DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
RICHMOND, VIRGINIA

REPORT ON AUDIT
FOR THE YEAR ENDED
JUNE 30, 1999

AUDITOR OF PUBLIC ACCOUNTS

COMMONWEALTH OF VIRGINIA

AUDIT SUMMARY

Our audit of the Department of Medical Assistance Services (the Department) for the year ended June 30, 1999, found:

- amounts reported in the Commonwealth Accounting and Reporting System for the Department were fairly stated;
- no material weaknesses in internal controls and its operation, however, we did find certain matters that we 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 where noted otherwise.

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

- Correct the Patient Intensity Rating System Scores in the Medicaid Management Information System
- Improve Medicaid Information Administration
- Review Available Resources for the Upgrade of Oracle Financials

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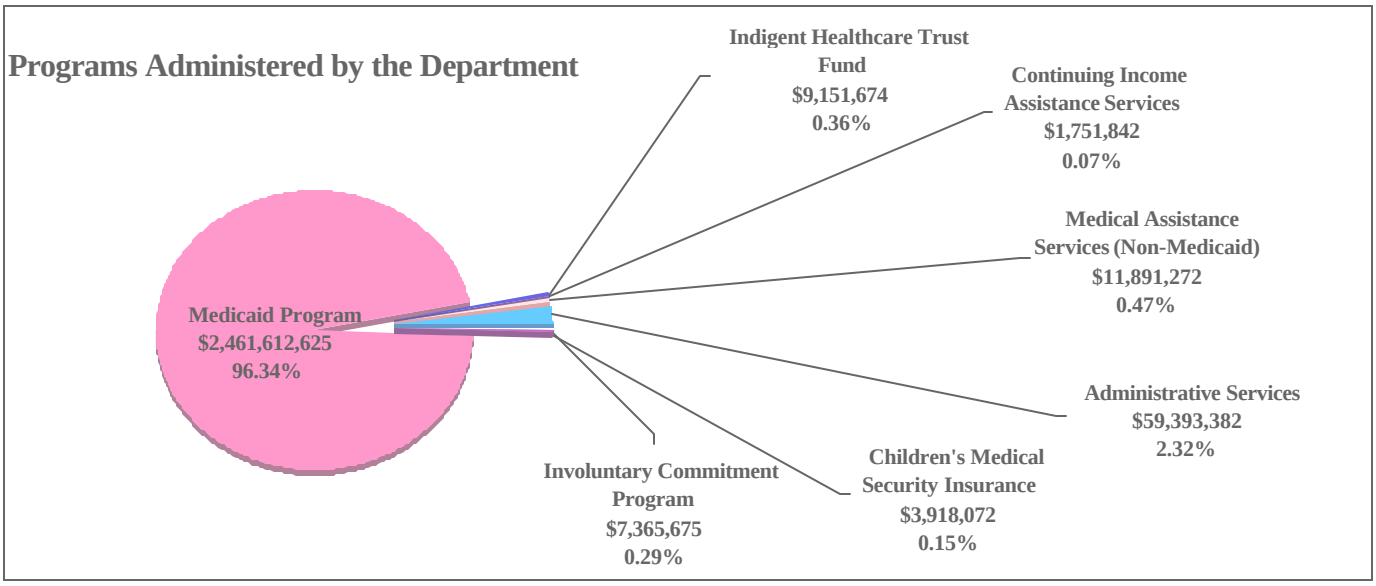
AGENCY HIGHLIGHTS

The Department of Medical Assistance Services administers the Commonwealth's indigent health care programs. These programs include Medicaid, Indigent Health Care Trust Fund, Income Assistance for Regular Assisted Living, Involuntary Mental Commitments, Children's Medical Security Insurance Plan, and other medical assistance services like HIV Assistance and State and Local Hospitalization. The Department spent $2.6 billion on these programs during fiscal year 1999. Below is a breakdown of total expenses by program.



During the last fiscal year, the Department concentrated on four projects requiring significant resources. These projects included the Department's efforts to make its systems Year 2000 (Y2K) compliant and deal with providers, who will not have successfully converted their systems. The Department continued working on the design and implementation of its Medicaid Management Information System. The Department continued the implementation of the Children's Medical Security Insurance Plan and assumed responsibility for paying certain cost in the Comprehensive Services Act.

SYSTEMS UPDATE

The Department provides medical assistance programs to over 375,000 average monthly recipients and contracts with over 45,000 medical and related care providers. As a result, the Department processes transactions in a highly automated environment. The Medicaid Management Information System tracks all Medicaid expenses by both recipient and provider. In addition, the Department uses the Oracle Financial Accounting System to report its operational expenses to the federal government and to interface with the Commonwealth's Accounting and Reporting System. Consequently, the Department has spent substantial resources to successfully make itself Y2K compliant. The next section provides an update on the status of their conversion and new system development.

In 1998, the Department began to identify and address critical business systems for Y2K compatibility. Currently, the Department has completed 100 percent of the renovation and testing of their critical systems and is working on testing and completing their mission important systems. Mission important activities are not essential to the critical operations of the agency.

The Department has developed contingency procedures to handle data exchange through interfaces including the transfer of eligibility data from the Department of Social Services, provider payments through the Department of Treasury, and the exchange of data with the federal government. The agency is testing these procedures to ensure their effectiveness. As of August 31, 1999, the Department spent $5.9 million for their Y2K efforts.

The Department assumes that all Medicaid providers will not be Y2K compliant on January 1, 2000. Therefore, the Department plans to pay providers using a process called "Windowing". "Windowing" uses computer programs to convert dates in data files to the correct date. For example, if the two digits at the end of a year are 49 or less, then the system automatically puts "20" in front of it and it becomes 2049. If the two digits at the end of the year are greater then 50, the system puts "19" in front of it and it becomes 1950. This Y2K methodology will only be effective until 2049. However, the Department plans to have the new Medicaid Management Information System fully operational by June 2001.

New Medicaid Management Information System

The Department contracted First Health Corporation in February 1998 to develop a new Medicaid Management Information System (MMIS) that includes planning, implementation, and fiscal agent activities. Specifically, the contract provides for bank account management, claims processing operations, system operations, maintenance, and future modification. The contract also provides for operation of the Department's other programs such as State and Local Hospitalization, Long-term Care, Involuntary Mental Commitments, Budget Control, Indigent Trust Fund, Children's Medical Security Insurance Plan and Managed Care. The new MMIS will serve two primary purposes: (1) to process health care transactions, and (2) to retrieve health care information.

The MMIS contract totals $15,523,911 for the Planning and Implementation and includes nine distinct tasks. First Health Corporation receives a predetermined percentage of the total contact price upon completion of each task. To date, First Health Corporation has completed two of the nine tasks, which is approximately $1.5 million or 10 percent of the contract price.

Review Available Resources for the Upgrade of Oracle Financials

The Department acquired the Third Party Liability Receivable system to improve its billing and tracking capabilities. This system uses an Oracle Financial software package and the Department made significant modification to the receivable module. This system is effective and has improved the Department's tracking, billing and collection of revenue from individuals having other sources of insurance while receiving Medicaid.

The Department is planning to upgrade this system to a newer version in the near future. This upgrade will provide the Department with some significant opportunities to take advantage of the newer version of Oracle Financial software enhanced capabilities.

Oracle Financial software is an enterprise system that allows an organization to integrate operations, functions and the flow of information across organizational structures, networks and systems. These systems allow management to design and modify workflows to improve efficiency within the structure of the software.

The implementation of enterprise systems requires that the organization have resources with an integrated knowledge of the system capabilities and the organization's existing operations. These resources are essential to take full advantage of the opportunity available with the upgrade to the new version. In addition, these resources will help the organization look at alternatives and different means of processing information.

Recommendation: Management should determine if it has sufficient resources to re-examine its processes, organizational structure and understanding of the software to fully take advantage of this opportunity. The Department may consider focusing on some employees for special training or look to other means for these resources. We believe that sufficient incremental savings will occur to recover the cost incurred of providing these resources and provide greater organizational flexibility.

NEW PROGRAMS

In addition to implementing Y2K compliant systems, the Department has also focused its attention on the development of new programs. The Children's Medical Security Insurance Plan is a program that is intended to provide health care coverage to uninsured children who are in low income families, but do not qualify for Medicaid. The Comprehensive Services Act is a program for "at risk" youth, which extends Medicaid covered services.

Virginia Children's Medical Security Insurance Plan

In November of 1998, the Commonwealth implemented the Children's Medical Security Insurance Plan. The program provides assistance with comprehensive health insurance coverage for eligible individuals under eighteen. An individual is eligible if they do not qualify for Medicaid, have no health insurance, or their policy, plan or contract does not provide a set level of health benefit coverage. Based on Department guidelines, the Department of Social Services determines recipient eligibility, and Benova, a contracted enrollment broker, educates and enrolls eligible recipients into an appropriate HMO or primary care provider.

The Children's Medical Security Insurance Plan uses the same provider network as Medicaid. In areas of the Commonwealth, where HMOs are available, recipients are enrolled in Medallion II. Otherwise, the Department will enroll recipients in Medallion, the Department's primary care provider program for fee for service.

Enrollment was 10,231 at June 1999, which was significantly below the Department's original projection. The Department of Social Services launched a (summer) outreach campaign to address this issue. As a result, enrollment increased to 15,350 by September 1999. The Department estimates that enrollment will increase to 63,200 by 2002.

Fiscal Year	Estimated Enrollment	Estimated Annual Expenditures	Federally Funded Expenditures	State Funded Expenditures
2000	35,786	$25,637,208	$16,964,141	$8,673,067
2001	57,208	$55,962,433	$37,080,708	$18,881,725
2002	63,200	$75,095,045	$49,788,015	$25,307,030

Comprehensive Services Act

The Comprehensive Services Act requires the Department to reimburse therapeutic treatment foster care and residential treatment as a service under the Early and Periodic Screening, Diagnosis and Treatment. The Department began to reimburse for therapeutic foster care January 1, 1999 and will reimburse for residential treatment in psychiatric facilities on January 1, 2000.

Therapeutic foster care provides a treatment environment for troubled children. Residential services cover inpatient psychiatric services. The Department will pre-authorize residential services as it does for all other similar services.

The Department plans to obtain a Federal Funding Participation rate for Medicaid medical dollars of 51.60 percent and the remaining 48.40 percent from local governments for the local match share.

GENERAL OPERATIONS

Following is a discussion of some the Department's other operations during fiscal year 1999. Incorporated with our discussion of operations, we have included any internal control or compliance findings we encountered during the audit. We have three sections in the remainder of the report, Medicaid Expenses, Non-Medicaid programs and Administrative Activities.

MEDICAID EXPENSES

The Department administers Medicaid under a State Plan approved by the U.S. Department of Health and Human Services' Health Care Financing Administration. The State Plan indicates the State's decisions concerning eligible groups, type and range of services, payment levels for services, and administrative and operating procedures.

Several other agencies work with the Department in delivering services or monitoring participants and providers. The Department of Social Services determines recipient eligibility. The Department of Health monitors the health and safety of Nursing Facilities. The Department of Health Professions maintains licensure documentation on Health Professionals. And, the Medicaid Fraud Control Unit at the Office of the Attorney General helps to control provider fraud in the Medicaid Program.

Medical assistance payments made up 96 percent of the Department's total expenses in fiscal year 1999 at $2.5 billion. The federal government and the Commonwealth jointly funded these expenses at 52 percent and 48 percent, respectively. The Department classifies medical assistance payments into twelve provider categories for federal reports. Below is a breakdown of expenses by provider type.

	1999 (in millions)		1998 (in millions)		1997 (in millions)		1996 (in millions)	
Inpatient Hospital	$ 489.1	19%	$ 491.0	21%	$ 487.2	21%	$ 488.5	22%
Nursing Facilities	424.2	17%	410.0	17%	397.7	17%	393.4	18%
Other Long Term Care	109.9	4%	113.2	5%	112.1	5%	96.7	4%
MHMR Facilities	221.5	9%	202.4	8%	182.8	8%	211.8	10%
Other Mental Health Programs	193.1	8%	184.2	8%	162.0	7%	140.0	6%
Prescribed Drugs	262.4	10%	222.0	9%	201.3	9%	178.2	8%
Physicians	159.2	6%	175.8	7%	177.0	8%	182.6	8%
All Other	186.6	7%	170.0	7%	161.7	7%	152.2	7%
Outpatient Hospital	118.4	5%	110.3	5%	107.5	5%	107.8	5%
Total Claim Payments	2,164.4	86%	2,079.9	87%	1,989.3	87%	1,951.2	89%
HMO Fees	222.8	9%	191.7	8%	193.2	8%	146.8	7%
Medicare Premiums	74.5	3%	72.1	3%	71.4	3%	69.1	3%
Administration	59.3	2%	49.5	2%	41.4	2%	36.8	2%
Other Medicaid Payments	356.6	14%	313.3	13%	306.0	13%	252.7	11%
Total Medicaid Payments	$ 2,521.0		$ 2,392.2		$ 2,295.3		$ 2,203.9	

Source: 1998 Virginia Medicaid Statistical Report CARS 1499 Report

Inpatient Hospital, Nursing Facilities, and Health Maintenance Organization represent the three largest payment categories for the Medicaid program. Over the last three years, they have accounted for 46 percent of the total expenses and are three areas undergoing significant change in either service delivery, recipient participation or growth. This section addresses some of the action the Department is taking in each of these areas.

Inpatient Hospital

Diagnosis Related Groupings Implementation

The Department and the Virginia Hospital Association cooperatively developed a new payment system, Diagnostic Related Groupings (DRG), to provide Medicaid payments to inpatient hospitals. DRGs reimburses hospitals an agreed upon amount per diagnosis, therefore, eliminating the need for the processing of cost settlements. The Department elected a two-year transition period, fiscal 1997 and 1998, to convert from the old per diem methodology to DRGs.

The Department awarded a contract to First Health in October 1997 to develop a DRG claims processing system within the existing MMIS. The Department should have begun processing claims for hospitals using the DRG methodology during fiscal year 1999. However, the Department and First Health did not have the MMIS requirements in place to allow claims processing under the new method. The Department expects to implement the new DRG claims system by January 1, 2000.

During fiscal year 1999, the Department continues to pay hospitals using the per diem methodology. The Department included in the per diem rates prior year operating costs and an inflation allowance for fiscal year 1999 payments. Although actual payments used the per diem rates, year-end settlements will incorporate an adjustment to the DRG rate for services rendered during the year. The Department estimates cost settlement payable will increase $8.1 million to $44.3 million for fiscal year 1999 to reflect the effects of the switch from per diems to DRGs.

Nursing Facility Expenditures

Nursing facilities provide long-term care services to eligible individuals. The criteria for assessing an individual's eligibility for Medicaid payment of nursing facility care consist of two components: 1) functional capacity and 2) medical or nursing needs. Before admitting persons to a nursing facility, there is a screening to determine the medical need or the potential for placement in an alternative community-based care program. While there are an unlimited number of nursing facility days, a patient undergoes semi-annual condition reviews to determine their continuing need and appropriate level of care.

Payments to nursing facilities accounted for 17 percent of total medical assistance payments in fiscal 1999. The nursing homes bill the Department on a per diem basis using approved rates. The Department uses the "Patient Intensity Rating System" or PIRS to reimburse providers of nursing facility care. PIRS is a patient-based methodology which links a nursing facility's per diem rate for direct patient care operating expenses to the intensity of services required by the patients. The Department and the Joint Legislative Audit and Review Commission are reviewing the adequacy of reimbursement rates for Nursing Facilities.

The Department's utilization review analysts make unannounced site visits to Nursing Facilities to determine if the facility is using accurate Activities of Daily Living Scores (ADL's) when billing Medicaid. This review also determines if a recipient is actually functioning at the level of care that the Department reimburses the Nursing Facility. The Department is not updating the Long-term Care information system when utilization review analysts find incorrect reporting of ADL scores, which could lead to erroneous payments to the Nursing Facilities. According to Title 42 of the Code of Federal Regulations Sec. 456.3, the Department must implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments.

Recommendation: We recommend that the Department correct Patient Intensity Rating System Scores in MMIS. In addition, the Department should develop procedures to ensure that the Long Term Care - Activities of Daily Living Scores, as determined by Utilization Review, are updated in MMIS.

Health Maintenance Organizations (HMOs)

Enrolling Medicaid recipients into a Managed Care program continues to be a Department priority. Managed Care programs include a variety of healthcare financing and delivery options designed to reduce costs by eliminating unnecessary and inappropriate services. Depending on the service area where they reside, recipients may enroll with either an HMO or a primary care provider (PCP).

At the beginning of fiscal year 1999, the Department had two active HMO programs, Options and Medallion II. During the 4th quarter of fiscal 1999, the Department transferred all Options recipients to Medallion II. Medallion II is the Commonwealth's mandatory HMO program that began in January 1996 in the Tidewater communities. Under this program, all recipients must select or receive assignments to one of seven HMOs.

Medallion II has since expanded into the Central Virginia region. The Department also plans to expand in the northwest region, including areas like Northern Virginia, Roanoke, and Charlottesville. HMO availability by locality has increased from 27 percent in 1997 to 34 percent in 1999.

Number and Percentage of Localities served by Medicaid HMOs

	July 1,1997	July 1,1998	July 1,1999
Medallion II Localities	7	13	46
Options Localities	29	17	-
Total Localities Served by HMOs	36	30	46
Total Localities in Virginia	134	134	134
% of Localities with Medicaid HMOs	27%	22%	34%

Medicaid recipients in HMOs as a percentage of those eligible for Medicaid has steadily increased from 22 percent in 1997 to 31 percent in 1999.

Number and Percentage of Enrollees in HMOs

	July 1,1997	July 1,1998	July 1,1999
Total Enrollees	113,341	103,411	149,697
Total Medicaid Eligibles	517,272	496,161	490,445
% of Medicaid Eligibles in HMOs	22%	21%	31%

Recipients automatically excluded from Managed Care enrollment are long term care residents, recipients participating in federal waivers, recipients with comprehensive insurance coverage (including Medicare), foster care children, aliens and refugees.

Capitation Rate Development

The HMOs received a capitated rate based on each recipient enrolled. PriceWaterhouseCoopers LLP through the Birch & Davis contract develops the capitation rate. HCFA Regulations require that rates not exceed the equivalent cost under a Fee for Service plan. Current rates equal 95 percent of the Fee for Service equivalent cost.

Analysis of cost saving for recipients in Medallion II

Fee for Service equivalent cost for Medallion II recipients	$209,326,166
Less Medallion II HMO capitation payments	(201,122,485)
Gross savings before direct administrative costs	8,203,681
Direct administrative costs:	
Less Benova FY99 expenditures	(1,509,277)
Less Birch & Davis FY99 expenditures	(1,200,000)
Net estimated savings	$ 5,494,404

Other Federal And State Compliance Findings

Complete Timely Investigations of Recipient Fraud

Finding: As noted in fiscal year 1998, the Department did not complete timely investigations of recipient fraud. In fiscal year 1999, the Department had 1,232 cases against Medicaid recipients, which were not actively investigated. We estimate the total value at approximately $7-$9 million. While the Department is unlikely to recover any amount equivalent to the fraud, active investigations can serve as a deterrent against recipient fraud.

According to the State Plan and Title 42 of the Code of Federal Regulations Section 455.16, "the Department must continue a full investigation until legal action is initiated, the case is closed due to insufficient evidence, or the matter is resolved between the department and recipient." The resolution may include sending a warning letter and or seeking recovery. The Department should investigate recipient fraud cases and initiate recovery from recipients, timely.

Recommendation: We recommend that the Recipient Audit Unit complete timely investigations for allegations of recipient fraud to increase the prompt identification of ineligible or fraudulent recipients. The Department should ensure the Unit has sufficient resources to complete these investigations timely.

Investigate Medicaid Eligibility Quality Control Error Cases

Finding: The Medicaid Eligibility Quality Control (MEQC) program is a joint effort of Social Services and the Department. The Department selects a sample of enrolled recipients and Social Services re-determines recipient eligibility. After Social Services completes their investigations, they report the results back to the Department for further investigation. There were 22 MEQC cases, with a potential estimated recovery of $84 thousand, which the Department did not investigate in fiscal year 1999.

According to Title 42 of the Code of Federal Regulations 431.820 (a), the Department must take action to correct any active or negative case action errors found in the sample cases. Corrective action would involve further investigation of the ineligible cases identified by Social Services and an attempt to recover the misspent funds.

Recommendation: We recommend that the Department investigate recipient ineligibility cases identified by Social Services. The Department should ensure that sufficient resources are available to complete these investigations.

Improve Provider Enrollment Documentation

Finding: According to Title 42 of the Code of Federal Regulations, Sec. 431.107, there should be an agreement between the Medicaid agency and each provider on file. The First Health Provider Enrollment unit, a Department contractor has responsibility for maintaining provider enrollment documentation and we found that one of five provider agreements was unavailable.

Recommendation: We recommend that the Department better manage the First Health Services Corporation contract in order to obtain access to Provider documentation.

Internal Control Findings

Improve Medicaid Information Security Administration

Finding: As noted in fiscal year 1998, the Department does not have an Information System Security officer who reviews system access for MMIS. This can result in inappropriate access to MMIS. In fiscal year 1999, eleven individuals have system access to the GEO Fee files, which is critical for paying claims. Six of the individuals are no longer with the agency. This lack of security over the GEO Fee files places the Department at an unnecessary risk of making improper and inaccurate payments.

Recommendation: We recommend that the Department continue their efforts to enforce security policy and review user access to reduce the risks associated with inappropriate access to Medicaid data. Specifically, management should require Division Supervisors to review user access as job responsibility changes.

Improve Security Controls for Technician Codes

Finding: As noted in fiscal year 1998, the Department does not maintain adequate security to prevent unauthorized use of technician codes. The codes are not machine addressed or employee specific and do not have password protection. The lack of password protection allows anyone accessing the resolution screen to resolve claims with any technician code. Therefore, the Department can not hold technicians accountable for their actions to resolve pended claims.

Recommendation: We recommend that the Department implement security controls over technician codes to ensure accountability of all pended resolutions.

NON-MEDICAID PROGRAMS

In addition to Medicaid, the Department also administers the following non-Medicaid programs:

- Involuntary Mental Commitments Program
- Virginia Children's Medical Security Insurance Plan
- Indigent Healthcare Trust Fund
- Continuing Income Assistance Program
- Medical Assistance Services (Non-Medicaid)

Total Non-Medicaid expenditures were $34,078,535 and $33,630,521 in fiscal years 1999 and 1998, respectively, making up approximately two percent of the agency's total expenditures in both years.

Involuntary Commitment Program

The Involuntary Commitment Program manages and reimburses providers and others for the care of individuals under Temporary Detention Orders. The courts issue temporary detention orders, when it has probable cause to believe that an individual presents an imminent danger to self or others as a result of mental illness. Providers receive reimbursement based on the number of days detained and the availability of any other type of medical coverage. The Department administers this function for the Supreme Court of Virginia.

Virginia Children's Medical Security Insurance Plan

The Trust Fund can receive state appropriations, employer contributions, and all grants, donations, gifts, and bequests from any source, public or private, for matching federal funds.

Indigent Healthcare Trust Fund

The Indigent Healthcare Trust Fund receives General Fund appropriations and contributions from hospitals and other sources for the purpose of distributing funds to hospitals with a disproportionate share of charity cases.

Continuing Income Assistance Services

Licensed Adult Care Residences provide regular assisted living services to persons who have dependencies in two or more daily living activities. This state-funded program provides the Adult Care Residence with a per diem reimbursement of $3.00 per day (not to exceed $90 monthly), in addition to the Auxiliary Grant or General Relief payment. The Department considers the reimbursement as payment for the Adult Care Residence's administrative costs.

Medical Assistance Services (Non-Medicaid)

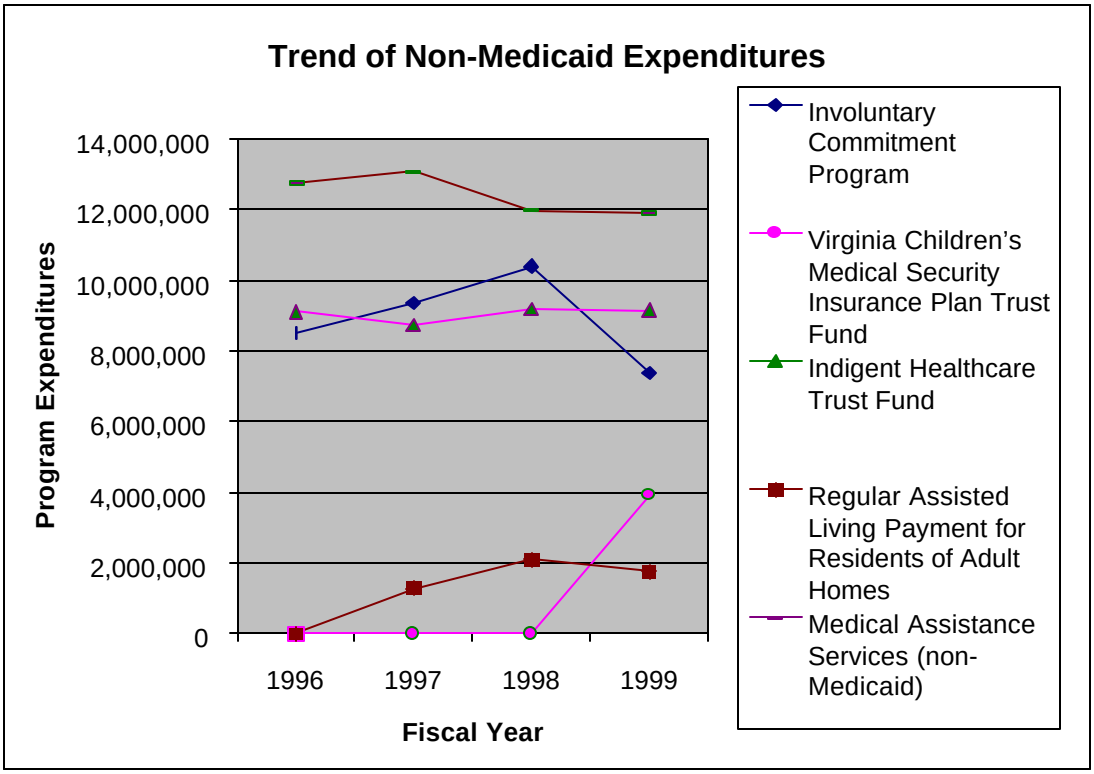
Health Premium Assistance for HIV-Positive Individuals

There are two premium assistance programs administered by the Department that benefit HIV-positive individuals. One is under the Medicaid HIPP Option and the other is a general funded program referred to as the HIV Assistance Program. The HIV Assistance Program is a non-Medicaid program that pays the premium for health insurance of individuals diagnosed with HIV/AIDS whose physician certifies them as disabled. HIV clinics, providers, and the Department of Health refer individuals to the Department for eligibility determination.

State and Local Hospitalization Program

This program is a cooperative effort between the Commonwealth and the localities to provide indigent individuals with access to inpatient, outpatient, ambulatory surgical, and local health department services. The Commonwealth, through general fund appropriations, provides at least 75 percent of the program's funding. Localities must participate and fund the remaining 25 percent of the program costs.

A four-year trend of each program's expenses indicates a significant decrease in Involuntary Commitment expenses due to a change in reimbursement rates, and a significant increase in the Children's Medical Security Insurance Plan due to the initiation of the program:



ADMINISTRATIVE ACTIVITIES

External Contracts

The Department spent approximately $60 million for administrative services during fiscal year 1999. Of this amount, 82 percent consisted of contractual services for Y2K conversion, MMIS design, managed care, and cost settlements. Contractual services increased from $37 million in fiscal 1998 to $49 million in fiscal 1999. The significant increase in contractual service comes from the emphasis on Y2K conversion and implementing the new MMIS system.

	1999	1998	$ Change	%Change
Payrolls	$12,345,792	$13,021,846	$ (676,054)	-5%
FHC-Computer Services-Medicaid	12,230,368	9,486,130	2,744,238	29%
Information Management Design	6,516,689	2,067,745	4,448,944	215%
Management Services	13,204,206	9,945,552	3,258,654	33%
Auditing Services	4,431,165	2,509,800	1,921,365	77%
Other Expenses	10,770,038	12,453,647	(1,683,609)	-14%
Total Administrative Expenses	$59,498,258	$49,484,720	$10,013,541	20%

Reconciliation of Medicaid Bank Accounts

The Department uses a fiscal agent, First Health Services Corporation, to pay all providers for services to recipients. First Health uses MMIS to do an automated review of the provider billings to determine that recipients are eligible and that the claims fall within the Department's guidelines. If the claim passes the automated review, First Health pays the provider using its Zero Balance Account and notifies the Department of amounts paid.

The Commonwealth maintains a Medicaid Concentration Account to account for medical assistance payments. At the Department's request, the Commonwealth's Department of Treasury transfers funds from the General Fund to the Medicaid Concentration Account.

As provider checks clear the bank, the Bank transfers funds from the Medicaid Concentration Account to First Health's Zero Balance Account. The Department reconciles the Medicaid Concentration Account to the Commonwealth's Accounting and Reporting System (CARS) and to First Health's Zero Balance Account.

Recommendation: The Department has attempted to reconcile the balance in First Health's Zero Balance Account to CARS. Since, the Department does not have full access to all of First Health's accounting transactions; it cannot, therefore, make adjustments for reconciling items. Thus the reconciliation listed numerous items as reconciling and unless the process changes, the listing will only continue to grow.

Due to the inefficiency of the reconciliation process, we recommend that the Department discontinue reconciling CARS to the Zero Balance Account. However, the Department should continue to monitor all transfers between the Commonwealth's Medicaid Concentration Account and First Health's Zero Balance Account to ensure accuracy and compliance with the Cash Management Improvement Act agreement with the federal government.

December 1, 1999

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

The Honorable Richard J. Holland
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, 1999. 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.

- Improve Medicaid Information Security Administration
- Complete Timely Investigations of Recipient Fraud
- Improve Security Controls for Technician Codes

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 December 1, 1999.

AUDITOR OF PUBLIC ACCOUNTS

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