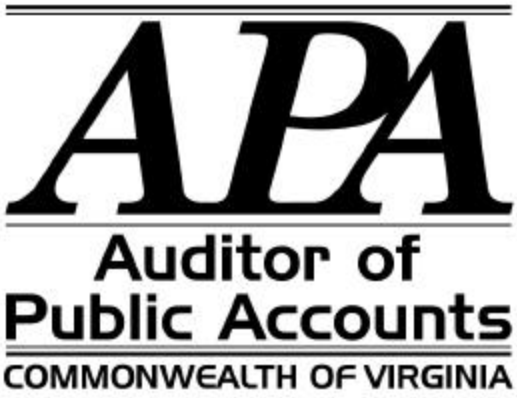
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

RICHMOND, VIRGINIA

REPORT ON AUDIT

FOR THE YEAR ENDED

JUNE 30, 2000



AUDIT SUMMARY

Our audit of the Department of Medical Assistance Services (the Department) for the year ended June 30, 2000, found:

- amounts reported in the Commonwealth Accounting and Reporting System for the Department were fairly stated;

- material weaknesses in internal controls and certain matters that we simply consider reportable conditions;

- instances of noncompliance with the selected provisions of applicable laws and regulations; and

- adequate corrective action with respect to audit findings reported in the prior year except in one instance.

Below are the more significant items we recommended to the Department:

- The Department should implement an information systems request to create an edit that would prevent convicted recipients from re-enrolling in the Medicaid program within the 12-month sanction period. In addition, the Department should continue to inform eligibility workers in the local social service offices of proper procedures for coding convicted recipients.

- The Department should ensure that the local social service offices correct the Medicaid Management Information System for any errors found in the Medicaid Eligibility Quality Control program.

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OVERVIEW

The Department administers the Commonwealth's indigent health care programs. These programs fund medical services for low-income individuals in hospitals, nursing homes, adult care residences, mental health facilities, and home health care settings.

Indigent health care programs include **Medicaid**, which is one of the Commonwealth's largest federally funded programs. Medicaid provides medical assistance for a large variety of services including psychiatric, laboratory, private nursing, medical transportation, prescription drugs, medical equipment, and other services. Other indigent health care programs include **Children's Health Insurance**, which subsidizes health insurance for children in families that do not qualify for Medicaid. **Assisted Living** financially assists residents of adult homes; the **Involuntary Mental Commitment** reimburses providers for the care of individuals who endanger themselves and others; and **HIV Assistance** subsidizes health insurance for HIV positive individuals. The **State and Local Hospitalization** program is a cooperative effort between the Commonwealth and localities to provide indigent individuals with certain medical services; and the **Indigent Health Care Trust Fund** uses contributions from the Commonwealth and state acute care hospitals to fund healthcare institutions that disproportionately provide charity care.

This report will primarily focus on the administration of Medicaid and the Children's Health Insurance Program. We will begin our discussion with an agency highlight section that will concentrate on the implementation of various system upgrade projects in the agency. In addition, we will discuss new legislation affecting the Children's Health Insurance Program. We have also included a general operations section that will primarily focus on the Medicaid program. We will discuss the quality control and utilization and review functions. And, to conclude, we will address administrative costs.

AGENCY HIGHLIGHTS

Medicaid Management Information System

The Department plans to have the new Medicaid Management Information System (MMIS) in operation by June 30, 2001. This system will process health care transactions and retrieve health care data. To date, the Department has completed four of nine tasks that the project must undergo. The project is currently in Task 5, Systems Development and Unit Testing. This task involves, systems testing, integration testing, user documentation, development of the training plan and materials, security plan development, and the development of the back-up and recovery plan. Below are the remaining four tasks and their expected completion dates.

- Task 6 - Testing and Training *(April 10, 2001)*
- Task 7 - Implementation *(June 29, 2001)*
- Task 8 - Post-Implementation Evaluation and Enhancements *(Not scheduled until after Implementation)*
- Task 9 - Final Acceptance Test and HCFA Certification *(Not scheduled until after Evaluation)*

A risk assessment performed by an independent contractor for the Department states that it is improbable that the Department will meet this deadline. As a result, the Department changed its contract with First Health Services, Inc. to explicitly state that First Health would complete the upgrade by June 30, 2001. In exchange, the Department increase the contract price by almost $10 million to cover "out of scope" issues identified by two independent sources and recommended by the Attorney General's Office to accomplish this goal.

Health Insurance Portability and Accountability Act of 1996

The new MMIS must also incorporate the Health Insurance Portability and Accountability Act (HIPAA) requirements. HIPAA is a federal law that affects the entire healthcare industry, including providers, payers, health plans, clearinghouses, and individuals. HIPAA standardizes certain electronic transaction formats and establishes national identifiers for providers, employers, health plans, and individuals. In addition, the U.S. Congress expanded the HIPAA requirements to include security regulations for the U.S. Department of Health and Human Services and a Medical Privacy law. The Security Regulations require that the entity have an information security program that includes policies, procedures, technical and physical controls, education and an information security officer. The Privacy Rule requires security policies and procedures, a privacy officer, complaint handling procedures, de-identified data and verification of the information requestor's identity and authority.

The expected date of required compliance with HIPAA is October 16, 2002. The Department will implement some of these requirements into the new MMIS by June 30, 2001. The Department is currently working on a HIPAA advanced planning document to ensure that it meets the remaining requirements by the required date.

Oracle Support

In addition, to meeting the 2001 MMIS deadline and the 2002 HIPAA deadline, the Department realized that it is also at risk of losing Oracle software support. The version of Oracle Financials used by the Department for internal accounting and federal reporting purposes will soon become outdated. The Oracle Corporation will end their "error correction" support on December 31, 2001 and will no longer provide "assistance support" after December 31, 2004.

The Department has been working with the Department of Information Technology (DIT) to decide whether to upgrade to an Internet or non-Internet version of Oracle. DIT recommended that the Department upgrade to the Internet version of Oracle Financials due to flexibility and cost. Below is a comparison of characteristics and cost information noted by DIT:

Version 11i (Internet)

- Collapsing of Multiple Data Centers into one
- Support of a globally disbursed workforce
- Support of a mobile work force
- Support of users that prefer to be self-serving
- Easy upgrades/no deployment issues

Version 11 (non-Internet)

- Supports a largely stationary/workforce
- Has initial deployment issues (Requires manual set up for each PC user)

Primary budget costs for an upgrade to Version 11 or 11i

- Do Not Upgrade $1,858,128.20
- Upgrade to Version 11 $1,842,505.00
- Upgrade to Version 11i $1,660,892.76

  These primary budget costs for decision analysis reflect cost through calendar year 2004.

The Department agreed with DIT's recommendation and plans this upgrade (from 10.7 to 11i) in the fall of 2001.

New Legislation effecting the Commonwealth's Children's Health Insurance Program

The 2000 General Assembly Session introduced new legislation to amend the Title XXI State Plan for the Children's Medical Security Insurance Program (CMSIP). As a result, the Department submitted an amended plan to HCFA on June 23, 2000 renaming the program to the Family Access to Medical Insurance Security (FAMIS) and separated it from the state's Title XIX plan (Medicaid). The amendments attempt to revise the image of the program, simplify and speed-up the eligibility determination and enrollment process, and increase access to a broader array of providers through private-sector health insurance programs.

The remainder of this section will address the Department's proposed changes to the program.

Eligibility

The current Title XXI program covers children under 19 with family income up to 185 percent of the federal poverty level. The amended plan extends eligibility to families with income at or below 200 percent of the federal poverty level. Eligibility re-evaluations will be performed when there is a change in income and family situation. Otherwise, FAMIS cases will undergo an annually review to determine continued eligibility.

Employer-Sponsored Health Insurance

The Commonwealth may elect to provide coverage for children who meet the FAMIS eligibility criteria and have access to health insurance coverage through their parent's employer sponsored health insurance. By enrolling children in Employer-Sponsored Health Insurance (ESHI), the Commonwealth pays for the employee's share of the premium if the family meets the following requirements.

- The family wants to participate in the premium assistance program.
- The child has not had group coverage within the previous six months.
- The employer contributes at least 50 percent of the premium for family coverage.
- The cost of family coverage under ESHI is equal to or less than the Commonwealth's cost of obtaining coverage under FAMIS only for the eligible targeted low-income children.
- The family must apply for the full premium contribution from the employer.

The Department is requesting an exception to the requirement in HCFA's proposed regulations that the employer must contribute at least 60 percent towards the cost of family coverage. The Department requests that the statewide minimum employer contribution be 50 percent of the cost of family coverage. The Department has informed HCFA that it will collect information of the levels of employer contributions available through the employer-sponsored plans that qualify for subsidy and monitor the levels of employer contributions. If a pattern of declining contributions emerges, the Department can change the required level of employer contributions.

The Department has also acknowledged that covering eligible children may result in coverage of the parents of these children; however, this is incidental coverage. Participation in the ESHI component of FAMIS is optional. Families who do not wish to participate in the premium assistance program may enroll their eligible children in the regular FAMIS program.

Enrollment

In Virginia, the Department of Social Services will determine eligibility for CMSIP coverage. Applicants have the option of mailing in their application for assistance and needed verifications, so that no face-to-face interview is necessary. Head Start locations around the Commonwealth will provide information to potentially eligible individuals concerning the types of coverage available. Virginia also has eligibility workers out-stationed in selected hospital sites and local health departments to identify and enroll potentially eligible CMSIP participants. In addition, community groups have trained volunteers in the communities to help parents of potential CMSIP eligible individuals by answering questions and helping to complete applications and gather verifications needed to process cases.

Central FAMIS processing site

FAMIS will contract with an entity to establish a central processing site for receipt and review of FAMIS applications and for making eligibility determinations for FAMIS. The central site will receive FAMIS applications from numerous sources. Families can apply by mail, phone, fax, Internet, or in person. Local social service agencies, as well as providers and health plans, may provide applications and assist families with completing FAMIS application; however, eligibility processing for FAMIS will occur at the central site.

Contract staff at the central site will review documentation and input data from the FAMIS application into an automated system that will screen the data for potential Medicaid eligibility. If a child appears eligible for Medicaid, the contract staff will transfer the application and/or automated data to Medicaid state agency staff co-located at the central site. State staff will initiate follow-up contact and assist families with completing the Medicaid application and eligibility determination process.

While Medicaid state agency staff will do the initial enrollment, ongoing case maintenance for Medicaid cases will go through the local Social Services department in the locality where the child resides. The local Social Services department will conduct Medicaid re-determinations annually and when changes occur in income or family situation. Children found ineligible for Medicaid by local Social Services department will undergo referral to the central site for an evaluation of FAMIS eligibility. Children determined FAMIS eligible will have their cases maintained at the central site.

Providers

The FAMIS program will provide a comprehensive array of health care benefits for eligible enrollees. The Department proposes to contract statewide with various health insurers, such as health maintenance organizations (HMOs), preferred provider organizations, and managed care entities to provide a comprehensive health benefits plan. The Department's request for proposal for FAMIS health plans will include a requirement that the plans must develop and have in place utilization review policies and procedures to ensure that services provided to enrollees are medically necessary and appropriate. Interested health plans must address the use of referrals, prior authorization, and enrollee education on these and other utilization controls and/or specific health plan requirements. Providers must have procedures for identifying and addressing patterns of over and under utilization by enrollees included in the responses' request for proposal.

Cost Sharing

Unlike CMSIP, FAMIS requires families to assist with premium payments and co-payments. Title XXI requires that cost sharing not exceed an amount that is "nominal" under Medicaid law, with appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable. Families will have the following monthly premiums.

< or = 150% of Federal Poverty Level	> 150% of Federal Poverty Level
None	$15 per child per month with a maximum of $45 per family per month

In addition to premium requirements, there is also a coinsurance requirement. Families will have to pay the following annual coinsurance based on their income level.

Poverty Levels	100%	135%	150%	175%	200%
Maximum annual co-payments limit	$200	$200	$350	$350	$350

Total cost sharing limit is 2.5 percent of a family's income for the year for income equal to or under 150 percent of the federal poverty level, and 5 percent for family incomes above 150 percent of the federal poverty level. Families that fail to pay their family contribution risk disenrollment.

FAMIS Expenditure Projections

The Virginia Healthcare Foundation conducted two surveys of health access in Virginia. The latest survey was conducted in the Spring of 1997 for the year 1996 of a representative sample of 1,861 households (representing 4,694 individuals). The Department used estimates derived from this survey and census data to plan and develop CMSIP/FAMIS. As a result, the Department projected the following enrollment and medical assistance services expenses.

Federal Fiscal Year	Projected Enrollment	Projected Federal Funds	Projected State Funds	Total Projected Medical Expenditures
2000	28,068	$16,945,137	$ 8,663,352	$25,608,489
2001	45,905	$28,430,235	$14,450,964	$42,881,199
2002	61,528	$47,857,315	$24,325,664	$72,182,978
2003	61,564	$54,345,770	$27,623,717	$81,969,487

State funding will come from two sources: State General Funds and the Family Access to Medical Insurance Security Plan Trust Fund. The 1997 General Assembly established the trust fund in anticipation of 1998 General Assembly enactment of the children's health insurance program. And the Commonwealth repealed a partial tax exemption for the Blue Cross and Blue Shield Companies that no longer provide insurance of last resort as a result of HIPAA reforms. The Assembly directed the Fund to pay in part the Commonwealth's share of expenses under the new children's health insurance program. Fund Income comes from an increased health insurance premium tax that should generate between $9 and $10 million annually. The remainder of the Commonwealth's share will come from State General Funds.

Administrative Expense Projections

The Department has not yet determined who will administer FAMIS. Initially, the Department plans to contract for most of the administrative tasks. However, the same division managing the Medicaid Health Insurance Premium Payment (HIPP) program will have some of the administrative tasks. The Department plans on using a contractor to perform all of the previously discussed function it is now doing.

The Department plans to spend 10 percent of the grant for administrative purposes. If the Department incurs administrative cost in excess of the amount available under the 10 percent cap, these additional costs will come state funding. The Department has projected administrative costs at about 11 percent per fiscal year.

Federal Fiscal Year	Projected Enrollment	Estimated Federal Funds	Projected State Funds	Total Projected Administrative Expenditures
2000	28,068	$1,882,793	$ 962,595	$ 2,845,388
2001	45,905	$3,158,915	$1,605,663	$4,764,2578
2002	61,528	$5,317,479	$2,702,852	$ 8,020,331
2003	61,564	$6,038,419	$3,069,302	$ 9,107,721

Strategic Objectives and Performance Goals

The Department has developed three objectives for increasing the extent of creditable health coverage among low-income children. These three objectives are:

I. To reduce the number of uninsured children
II. To improve the health care status of children
III. To conduct effective outreach to encourage enrollment in health insurance plans

In order to successfully accomplish these objectives the Department has also developed performance goals as follows:

Strategic Objective I

Performance Goal	Measurement Strategy
Increase the number of Medicaid eligible children enrolled in Medicaid	DMAS enrollment data
Enroll **61,500** children in FAMIS by the close of FFY2002	DMAS enrollment data
Reduce the percentage of uninsured children	Health access survey

Strategic Objective II

Performance Goals	Measurement Strategy
Increase the number of children with a usual source of care	DMAS enrollment data
Increase the percentage of children with immunization	Health plan submitted data
Increase the number of children receiving appropriate well-child care	Health plan submitted data

Strategic Objective III

Performance Goals	Measurement Strategy
Develop and implement a comprehensive, statewide community-based outreach plan	Published plan and administrative records from outreach campaign
Obtain the active participation of community-based organizations	Administrative records from outreach campaign
Obtain the active participation of other state agencies	Administrative records from outreach campaign
Obtain the active participation of business community	Administrative records from outreach campaign
Obtain the active participation of school districts	Administrative records from outreach campaign

Summary

The Department cannot implement the amended Title XXI plan until HCFA completes its review. The Department expects approval in January 2001.

GENERAL OPERATIONS

The U.S. Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA) administers the Medicaid program in cooperation with State governments. The State Plan approved by the Virginia General Assembly and HCFA includes the regulations governing the Medicaid program in the Commonwealth. The Department is the single state agency designated by the State Plan to administer the Medicaid program. Medicaid pays for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children.

Medicaid is an entitlement program that services about 400,000 recipients across Virginia. Below is a table that identifies the categories of services they receive and the cost of these services per recipient.

Cost Per Recipient	1996	1997	1998	1999	2000
Lab and X-ray Services	$82	$81	$70	$90	$93
Family Planning Services Summary	103	99	98	118	122
EPSDT Screening Services	104	104	92	98	101
Dental Services	127	129	131	210	215
Other Practitioner Services	136	131	117	107	104
Physician Services	344	369	384	410	431
Outpatient Hospital Services	397	428	453	476	495
Other Care Summary	484	582	619	570	667
Prescribed Drugs	509	605	714	850	1,091
Home Health Services	959	1,109	1,112	1,108	1,111
Managed Care Programs				1,086	1,539
Clinic Services	1,164	1,492	1,805	525	643
Mental Health Facility Services *				2,585	2,806
Personal Care Support Services *				3,324	2,224
Inpatient Hospital	3,767	3,156	3,303	3,421	3,466
Nursing Facility Services	14,241	14,171	14,149	14,447	16,359
Home/Community-Based Waiver Services *				23,074	24,972
ICF - MR Services	$59,536	$60,259	$64,749	$73,999	$80,985

The Federal and State governments jointly finance the Medicaid program 51.67 and 48.33 percent, respectively. Medical services totaled $2.6 billion in fiscal 2000. The Department consistently attempts to find methods to reduce Medicaid cost without sacrificing the quality of patient care. The Department has an initiative called the Disease State Management, which improves the treatment of target diseases (especially chronic), which use significant resources.

The goal of the Disease State Management is high quality, cost effective care for all patients. The program targets chronic diseases like Diabetes, Hypertension/Congestive Heart Failure, Depression, Gastro esophageal Reflux Disease/Peptic Ulcer Disease, and Asthma/Chronic Obstructive Pulmonary Disease. With this program the Commonwealth is trying to use preventative measures in order to reduce costs related to

some of the diseases that use significant resources. The Department has contracted with Heritage Information Systems to assist in this effort.

In addition to using preventive measures to control cost, the Department must also consider retrospective factors like identifying ineligible, abusive, and fraudulent recipients and providers in the Program. HFCA requires states to incorporate quality control and utilization review functions in the State Plan to address these factors. The next section identifies these units within the Department and discusses their purpose and processes.

Medicaid Eligibility Quality Control

HCFA requires each state to operate an HCFA-approved Medicaid Eligibility Quality Control (MEQC) system. The MEQC system re-determinations beneficiary eligibility for Medicaid and projects the number and dollar impact of payments to ineligible beneficiaries. Historically, the Commonwealth has reported a 3 percent error rate, which met federal standards. As a result of this low error rate, the Commonwealth is participating in a MEQC Pilot Project. This pilot differs from the traditional system in that it provides States an opportunity to customize their eligibility quality control process to address specific problems affecting their state. Currently, HCFA has permitted 24 states including Virginia in this Medicaid pilot project. By establishing a pilot, these states can experiment with alternative testing methods without risk of federal sanctions.

Two individuals administer Virginia's MEQC pilot project in conjunction with several Quality Control staff at the Department of Social Services. Together they agreed to implement the pilot in two phases; phase one targets the localities with the most problems, while phase two targets long-term care recipients. The two agencies also agreed that the Department has responsibility for selecting a monthly sample for testing by Social Services regional quality control reviewers. At the completion of the six-month pilots, the Department and Social Services will issue a statewide summary report and corrective action plan to HCFA.

Phase One

Phase one of the pilot focused on seven of the Commonwealth's most problematic Social Services localities. The Department and the Social Services used historical data from the traditional MEQC process to identify the seven localities with the highest error rates. Initially, Phase One covered a six-month period April 1999 through September 1999, however, the Department extended Phase One for an additional six months October 1999 through March 2000. The objective of phase one is to identify case errors. In other words, instances where eligibility was incorrectly determined, program designations were incorrect, or other instances where the recipient's data was incorrect. The following table identifies differences between Phase One of the pilot and the traditional Quality Control system.

	Pilot QC	**Traditional QC**
Cases are randomly selected from:	7 DSS localities	all 52 DSS localities
Reviews are processed by:	possibly QC staff outside of the locality's region	QC staff within the locality's region
Information is gathered via:	review form	home visit
No. of days from request to submit cases for review	7 workdays	5 workdays

Of the 840 cases selected for review during the first six months of the pilot, Social Services identified 114 error cases. As noted above, this six-month period ended September 1999. At October 2000, we found that the Department and Social Services had not issued a statewide summary or corrective action plan to HCFA. In addition, we found two error cases with totally ineligible recipients still active on MMIS.

According to the State Plan, the agency must submit summary reports of the findings for all active cases in the 6-month sample by July 31 of each year for the previous April-September sampling period . In addition, "by September 15 of each year, the Department should submit to HCFA a report on its error rate analysis and a corrective action plan based on that analysis."

Recommendation: The Department should work with Social Services to identify a reasonable time period for making corrections in MMIS and for compiling the six-month summary report. In addition, the Department should ensure that Social Services corrects MMIS for any errors found in the MEQC pilot.

Phase Two

Phase Two of the pilot focuses on long-term care recipients. Under Phase One, only seven localities were subject to review, in contrast, all long-term care cases are subject to review. Phase Two covers a one-year period April 2000 through March 2001. The objective is identifying payment errors. In other words, instances where Medicaid has overpaid or underpaid a provider for services to a Medicaid beneficiary. Social Services is currently reviewing cases for Phase Two of the pilot.

Overall the MEQC Pilot Project has made Quality Control a risk-based function. However, the Department and Social Services are a year behind schedule reporting the results of the first six-month period of Phase One. This delay can affect the effectiveness of the overall Pilot.

Medicaid Utilization and Review

In addition to using quality control procedures to control Medicaid costs, HCFA also requires that each state have methods and procedures to safeguard against unnecessary use of care and services. These procedures should include methods for identifying suspected fraud cases, methods for investigating these cases, and procedures for referring these cases to law enforcement officials. The Department has established five utilization and review units to carry out this function.

- Recipient Monitoring Unit
- Recipient Audit Unit
- Provider Review Unit
- Facility & Home-Based Services Unit
- Waiver Services Unit

Recipient Monitoring Unit

The Department's Recipient Monitoring Unit (RMU) reviews non-institutional recipient activity to identify recipients who use services at a frequency or amount that is not medically necessary according to State utilization guidelines. The source of this information is claims data obtained from MMIS. The Department uses the Surveillance Utilization Review (SUR) subsystem in MMIS to detect abusive recipients. This subsystem identifies activity that exceeds the norms found within peer groups. In addition, the unit also receives referrals from various sources like providers, recipients, other state agencies, the community and other units within the Department.

Initially all cases undergo an "integrity" review that analyzes the recipient's paid claims history for a specified period to identify inappropriate utilization patterns. Then, there is a review of medical records to substantiate the need for services. If the review determines the recipient's activity is abusive, the case will undergo a "full scale" review. Recipient cases in full-scale review usually result in the recipient's placement in the Client Medical Management Program (CMMP). CMMP restricts a recipient to one provider and one pharmacy and the Department then tracks the individual's use of medical service for three years.

Examples of abusive patterns found by the RMU include instances where recipients use emergency room services for routine medical problems, or instances where recipients use multiple prescribers to obtain excessive or duplicative medications. If RMU detects illegal prescription drug activity, the case goes to the appropriate law enforcement agency. The RMU analysts refer cases of suspected fraud, such as card sharing, to the Recipient Audit Unit.

Recipient Audit Unit

The Recipient Audit Unit (RAU) investigates allegations of recipient eligibility fraud. The RAU receives most allegations from local social service offices; however, allegations also come from local health departments, law enforcement agencies, Medicare, family members, and other units within the Department. RAU prioritize cases daily using the following factors: source of allegation, availability of liquid resources, type of fraud, amount of misspent funds, and other considerations.

RAU performs a cursory review to determine the validity of the allegations. If valid, personnel log the case into the units Fraud and Abuse Investigation Reporting System. Investigators gather claims and other evidence to determine the period of the recipient's ineligibility. Evidence may include the eligibility file from the Social Services locality, bank statements, employer statements, IRS tax dividend statements, and copies of deeds, marriage certificates, and medical records. The investigator decides if the recipient intentionally misrepresented the information, the recipient did not understand or did not know of the existence of income, or the eligibility worker at the Social Services locality made an error. If corrective action is necessary, RAU refers the case to the Commonwealth Attorney for criminal prosecution or to the Attorney General for civil litigation or establishes collection independently based on its findings. Convicted recipients have no Medicaid access for 12 months.

While examining the operations of the RAU we identified four internal control weaknesses and areas of non-compliance. The first finding addresses an edit check in MMIS. The second finding comes from the fiscal 1999 report and addresses uninvestigated MEQC error cases. The third finding addresses Money Payment cases. And lastly, the fourth finding deals with eligibility determination errors.

We found that the Department's recipient fraud code allows convicted recipients to re-apply for Medicaid within the 12-month sanction period. The Department's RAU has been aware of the problem since 1997. As a result, the unit drafted two information system requests (ISR) to correct the edit. The Department deferred the implementation of the ISRs until the implementation of the new MMIS scheduled for June 30, 2001.

In addition, we identified cases in the RAU's FAIR tracking system coded as convictions and compared them to the data found in MMIS. We found that 10 cases tested with convictions did not have the same coding in MMIS.

Recommendation: We recommend that the Department implement the ISR to comply with the State Plan, which sites that, "Eligibility will be denied any individual for a period of twelve (12) months following the date of their conviction for fraud against the program." In addition, the Department should continue to inform

eligibility workers in the local social service offices of proper procedures for coding convicted recipients in MMIS.

Using the Social Services MEQC database, we found nine individuals identified through the MEQC process as "totally ineligible" for Medicaid benefits. The Department did not investigate five of the nine cases. The RAU and the Quality Control Unit within the Department's Program Operations Division are not coordinating their activities. According to 42 CFR 431.820 (a), DMAS must take action to correct any active or negative case action errors found.

Recommendation: We recommend that the Department investigate error cases referred by Social Services.

In addition to Medicaid Only cases, the RAU also tracks and oversees the successful recovery of Money Payment cases. Money Payment cases involve fraud investigations of recipients receiving Medicaid, TANF and Food Stamps. The local social service offices investigate these cases and recover the misspent funds. The Commonwealth's Social Service Fraud Free Program is tracking these cases. However, we found that the Department does not have access to this database, nor does the Department receive a report from the database. Although the Department actively pursues the status of these investigations by sending quarterly letters to local social service offices, the Department is not confident that this information is adequate to follow the status of all the Money Payment cases under investigation by Social Services.

According to the Memorandum of Understanding between the Department and Social Services, Social Services shall require the local social service offices to investigate allegations of Medicaid fraud when such fraud relates to Temporary Assistance for Needy Families (TANF) or Auxiliary Grant (AG) program cases. In addition, local social service offices must recover Medicaid overpayments only after collecting all social services benefit program overpayments. Finally, the local social service agency must notify the Department of every known instance relating to non-entitled use of Medicaid services, regardless of the reason for such non-entitlement.

Recommendation: The Department should request a copy of the database periodically in order to properly oversee compliance with the Code of Federal Regulations Title 42, Section 455, which relate to Medicaid program integrity.

Lastly, we also found that about 95 percent of the cases investigated by the Department's RAU are the result of administrative errors made by social service workers. As a result, individuals receive improper authorization for Medicaid benefits and the RAU has a large volume of recipient cases to investigate.

Recommendation: We recommend that the Department consider reviewing the Medicaid eligibility training materials presented by DSS.

Provider Review Unit

The Provider Review Unit (PRU) monitors provider activity for frequency, appropriateness, and quality of care. This includes identifying abusive patterns of provider utilization, identifying misspent funds, developing corrective action plans, and recommending policy changes to prevent abusive billing practices. The source of this information is claims data obtained from MMIS. Like the RMU, PRU uses the SUR subsystem to detect provider abuse by determining which providers are exceeding the norms for their peer group. The unit also receives referrals from various sources like recipients, other state agencies, the community and other units within the Department.

Typical abusive patterns may include billing multiple service units, billing lab tests individually rather than as panels, procedures unrelated to diagnosis coding, and high numbers of laboratory procedures per client.

During the integrity review, the PRU performs a desk audit using a limited sample of claims to detect inappropriate utilization or billings. Cases where the Department over paid the provider by at least $1,000, advances the review from the status of integrity review to full-scale review. PRU selects 10 percent of provider's recipients claims within a month, to receive an Explanation of Medicaid Benefits (EOMB) statement of the claims paid on their behalf. The recipients review the claims and return the form identifying any services, which they state they did not receive. The Department bills the provider for any Medicaid overpayments identified. In the event that the PRU believes they can prove fraud, they refer the case to the Medicaid Fraud Control Unit at the Attorney General's Office.

The Department conducts provider appeals in accordance with the Administrative Process Act. The initial phase of the appeal's process is the "reconsideration" to audit findings. The second step is the informal fact-finding conference (IFFC) scheduled at the provider's request. The provider has this opportunity to present documentation or material relevant to the review. If the provider does not agree with the findings of the Department following the IFFC, he may request a formal evidential hearing. The Department requests a hearing officer from the Supreme Court of Virginia and the hearing officer uses courtroom procedures in the evidential hearing.

The recovery of overpayments for full-scale reviews has increased dramatically. The unit recently converted from a Wang Pace system to an ORACLE database to increase its ability to track referrals and appeals. This new tracking system allows the PRU to track the number and status of cases investigated by the unit.

However, we found that the PRU's Oracle database does not include any investigations before July 2000. PRU began using the Oracle database to track the status of its investigations in July 2000, but did not transfer the on-going investigations from the old database to the new database. In addition, the database does not indicate whether the case is in "reconsideration" or an "appeal" status. Failure to track PRU cases makes it difficult to determine the status of an investigation, and the productivity of the unit.

Recommendation: The Department should continue to update the Oracle database to include cases before July 2000 and to include the fields necessary to adequately manage the unit.

Facility & Home-based Services

The Facility & Home-based services unit does utilization and review for the following provider types.

- Nursing Homes
- Assisted Living Services
- Home Health Care Services *(include nursing, physical and speech therapy, and aid visits to recipients residence)*
- Rehabilitation Services *(includes inpatient and outpatient services)*
- Durable Medical Equipment *(include various medical equipment like hospital beds, wheelchairs, etc.)*
- Hospice Care *(includes recipients who are terminally ill)*

The unit performs onsite reviews to ensure the provider actually provides the appropriate level of care authorized. The unit recently updated provider manuals, and ensures that the providers apply the policies and regulations as set forth by the agency.

In addition to reviewing the level of care and the implementation of policies and procedures, the unit also performs pre-admission screening for hospice care. Pre-admission screening preauthorizes the level of care it will reimburse the provider before the recipient receiving any care. The Department has contracted with West Virginia Medical Institute to perform pre-authorization for it waiver services.

Instead of using SUR to identify unusual activity, the Facility & Home-based services unit uses SAS programs to extract data from MMIS. Therefore, instead of the system automatically querying itself for activity outside of normal peer groups, the unit can write their own queries to identify specific transactions. The concentration of the review may also depend on complaints received by the community, Attorney General's office, the Medicaid Fraud Unit, or the Provider Review Unit.

Waiver Services

Waivers provide the flexibility to the States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of beneficiaries. Waivers allow exceptions to State Plan requirements and permit a State to implement programs or activities on a time-limited basis, or subject to specific safeguards for the protection of beneficiaries and the program.

The Waiver Services unit performs utilization and review procedures to determine that providers are complying with the terms of the waivers. The Department administers the following waiver services.

- Mental Retardation Waiver *(provides 9 types of services to individual that are mental retarded)*
- Elderly & Disabled Waiver *(includes personal, respite care, and adult day health care services)*
- Aids Waiver *(includes personal care, private duty nursing, respite care and nutritional supplements)*
- Technology Assistance Waiver *(provides services to children and adults that require high-technology equipment)*
- Consumer Directed Personal Attendant Services Waiver *(allows the consumer to direct the care they receive)*
- Individual and Family Development Disabilities Support Waiver *(provides 16 services for individuals under 21)*

HCFA withdrew federal participation (approximately $1.5 million) in the Virginia Intensive Assisted Living (IAL) Waiver program based on its review conducted between December 13 and 17, 1999. The HCFA review team concluded that the Department had not complied with the assurances offered in making the request for the waiver program. Currently, the General Fund is absorbing the cost from the loss of the IAL Waiver.

On March 24, 1999 the Department discovered what it subsequently determined to be a series of irregularities involving an employee in its Waiver Services Unit. The Department took immediate steps to notify the office of the Auditor of Public Accounts and the State Police. At the same time the Department immediately addressed the compromised internal controls, which the employee had exploited. By the time the Auditor issued a report dated September 20, 2000, the Department had either addressed the control

weaknesses identified therein or had anticipated their correction with the installation of the Department's new Medicaid Management Information System (projected to go live in June 2001).

Medicaid Administrative Cost

Administrative costs within the Department totaled $60,145,456 for fiscal 2000. These costs were primarily associated with payroll expenses and contractual services. The table below shows the various categories of administrative expenses over the last four years.

EXPENDITURE CATEGORY	1997	1998	1999	2000
Fringe benefits	$ 2,380,501	$ 2,513,266	$ 2,442,135	$ 2,880,161
Salaries	10,400,930	10,508,580	9,903,661	10,956,380
Printing and distribution	2,972,800	2,875,954	2,728,858	2,912,107
Data processing	2,760,097	4,609,343	8,296,582	7,739,784
Medical services	1,400,593	1,640,302	1,130,493	1,694,161
Contracted services	9,200,991	13,609,174	18,809,403	19,772,636
Telecommunications	586,881	501,894	560,219	510,858
Supplies	394,257	700,782	691,359	596,351
Travel and education	236,349	233,262	175,730	255,525
Awards and claims	26,891	5,447	3,742	3,547
Insurance	39,094	35,807	43,193	73,262
Rent	1,470,482	1,476,865	1,561,044	1,431,158
Memberships/ Reference Mtls	53,022	39,498	57,979	77,380
Equipment and structures	33,056	70,299	18,176	290,362
Other	116,508	163,890	176,318	214,421
Subtotal DMAS	**$ 32,072,452**	**$ 38,984,363**	**$ 46,598,892**	**$ 49,408,093**
Interagency Transfers	587,139	1,223,867	1,051,173	936,889
Subtotal other agencies	**$ 587,139**	**$ 1,223,867**	**$ 1,051,173**	**$ 936,889**
Claims Processing	8,723,835	9,276,487	11,743,318	9,800,474
Subtotal fiscal agent	**$ 8,723,835**	**$ 9,276,487**	**$ 11,743,318**	**$ 9,800,474**
TOTAL	**$ 41,383,426**	**$ 49,484,717**	**$ 59,393,383**	**$ 60,145,456**

Payments to contractors make up about 50 percent of the total administrative expenditures at the Department. The services that are provided by contractors at DMAS range from Audits of Medicaid Cost Reports and Recipient Enrollment Services to the Implementation of the New MMIS system.

Commonwealth of Virginia

Walter J. Kucharski, Auditor

Auditor of Public Accounts
P.O. Box 1295
Richmond, Virginia 23218

November 27, 2000

The Honorable James S. Gilmore, III
Governor of Virginia
State Capitol
Richmond, Virginia

The Honorable Vincent F. Callahan, Jr.
Chairman, Joint Legislative Audit
and Review Commission
General Assembly Building
Richmond, Virginia

INDEPENDENT AUDITOR'S REPORT

We have audited the financial records and operations of the **Department of Medical Assistance Services** for the year ended June 30, 2000. We conducted our audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Our audit objectives, scope, and methodology follow:

Audit Objectives, Scope and Methodology

Our audit's primary objectives were to:

- evaluate the accuracy of financial transactions recorded on the Commonwealth's Accounting and Reporting System;
- review the Department's system development and implementation efforts;
- review the Department's internal controls over the Medicaid program;
- determine whether management administered federal assistance programs in compliance with applicable laws and regulations; and
- determine the status of findings contained in our prior year report.

We obtained an understanding of the relevant policies and procedures for the Department's internal accounting controls. We evaluated and considered materiality and control risk in determining the nature and extent of our audit procedures. We performed audit tests to determine whether policies and procedures were adequate, had been placed in operation, and were being followed. In meeting our audit objectives, we also assessed compliance with applicable laws and regulations; tested transactions; examined files, documents, policies and procedures; interviewed agency management and staff; and observed the Department's and fiscal agent's operations.

Management's Responsibility

The Department's management has responsibility for establishing and maintaining internal controls and complying with applicable laws and regulations. The objectives of internal controls are to provide reasonable, but not absolute, assurance that assets are safeguarded and transactions are processed in accordance with management's authorization, properly recorded, and comply with applicable laws and regulations.

Our audit was more limited than would be necessary to provide an opinion on internal controls or on overall compliance with laws and regulations. Because of inherent limitations in any internal control, errors, irregularities, or noncompliance may nevertheless occur and not be detected. Also, projecting the evaluation of internal controls to future periods is subject to the risk that the procedures may become inadequate because of changes in conditions, or that the effectiveness of the design and operation of policies and procedures may deteriorate.

Audit Conclusions

We found that the Department properly stated, in all material respects, the amounts recorded and reported in the Commonwealth Accounting and Reporting System. The Department records its financial transactions on the cash basis of accounting, which is a comprehensive basis of accounting other than generally accepted accounting principles.

We noted certain matters involving internal controls and its operation that we considered to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of internal controls that, in our judgment, could adversely affect the Department's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial records. We believe none of the reportable conditions included in this report are material weaknesses.

The results of our tests of compliance found issues of noncompliance that we are required to report herein under Government Auditing Standards, which are described in our report.

The Department has not taken adequate corrective action with respect to the previously reported findings listed below. Accordingly, we included these findings in this report.

- Investigate Medicaid Eligibility Quality Control error cases

The Department has taken adequate corrective action with respect to all other audit findings reported in the prior year that are not repeated in this report.

EXIT CONFERENCE

We discussed this report with management at an exit conference held on January 19, 2001.

AUDITOR OF PUBLIC ACCOUNTS

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