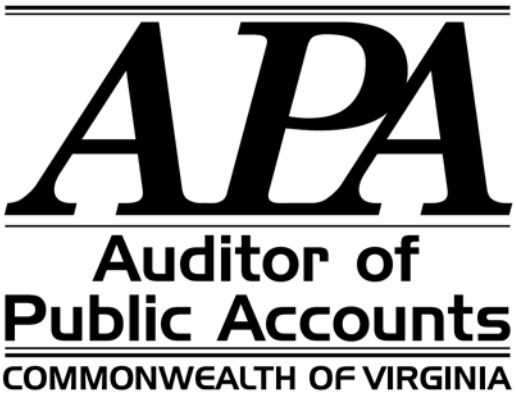
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

RICHMOND, VIRGINIA

REPORT ON AUDIT

FOR THE YEAR ENDED

JUNE 30, 2004



AUDIT SUMMARY

Our audit of the Department of Medical Assistance Services for the year ended June 30, 2004, found:

- amounts reported in the Commonwealth Accounting and Reporting System and the Department's accounting records were fairly stated;

- weaknesses in internal controls that we consider reportable conditions;

- no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards; and

- adequate corrective action for all prior year audit findings.

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AGENCY OVERVIEW

The Department of Medical Assistance Services (the Department) administers the Commonwealth's indigent health care programs. These programs include Medicaid, Family Access to Medical Insurance Security (FAMIS), Medical Assistance for Low-Income Children (FAMIS Plus), the Indigent Health Care Trust Fund, Income Assistance for Regular Assisted Living, Involuntary Mental Commitments, and other medical assistance services such as HIV assistance and state and local hospitalization.

The Medicaid program provides medical coverage to individuals who are aged, blind, disabled, pregnant, and eligible children, living in families with gross income below 100 percent of the federal poverty level. FAMIS Plus, previously know as Medicaid Expansion, provides coverage to children from age six through 18 in families with gross income between 100 and 133 percent of the federal poverty level. FAMIS covers children from birth to age 19 in families with gross income between 133 and 200 percent of the federal poverty level.

FINANCIAL INFORMATION

The schedules below summarize the Department's budgeted revenues and expenses compared with actual results for Fiscal 2004.

Analysis of Budgeted and Actual Funding Sources
Fiscal Year Ended June 30, 2004 Table 1

Funding Source	Original Budget	Adjusted Budget	Actual
General fund appropriations	$ 1,877,700,241	$ 1,911,496,387	$ 1,911,496,387
Special revenue funds	7,850,000	51,775,220	49,358,464
Dedicated special revenue	14,123,424	14,271,187	14,102,235
Federal grants	2,130,607,033	2,209,926,904	2,230,197,565
Total resources	$ 4,030,280,698	$ 4,187,469,698	$ 4,205,154,651

The Department adjusted its original general and federal fund budgets primarily for inflation in Medicaid costs and for providing services to an increasing number of low-income children, elderly, and disabled persons. Actual revenue exceeded the amount budgeted primarily due to a temporary increase in the federal Medicaid match rate pursuant to the Jobs and Growth Tax Relief Reconciliation Act of 2003, which increased from 50.53 percent to 54.40 percent and netted the Commonwealth approximately $33 million.

The Department adjusted its original special revenue budget in order to receive revenue from several localities within the Commonwealth having locally-owned-and-operated nursing homes and hospitals. In accordance with special provisions of the federal Medicaid legislation, the Department received as special revenue a total of $37.7 million and recorded a corresponding expense of $23.7 million shown as intergovernmental transfers in Table 4.

Analysis of Budgeted and Actual Expenses by Program
Fiscal Year Ended June 30, 2004 Table 2

Program	Original Budget	Adjusted Budget	Actual
Medicaid	$3,780,683,955	$ 3,938,481,772	$3,895,466,765
Administration and support services	124,079,389	126,926,326	120,510,856
FAMIS (Includes administrative costs)	59,161,906	59,318,722	58,540,171
FAMIS Plus	31,907,188	31,046,855	29,236,204
Medical assistance services (Non-Medicaid)	14,122,481	14,270,244	13,016,250
Appellate processes	9,426,996	6,926,996	5,712,885
Indigent health care trust fund	9,285,831	9,285,831	6,830,594
Continuing income assistance services	1,612,952	1,212,952	1,076,027
Total	$4,030,280,698	$ 4,187,469,698	$ 4,130,389,752

Analysis of Expenses by Program Funding Source
Fiscal Year Ended June 30, 2004 Table 3

Program	General Fund	Special Revenues	Dedicated Special Revenues	Federal Grants
Medicaid	$1,812,282,295	$ 35,193,731	$ 1,395,482	$ 2,046,595,257
Administration and support services	48,826,869	1,184,193	-	70,499,794
FAMIS (Includes administrative costs)	7,744,948	-	12,606,179	38,189,044
FAMIS Plus	10,156,080	-	-	19,080,124
Medical assistance services (Non-Medicaid)	10,997,471	2,018,779	-	-
Appellate processes	5,712,885	-	-	-
Indigent health care trust fund	4,285,800	2,544,794	-	-
Continuing income assistance services	1,076,027	-	-	-
Total	$1,901,082,375	$ 40,941,497	$14,001,661	$ 2,174,364,219

Total Department expenses for all programs amounted to $4.13 billion in Fiscal 2004. Approximately, 96 percent of this amount represents medical expenses attributable to the Medicaid, FAMIS, and FAMIS Plus programs. Another three percent of the total amount represents administrative expenses for these three programs.

Medicaid

The Department spent $3.89 billion on Medicaid Assistance Services. The following chart shows total medical expenses for the Medicaid program by provider type.

Medicaid Expenses by Provider Type
Fiscal Year Ended June 30, 2004
Compared With the Three Previous Fiscal Years

Table 4

	2004	2003	2002	2001
Nursing Facility	$ 623,759,124	$ 582,787,725	$ 539,268,035	$ 519,117,960
Managed Care Organizations (MCO)	822,941,745	768,548,306	490,879,442	372,488,621
Prescribed Drugs	568,887,798	498,672,240	445,195,673	412,672,142
Inpatient Hospital - Regular	483,247,785	402,014,317	401,859,141	426,261,052
Home and Community Based Waivers	401,779,716	352,596,635	318,007,100	287,562,995
Intensive Care Facility/Mental Retardation/Public Facilities	193,136,174	178,053,785	218,492,490	179,127,169
Mental Health Facility	247,075,233	222,858,621	185,491,843	157,876,189
Inpatient Hospital - Enhanced Disproportionate Share	72,675,032	121,359,950	122,513,616	138,856,454
Physician	133,720,252	122,063,767	127,307,456	138,450,315
Outpatient Hospital	99,455,728	111,118,885	107,438,441	114,226,353
Health Insurance Premiums	119,820,295	90,894,139	97,298,222	80,885,022
Other Care Services	46,242,252	46,785,117	49,710,397	127,200,119
Clinic	33,659,555	33,846,096	34,756,028	35,876,395
Intensive Care Facility/Mental Retardation/Private Facilities	25,460,429	21,127,148	18,299,608	19,292,971
Targeted Case Management	14,916,263	17,714,882	17,352,425	20,292,009
Lab and Radiological	14,364,597	13,551,057	13,052,372	14,176,416
Dental	12,677,140	12,026,005	12,774,312	14,316,446
Other Practioners	12,348,782	13,072,417	12,562,381	11,777,207
Rural Health Clinic	11,086,814	9,163,116	8,066,079	8,933,928
Hospice Benefits	9,514,896	9,613,604	7,045,884	5,921,051
Early and Periodic Screening, Diagnosis & Treatment Services	6,580,917	5,300,495	6,429,903	7,629,970
Home Health	3,048,813	4,411,341	5,002,691	5,211,239
Prepaid Health Plans	3,596,304	3,722,002	2,811,449	3,025,300
Federally Qualified Health Center	3,409,375	1,915,894	1,940,064	2,074,675
Intergovernmental Transfers	23,693,732	57,129,557	500,821,602	-
Drug Rebates	(91,636,289)	(73,263,453)	(65,610,593)	(70,691,112)
Total	$3,895,462,463	$3,627,083,648	$3,678,766,061	$3,032,560,886

Note: Source of information is Department of Medical Assistance's Accounting System

In addition to Medical Assistance Services, the Department spent $120 million on administrative costs. The schedule below summarizes the administrative expenses related to the Medicaid program.

Personal services	$ 19,171,886
Contractual services and other	96,610,237
Supplies and materials	454,307
Indirect Cost Recovery and other	214,636
Rent, and other continuous charges	2,696,601
Property, plant, and equipment	1,363,189
Total expenses	$ 120,510,856

Contractor Payments	Fiscal 2004
Logisticare	$ 43,499,999
First Health Services	34,983,163
West Virginia Medical Institute	4,403,968
Clifton Gunderson & Co.	3,740,718
Other	8,652,243
Total	$ 95,280,091

Of the $96 million spent on contractual services, the Department paid its largest vendor, Logisticare $43.5 million. Logisticare is the Department's transportation broker and manages all non-emergency medical transportation within the Commonwealth. The Department paid its second largest vendor, First Health Services Corporation (First Health), $34.9 million. As the Department's fiscal agent, First Health runs the day-to-day operations of the Medicaid program by processing claims and enrolling providers. First Health is also responsible for maintaining the Department's Medicaid Management Information System (MMIS).

FAMIS

FAMIS' medical expenses amounted to $58.5 million; of this amount, $41.1 million represents managed care organization payments, a decrease of $0.4 million from Fiscal 2003. Administrative expenses totaled $4.5 million with 75 percent paid for management services, which include consultant and contractor fees.

FAMIS Plus

Medical expenses for the FAMIS Plus program amounted to $29.2 million; of this amount, $16.1 million represents managed care organization payments. The Fiscal 2004 amount represents the first full year of the programs operation, which is an increase of $5.6 million from Fiscal 2003, when the program began in September of 2002.

OTHER AGENCY MATTERS

MEQC Project

The Centers for Medicaid and Medicare Services (CMS) requires each state to operate an approved Medicaid Eligibility Quality Control (MEQC) system. The MEQC system re-determines recipient eligibility for Medicaid and projects the dollar impact of payments to ineligible beneficiaries. As a result of the Commonwealth's historically low error rate, the Commonwealth received authorization to participate 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.

In the past, the Department has not had adequate policies and procedures to monitor and control the submission, resolution, and completion of the MEQC pilots. In Fiscal 2004, there was improvement in this area, as shown by the completion of the corrective action plans for the two pilots conducted and submitted to CMS on a timely basis. The Department has improved communications with the Department of Social Services, and strengthened the controls surrounding the review of this function.

PAM Project

The U.S. Congress enacted the Improper Payments Act of 2002, and required the U.S. Office of Management and Budget (OMB) to establish guidance for the act. OMB has directed each Federal Government executive agency, to review all of its programs and activities annually, identify those that may be susceptible to significant improper payments, estimate the annual amount of improper payments, and submit those estimates to Congress before March 31st of the following applicable year.

In Fiscal 2000, CMS adopted a Government Performance Reporting Act goal to develop a methodology for estimating improper payments for the Medicaid program. The Center for Medicaid and State Operations initiated the Medicaid Payment Accuracy (PAM) Project. The purpose of the PAM project is to conduct payment accuracy measurement studies in all states using a single methodology which will produce both state-specific and national level payment accuracy estimates.

Payment accuracy is the ratio of the dollar value of payments paid accurately to the dollar value of total payments made. There are three steps required to measure payment accuracy:

- Draw a representative random sample of paid claims and line items from the population of all paid Medicaid claims/line items;
- Review the sample of paid claims/line items to medical records and verify accuracy; and
- Compute a payment accuracy rate for the state.

The Department accepted a solicitation from CMS to participate in the PAM project. As of September 2004, the Virginia PAM project staff completed the conduct of the medical reviews and the eligibility reviews. The Managed Care Organization (MCO) team reviewed a managed care sample of 900 items, and the Medical Review team completed its reviews of the 900 items. The Department will consolidate the data from the processing, eligibility, and medical reviews; draft the accuracy rate calculations and final reporting in November; and submit the PAM Year 3 Final Report to CMS by December 31, 2004.

CMS has a new project for Fiscal 2005, which will look at all state Medicaid and state Children's Health Insurance Program (S-CHIP) agencies to determine a national error rate for these programs. This program is also part of the 2002 Improper Payment Information Act. The Department will participate in this Payment Error Rate Measurement (PERM) program.

CMS is currently proposing the PERM regulation and intends for the program to review payment accuracy for only approved individuals receiving approved services from qualified and approved providers. Upon implementation, states must perform claims processing, medical necessity, and eligibility audits from random samples of claims reviewed to confirm payment accuracy.

Preferred Drug List Program

The 2003 Appropriations Act directs the Department to amend the State Plan for Medical Assistance Services to modify the delivery system of pharmaceutical products to include a Preferred Drug List (PDL) program no later than January 1, 2004. The Pharmacy & Therapeutics (P&T) Committee recommended a "phased-in" approach to implementing the PDL program. The goal of this "phased-in" transition process is to minimize the impact of the program on the Medicaid recipients and providers. The Department implemented the PDL program in three phases, with the first phase starting on January 5, 2004, the second phase starting on April 1, 2004, and the third phase starting on July 1, 2004. The first phase had 13 therapeutic classes, the second phase had 11 therapeutic classes, and the third phase had 13 therapeutic classes. The PDL program will allow the Department to receive additional rebates along with the rebates already received from the Drug Rebate Program. In terms of savings, actual Medicaid pharmacy expenses were significantly below the Department's official forecast.

Medicaid Management Information System Post-Implementation

The CMS review team unconditionally certified the Medicaid Management Information System (MMIS) on May 18, 2004. Overall, MMIS is meeting provider business needs, and recipients are receiving services, but some problems still exist regarding reimbursement for certain provider groups. The Department continues to work with those affected groups in the provider community to resolve the remaining problems. First Health Services maintains the MMIS system and performs a number of services to support the Department; however, the Department oversees and determines the system controls.

Coventry Health Systems purchased First Health Services. According to the Department, the change in ownership will not affect the systems personnel, the users, or any controls currently in place.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) provides standards for the billing and payment of health claims, medical information, and federal protection for health information. This set of federal regulations creates standards for the preparation and communication of health information and controls the privacy of patient information. HIPAA encompasses system security, privacy, and electronic transaction requirements. Each set of requirements has a different compliance deadline. The Department has already met the deadlines to be compliant with the Privacy Rule and Electronic Transaction Standard and has until April 2005 to comply with the Final Security Rule.

The Department's entire network security division is First Health Services employees. The Department hired Clifton Gunderson to determine if systems security and access over the mainframe was

appropriate. The results of the review revealed some control weaknesses and recommended changes to user access to critical information. The Department is hiring a vendor to finalize all of their HIPPA compliant Information Technology Security Policies and expects to have this work completed by April 2005.

Managed Care

The Department administers three Medicaid programs: Fee-For-Service, MEDALLION, and Medallion II. MEDALLION and Medallion II are both managed care initiatives. MEDALLION uses a primary care case management (PCCM) system of care where enrollees have a primary care provider for primary medical services and is the gatekeeper to specialty services. Medallion II contracts with Managed Care Organizations (MCOs) to deliver health care services to enrollees under a capitated fee arrangement. There are currently five organizations representing seven managed care organizations that participate in the Medallion II program. They are Virginia Premier Health Plan, Sentara Family Care, UniCare Health Plan of VA, Care Net, and Anthem HealthKeepers Plus.

The Department's long term managed care program strategy is to maintain current health plan participation and health outcomes. The Department hopes to have another geographic expansion in 2005; but has not yet finalized a plan. The Department has encountered strong resistance to Managed Care in the remaining rural areas of the state and is unsure whether another expansion is possible.

Out of the 135 localities identified in Virginia, 32 localities are not in Managed Care. Managed Care is mandatory when there is more than one MCO enrolled in the area. Managed Care is mandatory for the eligible populations in the following regions: Tidewater, Central Virginia, Northern Virginia, and Roanoke. In 33 of the managed care localities with only one MCO operating, enrollees can enroll in either the MCO or the Medallion PCCM program.

Below is the recipient enrollment for the three Medicaid programs over the past two years. The table suggests that the trend towards mandatory managed care will continue to rise while fee-for-service declines.

	Fee for service	Medallion	Medallion II
Fiscal 2003	240,242	80,796	262,961
Fiscal 2004	208,622	89,469	308,024

INTERNAL CONTROL FINDINGS

Consumer Directed Personal Attendant Waiver Program

The Consumer Directed Personal Attendant (CDPAS) Waiver Program provides personal attendants to allow recipients to stay in a home environment rather than a more costly nursing home or other type of care facility. Under the program, recipients have a personal attendant assigned to them, to assist in meeting their personal needs. The recipients also participate in the hiring of attendants and providing information for their payment.

As the Federal Government has designed the program, there are some inherent high risk internal control problems. These risks include some of the following issues:

- An attendant may be a direct relative of the recipient and a resident of the recipient's home;
- Except for the recipient, the paying agency has no independent verification of the time spent by the attendant or the quality of care; and
- The recipients are spread over a wide geographical area and all monitoring depends on periodic and surprise visits by the paying agent or their designee.

The Department originally contracted with the Department of Rehabilitative Services to operate this program since they had responsibility for a similar state program. In fiscal 1999, Rehabilitative Services elected not to operate the program and the Department took over its operations.

The Department uses several contractors to assist in the operation of the program. West Virginia Medical Institute (WVMI) provides pre-authorization and utilization management services. Access Independence, a non-profit organization, physically prepares paychecks for the attendants.

After operating the program for several years and recognizing the high risk nature of the program, the Department Director asked the internal audit department to review the program's operations. In June 2004, the Internal Audit Department conducted and released its Control Self Assessment Report. The report found all of the same problems we found and other items.

The Department Director, Director of Internal Audit, and the Division Director are working together to determine the best solution to the internal control issues. All of our findings represent issues under review and considering the nature of the program, some of these problems may be difficult to address.

Improve CDPAS Payroll Database Integrity

The Department does not have adequate policies and procedures to ensure database integrity for personal attendant payroll. In our review of the Consumer-Directed Personal Attendant (CDPAS) Waiver Program, we noted multiple exceptions regarding the personal attendant payroll database.

Specifically, we noted the following:

- All users have the same access capabilities regardless of job responsibilities;

- Lack of separation of duties;

- No audit trail within the database to identify what user is performing what task;

- All control measures designed to prevent an attendant being paid in error can be overridden; and

- Timesheets identified in the review were paid without the personal attendant's signature.

The Department should develop and implement proper security policies and procedures over the CDPAS payroll database to ensure integrity of data.

Strengthen Case File Documentation

The Department's CDPAS Provider Manual states that the consumer-directed services facilitator must make in-home visits to CDPAS recipients to observe, evaluate, and document the adequacy and appropriateness of the personal attendant services. In the cases reviewed, evidence did not support determination of adequacy and appropriateness of personal attendant services. In addition, there was no evidence to indicate that the Department enforced the requirements before making payments to the provider.

The Provider Manual states that activities related to the maintenance of the home or preparation of meals should only be included on the plan of care for individuals who do not have someone available either living in the home with the individual or routinely coming in to provide assistance. In six out of the ten cases reviewed, hours for these activities were included in the plan of care even though there was an individual living in the home available to perform these activities.

Both of the situations above point out the need to enhance the documentation in the case files. The Department needs to make sure that all individuals responsible for case management understand the need and document information in the case file. This requirement is especially important if the caseworkers grant exceptions or allow recipients some flexibility in benefits received. Further, if regulation or manual policies and procedures are outdated, management should change the manual and requirements rather than allows caseworkers not to document their work.

Other Matters

Ensure Timely Credit to Medicaid program

Section 42CFR433.40 of the Code of Federal Regulations requires refunds of Federal Financial Participation (FFP) for checks remaining un-cashed beyond a period of 180 days from the issuance date. The State Medicaid agency must refund all FFP received for un-cashed checks by adjusting the applicable Quarterly Statement of Expenditures.

The Department failed to return FFP for un-cashed checks for the first three quarters of fiscal year 2004. The new MMIS system was not operating as intended; however, there were no interim procedures in place to ensure compliance. The Department is currently in the process of finalizing policies and procedures to ensure timely return of FFP for uncashed checks.

Follow policies and procedures for the processing of mental retardation waiver claims

The Department has an established written set of procedures for the manual processing of mental retardation waiver claims; however, we noted exceptions to these policies and procedures. More specifically, we noted the following problems:

- No audit trail showing verification of provider and recipient eligibility;
- No determination that claims fall within authorized cumulative claim limits; and
- Potential for duplicate claims processing both through the system and manually.

By not following the policies and procedures, the Department increases the risk of paying ineligible claims and federal questioned costs. The Department is addressing this issue and will begin claims processing through the MMIS system by the end of December 2004. We recommend that the Department perform a post-audit review of some manually processed claims.

Commonwealth of Virginia

Walter J. Kucharski, Auditor

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

November 23, 2004

The Honorable Mark R. Warner
Governor of Virginia
State Capitol
Richmond, Virginia

The Honorable Lacey E. Putney
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, 2004. We conducted our audit in accordance with Government Auditing Standards, issued by the Comptroller General of the United States.

Our audit's primary objectives were to evaluate the accuracy of recording financial transactions on the Commonwealth Accounting and Reporting System and in the Department's accounting records, review the adequacy of the Department's internal control, and test compliance with applicable laws and regulations. We also reviewed the Department's corrective actions of audit findings from prior year reports.

Our audit procedures included inquiries of appropriate personnel, inspection of documents and records, and observation of the Department's operations. We also tested transactions and performed such other auditing procedures, as we considered necessary to achieve our objectives. We reviewed the overall internal accounting controls, including controls for administering compliance with applicable laws and regulations. Our review encompassed controls over the following significant cycles, classes of transactions, and account balances:

Expenditures	Accounts Receivable
Revenues	Accounts Payable
General System Controls	

We obtained an understanding of the relevant internal control components sufficient to plan the audit. We considered materiality and control risk in determining the nature and extent of our audit procedures. We performed audit tests to determine whether the Department's controls were adequate, had been placed in operation, and were being followed. Our audit also included tests of compliance with provisions of applicable laws and regulations.

The Department's management has responsibility for establishing and maintaining internal control and complying with applicable laws and regulations. Internal control is a process designed to provide

reasonable, but not absolute, assurance regarding the reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations.

Our audit was more limited than would be necessary to provide assurance on internal control or to provide an opinion on overall compliance with laws and regulations. Because of inherent limitations in internal control, errors, irregularities, or noncompliance may nevertheless occur and not be detected. Also, projecting the evaluation of internal control to future periods is subject to the risk that the controls may become inadequate because of changes in conditions or that the effectiveness of the design and operation of controls 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 and in the Department's accounting records. The Department records its financial transactions on the cash basis of accounting, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States of America. The financial information presented in this report came directly from the Commonwealth Accounting and Reporting System and the Department's accounting records.

We noted certain matters involving internal control and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of internal control 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. The reportable conditions are described in the section titled "Internal Control Findings." We believe that the reportable conditions are not material weaknesses.

The results of our tests of compliance with applicable laws and regulations disclosed no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards.

The Department has taken adequate corrective action with respect to audit findings reported in the prior year.

This report is intended for the information and use of the Governor and General Assembly, management, and the citizens of the Commonwealth of Virginia and is a public record.

We discussed this report with management on December 14, 2004.

AUDITOR OF PUBLIC ACCOUNTS

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whb:47

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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December 14, 2004

Mr. Walter J. Kucharski
Auditor of Public Accounts
P.O. Box 1295
Richmond, Virginia 23218

Dear Mr. Kucharski:

We have reviewed your Report on Audit for the Year Ended June 30, 2004. We concur with your findings and will initiate corrective action.

If you have any questions, please do not hesitate to contact our Director of Internal Audit, Charles W. Lawver.

Sincerely,

PWFinnertyjs

Patrick W. Finnerty

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Richmond, Virginia

Patrick Finnerty, Agency Director

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