(Legal Counsel, Privacy, Civil Rights)

The **Legal Counsel** unit is staffed by both Division of Medicaid (DOM) attorneys and attorneys from the Attorney General's Office. The office provides legal consultation and representation to DOM in a variety of areas, including personnel matters, statutory and regulatory issues, procurements and contracting, recovery efforts, garnishments, levies, bankruptcies, and tax liens. The attorneys provide guidance on policy drafting and filing; receive and respond to public records requests; and represent the agency at various administrative hearings and before the State Employee Appeals Board, the United States Equal Employment Opportunity Commission, and state and federal courts. Office attorneys also assist the DOM Program Integrity office (PI) with legal assistance, in PI's role as liaison to the Medicaid Fraud Control Unit within the Attorney General's Office.

The **Privacy and Civil Rights** unit oversees agency compliance with the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* and other relevant privacy and civil rights laws. The Office:

- ensures that parties being given access to Medicaid data have signed agreements to use the data only for approved and appropriate purposes;
- coordinates with the Office of Information Technology Management regarding compliance with HIPAA's Security Rule;
- oversees the use of Business Associate Agreements, implemented to ensure that the Medicaid consultants and contractors will comply with and appropriately safeguard all Protected Health Information (PHI); and,
- handles the responsibility of agency-wide compliance with Section 1557 of the *Patient Protection and Affordable Care Act*, which prohibits discrimination based on race, color, national origin, sex, age or disabilities, and other relevant civil rights laws.

## Appeals

**Appeals** resolves conflicts that may arise (1) when a Medicaid beneficiary questions services or categories of coverage for which they are eligible, or (2) when a provider questions reimbursement, methodology for services provided, or a decision affecting their enrollment in the program. The Office coordinates, schedules, and organizes appeals relating to both MSCAN managed care and traditional fee-for-service.

# Finance

(Financial Administration, Comptroller, Healthcare Pricing Services and Supports, Managed Care Financial Oversight, Procurement and Contracts, Provider Reimbursement and Payment Methodology, Third Party Recovery, Property Management, and Imaging and Document Management)

**Finance** directs and manages DOM's accounting for agency operations, federal and state reporting, budgeting, contracting, reimbursement of providers, healthcare pricing, safekeeping of assets, recovery of funds, and the various fiscal management duties outlined below.

## Financial Administration

**Financial Administration** monitors agency funding and spending from federal and state sources; supports Medicaid strategy by prioritizing the incorporation of innovative payment methodologies and the use of quality metrics; and leads, coordinates, or supports cross-agency projects to improve effectiveness and efficiency. Financial Administration also oversees the Payment Error Rate Measurement for the agency.

## Comptroller

The **Comptroller** oversees DOM's financial management duties including **Accounting**, **Budgeting/Buy-In**, and **Financial Reporting,** as discussed below.

**Accounting** operational units manage the day-to-day responsibilities of purchasing and payment for goods and services provided to the agency, receipt of all funds, payroll for all employees and contract workers, travel for employees, and various other duties as outlined below:

**Purchasing** enters purchase information into the statewide financial information system (MAGIC) for the DOM Central Office and 30 regional offices.

**Accounts Payable & Travel** is responsible for proper payment of all invoices for goods and services received by the Central and regional offices and also for processing reimbursement vouchers for employee travel expenses, which includes ensuring compliance with DFA's travel reimbursement rules.

**Payroll** prepares, manages and reconciles monthly, supplemental, and contractual payrolls, which are processed in the Statewide Payroll and Human Resources System (SPAHRS) administered by the Mississippi State Personnel Board. Payroll is responsible for ensuring the accuracy of employee payroll and its compliance with Department of Finance and Administration policies, procedures, and authorized schedule. Payroll computes and records insurance and other miscellaneous deductions, collects forms for changes to federal/state tax exemptions, and handles other related duties such as name and address changes.

**Accounts Receivable** (A/R) is responsible for reviewing and depositing all monetary transactions payable to DOM in a timely manner and according to DFA policies. A/R handles the collection, processing, recording and reconciling of cash receipts (cash, checks, wire transfers, and inter-governmental transfers) using the correct MAGIC funds and revenue source codes. A/R draws federal grant funds based on current expenditures, prepares a weekly funds receipt report, processes the weekly transfer of funds to DOM's fiscal agent, sends invoices to hospitals and nursing homes for bed tax assessments, and assists with the budget as needed.

The **Budget/Buy In** unit coordinates with agency offices to prepare annual budget submissions; prepares and updates budget models based on expenditure projections; submits the agency budget to the Legislative Budget Office; and prepares monthly budget expenditure reports. This unit also manages Medicare/Buy-In (i.e., the approval and reconciliation of invoices for beneficiaries enrolled in both Medicare and Medicaid).

**Financial Reporting** reconciles agency expenditures with the drawdown of federal funds that are prepared by the Accounting unit; prepares reports of federal expenditures to the U.S. Centers for Medicare and Medicaid Services; manages the Cost Allocation Plan to account for the percentages of administrative costs claimed by the agency for federal reimbursement; and prepares the agency's GAAP packet (consisting of accounting reports and grant schedules that the Mississippi Department of Finance and Administration uses to prepare the state's Annual Comprehensive Financial Report).

## Healthcare Pricing Services and Supports

**Healthcare Pricing Services and Supports** (HPSS) manages Medicaid and CHIP procedure code and fee schedule maintenance (for fee-for-service reimbursement). HPSS also evaluates, maintains, and improves reimbursement policies for outpatient hospital services (through the Outpatient Prospective Payment System). In addition, HPSS facilitates the creation, modification, review, preparation, and analysis of data for claims and reimbursement reports, which can be to identify problems for resolution by management.

## Managed Care Financial Oversight

**Managed Care Financial Oversight** reviews and analyzes financial statements and other data provided by the Division of Medicaid's three managed care contractors (MCOs), coordinates audits of the MCO's financial and performance data, and works with the state's actuaries in managed care rate development. This unit oversees independent audits of the MCO's Medical Loss Ratios (MLRs) and reporting of the ratios to the federal Centers for Medicare and Medicaid Services. The MLR ratio calculations measure the percent that the MCOs spend on medical expenses compared to a contractually-required minimum percentage (the Minimum MLR rate, currently 87.5% for MississippiCAN and 85% for CHIP) and include administrative expenses and other required reporting information. Additional unit oversight responsibilities include analyzing trends in claims processing and enrollment counts, directing consultants to investigate claim payments and other operations when necessary, and assisting in identifying and quantifying issues for review. This unit also coordinates the development of directed payment programs across all functions of the agency and analyzes and monitors the associated metrics for quality of care.

## Procurement and Contracts

The **Office of Procurement and Contracts** (OPC) ensures all procurements and contracts comply with the relevant state and federal statutes, rules, and regulations. OPC oversees the selection of contracts that are awarded on a competitive basis, especially through the Request for Proposal process. OPC goals are to ensure fairness in competition among vendors, maximize the efficiency and value of state contracts, and safeguard state interests through development of sound contracts. DOM dedicates at least one attorney for the drafting and construction of OPC contracts.

The **Procurement** unit plans, organizes, coordinates and manages activities for information technology (IT) contracting and all other public procurement contracts at the agency. **Procurement** ensures that IT contracts comply with regulations of the Mississippi Department of Information Technology Services and that contracts for personal and professional services comply with Public Procurement Review Board regulations (under the Mississippi Department of Finance and Administration).

The **Contracts** unit provides legal advice and risk analysis to OPC and other DOM program areas to support procurement of IT services, professional and other agency services, and human resource benefits and services. The unit analyzes related operational, financial and technical issues to assist DOM in achieving procurement objectives and provides DOM executive management and business stakeholders with interpretations of contract terms and ITS and PPRB regulations.

### Provider Reimbursement and Payment Methodology

**Provider Reimbursement and Payment Methodology** (PRPM) calculates provider assessments for hospitals and nursing facilities, as provided for in state law, and supplemental payments to providers; sets fee-for-service rates for long-term care facilities, hospice providers, home health agencies, clinics (RHC, FQHC, Dept of Health, ESRD), and hospitals; ensures rate setting deadlines are met; and coordinates with staff and other offices to make recommendations for innovative payment methodologies. The PRPM unit is comprised of four units for accomplishing its responsibilities: Clinic, Hospital, Long-Term Care Reimbursement, and Supplemental Payments & Provider Assessments.

### Third Party Recovery

**Third Party Recovery** ensures the recovery of funds from third party sources, i.e., recovering money due to Medicaid from any third-party responsible for paying medical expenses of beneficiaries. TPR also ensures system updates are made for the purpose of cost avoidance, and coordinates with managed care organizations and other vendors to ensure compliance with Medicaid regulations for recovery and cost avoidance.

### Property Management

**Property Management** oversees lease contracts and related issues for regional offices, including managing leases for facility maintenance, lease renewals, and advertising for new property leases. Property Management also is responsible for maintaining proper records of the agency's inventory and managing vehicle fleet and parking assignments.

### Imaging and Document Management

**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 the Mississippi Department of Archives and History.

## Human Resources

The **Human Resources** unit provides policies, procedures, and directives to ensure that all employees are treated fairly and equitably regardless of race, color, creed, sex, religion, national origin, age, disability, or political affiliation. It administers DOM hiring and examination authority, ensures positions and employees are properly classified and compensated, initiates and maintains Personal Services Contracts, develops and maintains employment guidance documents, processes and resolves worker's compensation issues, oversees the maintenance and verification of all leave records, and provides advice and assistance on activities associated with human resources matters. The office ensures the agency's organizational structure is sound and provides leadership for developing and implementing professional development.

# Accountability and Compliance

(Program Integrity, Financial and Performance Audit, Compliance)

**Accountability and Compliance** is responsible for ensuring that agency contractors, vendors, long-term care institutions, and other healthcare providers comply with the terms of their contracts, and applicable federal and state rules, laws, and regulations. Through its various divisions, Accountability and Compliance helps to ensure that medical claims are paid correctly and investigates potential fraud, waste, and abuse of Medicaid funds by beneficiaries, providers or contractors. In addition to conducting routine audits and taking complaints from the public, the Office analyzes health claims data for indications of fraud or abuse. The Office assists DOM personnel with reviewing contracts prior to execution, helps in creating procedures for contract monitoring throughout the agency, and informs key senior staff of federal and state regulatory changes that directly or indirectly impact the agency. Accountability and Compliance also assists other offices with organizational and structural policies, workflows, and operations to improve responsiveness both internally and externally; assists other offices by advising them on the need for audits or investigative referrals; and coordinates with the Office of Internal Audit to manage external audits and audit responses.

## Program Integrity

The Program Integrity (PI) unit's mission is to help the Division of Medicaid ensure that claims are paid correctly and that providers and beneficiaries are not committing fraud. PI staff investigate alleged provider and beneficiary fraud or abuse and conduct routine audits of beneficiary eligibility. PI also oversees audits of other DOM healthcare contractors and acts as a liaison to the Medicaid Fraud Control Unit of the Attorney General's Office, the National Fraud Control Unit, the FBI, and other external law enforcement entities. Part of PI's strategy has been to analyze claims data using a variety of methods to obtain leads for investigations into possible fraud, waste and abuse. With the implementation of Gainwell's new MESA management information system, PI is currently in the process of determining possible methods of data analysis.

**Investigations** staff in the Office of Program Integrity conduct desk and on-site audits of providers and beneficiaries to verify healthcare services were billed correctly and services were rendered appropriately. Cases for review may result from complaints submitted on-line, faxed in, or mailed in; referrals from other DOM offices; or issues arising from data mining and analysis of healthcare utilization reports. After conducting a preliminary desk review (i.e., research and review of a small sample of medical records and review of other documents), auditors may determine that the investigation may need to be expanded to a full audit. In a full audit, a valid random sample is obtained from the statistician and an on-site audit conducted to collect additional medical records or other information. Services received are validated through a verification-of-services letter sent to a select number of beneficiaries to determine if services were received. Some audits result in a recovery of identified overpayments for claims that were improperly paid. Some cases may involve a review of a provider's billing practices to determine compliance with state and/or federal policy, which could result in the provider submitting a Corrective Action Plan (CAP) as part of provider education, in addition to obtaining repayment. However, if the evidence supports a credible allegation of fraud by the provider, then the case is automatically referred to the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General for possible criminal prosecution or civil action.

Examples of possible provider fraud or abuse include falsifying medical records (e.g., certificates of medical necessity or plans of treatment) to justify payment; soliciting or receiving kickbacks; and inappropriate billing practices such as upcoding and/or billing for more hours than allowed or substantiated. Examples of beneficiary fraud may include falsifying application information, providing false income documents, withholding relevant income information, etc.

**Medicaid Eligibility Quality Control (MEQC**) is a federally required program that monitors whether the process of approving applicants for receipt of Medicaid benefits is being conducted according to Federal and state regulations. The team of MEQC investigators verifies that persons receiving Medicaid benefits are eligible and ensures that applicants are not refused benefits to which they are entitled per federal regulations. Since persons initially determined to be eligible for Medicaid may not continue to remain eligible, MEQC also regularly verifies continued eligibility of recipients.

On a monthly basis, DOM's Central Office MEQC staff select a sample from a list of recipients pulled from DOM's eligibility information system. The sample may include applications that have been approved, denied, or closed without determination. Upon request, the regional office which processed the application sends a paper file of records to MEQC. MEQC then reviews the region's files and makes an independent assessment of accuracy. MEQC also investigates whistleblower complaints that allege beneficiaries are improperly receiving benefits. External complaints are received through the DOM fraud reporting system (via a 1-800 number or emails, a website form, or regular phone calls to MEQC offices).

The **Medical Review** staff consists of registered nurses (RNs) who, when investigations involve issues of medical judgment or determining medical necessity of treatment and services, examine claims of both providers and beneficiaries. The RNs use their medical expertise to determine whether services rendered have been appropriate, medically necessary, and provided under professionally recognized standards of health care.

The RNs conduct their work by receiving referrals from the Program Integrity fraud abuse hotline and Medicaid investigators, auditors, and program personnel. They may also obtain ideas for reviews (1) from outside sources such as medical-related and law enforcement-related agencies and boards, and (2) by reviewing automated data analysis reports from DOM information systems. Results of DOM medical reviews can lead to issuing sanctions, monetary recovery, a corrective action plan with a follow-up review, requiring that a provider undergo a peer review, and/or sending educational letters to providers.

**External Contract Management** staff are responsible for monitoring reports received from the three managed care organizations (MCO) each year, as required per the MCO contracts as part of DOM's Compliance Reporting Manual. Examples of MCO reports to DOM include information on provider and beneficiary investigations and complaints; a fraud, waste, and abuse activity report; and a fraud and abuse compliance plan. Through the unit's report monitoring efforts, it is able to coordinate MCO audit activities, investigations, and/or recovery efforts to make sure there is no overlap and/or duplication of provider reviews or audits between the three MCOs. For instance, unit staff approve all retrospective and prepayment reviews submitted by the MCOs before the MCO's audit work begins. Problems noted through review of the reports are forwarded to the Compliance attorney for resolution. ECM staff also attend regular meetings with the MCOs and with MCO contract auditors to assist in ensuring MCO compliance.

The unit is also responsible for overseeing the Recovery Audit Contractor (RAC) and its efforts to identify and remediate potential fraud, waste, and abuse. A RAC contract is required by Code of Federal Regulations Section 438; however, the contract recently expired, and no contractor responded successfully to an RFP to replace the prior contract. Therefore, DOM is in the process of requesting a federal Waiver to adjust RAC activities in Mississippi, until such time that a contract may be successfully awarded in the future.

## Financial and Performance Audit

**Financial and Performance Audit** conducts reviews that focus on healthcare provider compliance with Medicaid-related laws and regulations. Providers audited include individuals, long-term care institutions, contractors, and other healthcare entities. The audits are carried out by three units, as outlined below.

The **Electronic Health Records** unit monitors and audits 100% federal-funded technology grants made to Medicaid providers to implement specialized electronic health records systems. These CMS grants incentivize hospitals, physicians, dentists, and other providers to purchase the software in return for reporting Medicaid patient health data electronically. The audits seek to determine if grantees are using the software as intended.

The **Provider Cost Audit** unit conducts audits of the cost reports that nursing facilities submit to the DOM reimbursement unit. The unit also audits cost reports submitted by other types of facilities that provide long-term care services, such as inpatient hospitals. Additionally, this area is responsible for monitoring external audits of the federal disproportionate share hospital (DSH) payments, as required by CMS. A DSH payment is intended to compensate a hospital when its costs of providing services to Medicaid beneficiaries (and the uninsured) are not covered by reimbursements from Medicaid. DOM enters agreements with the specialized audit firm Myers and Stauffer, LC to conduct the DSH audits and provide the CMS mandated independent audit report for the audit period.

The **Provider Monitoring** unit conducts audits of providers that utilize various Medicaid waiver programs. The unit conducts both desk reviews and on-site audits to verify that participating providers of beneficiary services have complied with program requirements. Types of audits include conducting environmental inspections and reviews of provider staff qualifications; reviewing whether providers are qualified per program requirements; auditing claims and payments; and monitoring and conducting follow-up audits of corrective action plans. Waiver programs audited include the following: Independent Living, Traumatic Brain Injury/Spinal Cord Injury, Intellectual Disabilities/Developmentally Disabled, Assisted Living, and Elderly and Disabled (E&D) waivers. ED waivers include Personal Care and In-Home Respite, Adult Daycare Centers, Planning and Development Districts, and Home Delivered Meals. In addition to the waivers, this unit is tasked with auditing the resident trust funds maintained by long-term care providers and verifying compliance under the False Claims Act for providers receiving more than $5 Million from Medicaid during the fiscal year.

## Compliance

Compliance is both an internal and external facing function, encompassing ongoing efforts to maintain and improve adherence to rules, regulations, laws, policies, and contractual obligations within and external to DOM and to ensure effective and sound operations. The **Compliance** unit has several functions and works closely with program area contract and project managers. The unit's support and oversight functions include:

- audits of any entity that conducts business with DOM as necessary;
- ongoing contractual reviews;
- operational reviews as requested by program areas to assist with workflow and operational efficiency;
- review and oversight of coordinated care contractors' (also known as managed care organizations) data submission review, which raises the level of CCO accountability to DOM, along with the accountability of various program areas within the agency;
- imposition of sanctions against and related next steps for contractors that fail to meet their contractual obligations and are in breach of their contracts, based on document reviews and deliverables;
- oversight and annual updates of the agency's Internal Control Assessments (ICAs) and Internal Control Plan as required by the Department of Finance and Administration (DFA);

- coordination and oversight assistance with audits conducted by external agencies to ensure the best outcomes and understanding of external auditors findings. This also includes root cause analysis on any findings that can impact operations and compliance with external regulations, laws, or requirements.

Compliance coordinates with all DOM offices in maintaining the Internal Control Plan and Assessments for overall awareness of internal controls within the agency. (The agency's Internal Control Plan outlines the five generally accepted Internal Control Components: a strong Control Environment atmosphere that is set by leadership, ongoing agency Risk Assessment, Control Activities and procedures that allow the agency to meet its objectives, Information and Communication throughout the agency, and responsible Monitoring procedures for overseeing of agency programs and contracts.)

Compliance also conducts a variety of audits and analyses, including independent audits of managed care organizations as required by the state legislature, financial analysis of contract data, and other performance and compliance-related reviews as needed by the agency.

## Internal Audit

The **Office of Internal Audit** evaluates agency programs, policies, procedures, and processes to assist with the ongoing improvement of operational activities and internal controls. **Internal Audit** operates independently and reports to the Executive Director of the Division of Medicaid. The Office also reports administratively to the Deputy Administrator for Accountability and Compliance. Internal Audit determines the focus of its projects by preparing and implementing an annual risk-based audit plan. A list of primary risks is developed in conjunction with the Executive Director. Internal Audit staff examine issues related to agency business practices and administrative efficiency and work with Accountability and Compliance and all other units of the Division of Medicaid to improve agency operations.

## Executive Support

The **Executive Assistant** supports the Executive Director's process of defining project expectations and agency goals. The Executive Assistant also seeks to ensure clear communication and create efficient ways for management cooperation. On behalf of the Executive Director, the Executive Assistant collaborates with the Communications Officer and other senior leadership.

Also serving as the agency's Emergency Coordination Officer, the Executive Assistant oversees disaster management and the preparation and implementation of the agency's Disaster Management Plan. Along with the agency's Communications Officer, the Executive Assistant coordinates disaster, emergency, and inclement weather messages to staff.

The **Attorney Team Lead for Special Initiatives** reports to the Executive Director and is responsible for leading specific policy-related initiatives, working with business lines across the agency to develop and coordinate novel policy, strategic initiatives, internal and external partnerships, and other special projects aimed at improving quality and outcomes for beneficiaries while reducing costs to the state.

The **External Affairs** unit reports to the Executive Director and serves as the primary point of contact for elected officials and legislative staff. External Affairs is responsible for developing, refining, and communicating agency

policy positions with external constituencies, including the governor's office, the Mississippi Legislature, Congressional staff, provider associations, advocacy groups, other state agencies, and other third parties. External Affairs also works to ensure transparency and optimize stakeholder relationships; coordinates and responds to external legislative and congressional requests for information, including assistance with inquiries from their constituents; and advises the Executive Director on matters of policy and strategy.

## *Appendix B:*

# Specific Risk Assessment Responses and Strategies

Methods of responding to identified risks in the environment:

- Avoiding Risk—continuously evaluating operations to identify and reduce, modify, or end those activities that give rise to risk.

- 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.

- 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.

- Identifying Strategies for Risk—through root cause analysis, analyzing the underlying causes of the risk to the organizations so that the agency can create and implement strategies to further mitigate risk.

- 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.

## *Appendix C:*

# Detailed List of DOM Risks

In previous planning sessions, Division of Medicaid (DOM) management identified the following specific risks that would impact accurate processing of transactions for financial reporting and compliance. DOM managers implement control procedures to mitigate these risks.

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

- Provider enrollment functions
- Medicaid eligibility determination
- Claims processing systems for fee-for-service
- 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 by the federal government
- Allowable costs and cost principles set by the federal government
- Provider rate-setting procedures for managed care and fee-for-service healthcare delivery
- Federal reporting requirements for the CMS 21 federal report and CMS 64 federal report

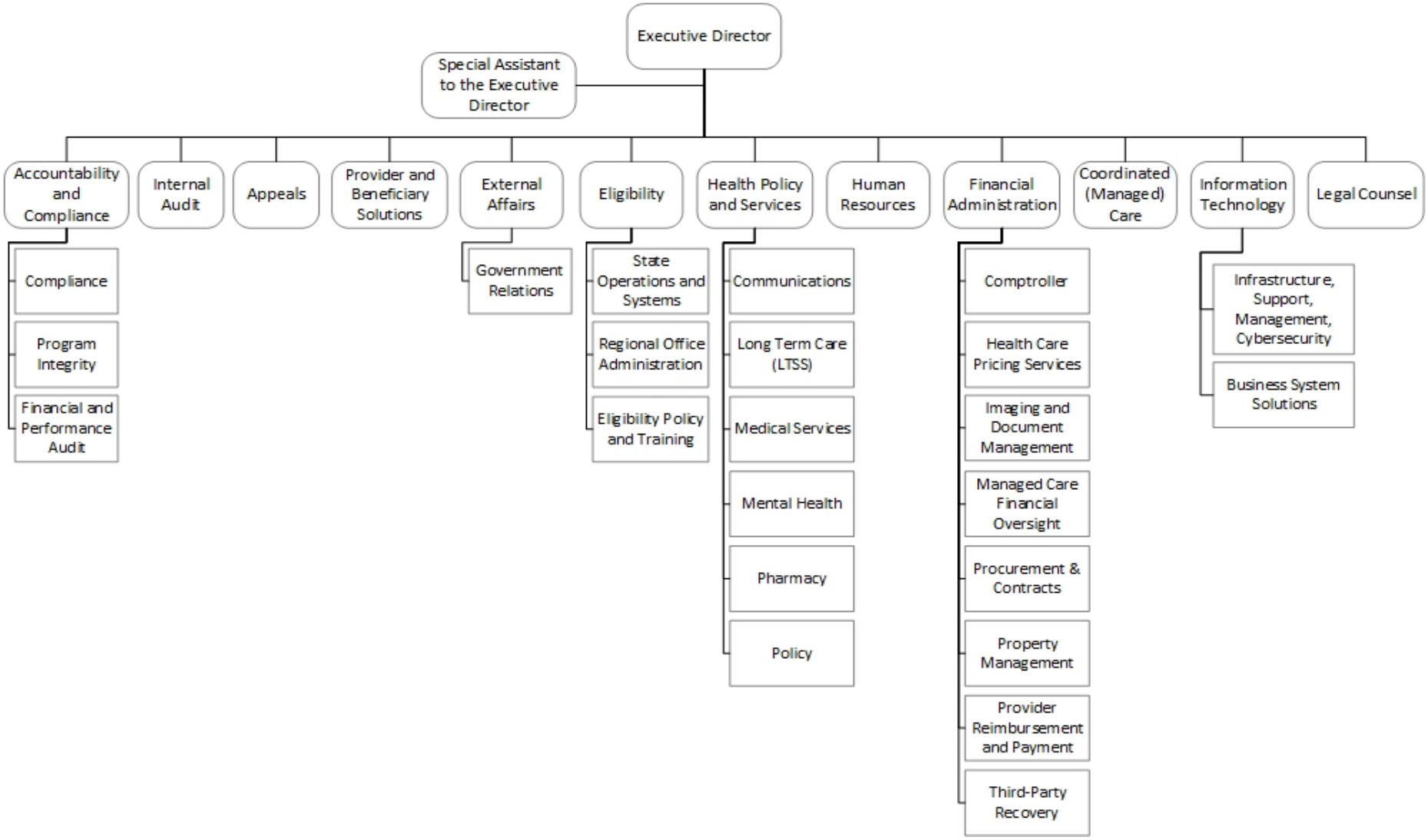
Areas of Risk Related to the Administrative Cost Functions of Medicaid Programs

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

## *Appendix D*

# Division of Medicaid Organizational Chart

September 2022



# *Appendix E:*

## Summary of DOM's Five Components of Internal Control

**1. Control Environment**

*To promote an atmosphere of strong internal control, DOM management:*

- *demonstrates commitment to integrity and ethical values*
- *oversees the agency's system of internal controls*
  *(e.g., Internal Control Plan and Assessments and detailed procedures)*
- *establishes organizational structures, assigns responsibility, and delegates authority to achieve DOM objectives*
- *commits to recruiting, developing, and retaining competent individuals*
- *holds individuals accountable for their internal control responsibilities.*

**2. Risk Assessment**

*DOM management should, with the support and assistance of staff:*

- *define objectives clearly to enable identification of risks*
- *identify, analyze and respond to risks related to achieving the objectives*
- *understand and address the potential for fraud*
- *identify, analyze, and respond to significant changes that could affect internal control.*

**3. Control Activities**

*DOM management should, with the support and assistance of staff:*

- *design control activities to achieve objectives and respond to risks*
  *(e.g., Segregation of financial duties, supervisory and management approvals, assurance of accurate and timely records, rules for safekeeping of assets)*
- *design DOM's information system to achieve objectives and respond to risks*
  *(e.g., Information processing rules, security, edits for accuracy, capacity)*
- *implement control activities through policies and procedures*
  *(e.g., for programs, personnel, technology).*

**4. Information and Communication**

*DOM management should, with the support and assistance of staff:*

- *use relevant, quality information to achieve agency objectives*
- *internally communicate quality information to achieve DOM objectives*
- *externally communicate quality information to achieve DOM objectives.*

**5. Monitoring**

*DOM management and staff should:*

- *conduct internal control monitoring activities and evaluate results*
- *communicate and remediate identified internal control deficiencies.*

Note: This summary of internal control principles is based on work initially developed by The Committee of Sponsoring Organizations (see COSO Framework) and the federal standards created in response to COSO. According to the Department of Finance and Administration (DFA), the State adheres to the policies found in the Standards for Internal Control in the Federal Government developed by the U.S. Government Accountability Office. (See the internal control section of the DFA MAAPP manual for additional information on internal controls.)