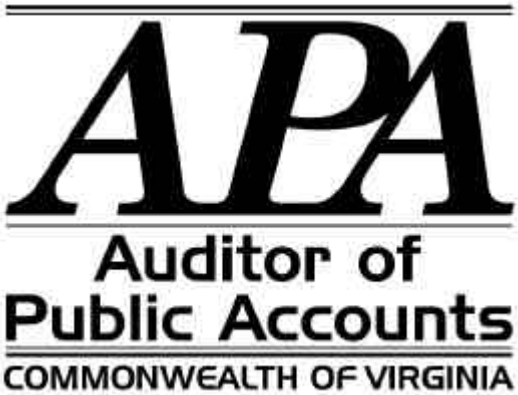
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

RICHMOND, VIRGINIA

REPORT ON AUDIT

FOR THE YEAR ENDED

JUNE 30, 2001



AUDIT SUMMARY

Our audit of the Department of Medical Assistance Services for the year ended June 30, 2001, found:

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

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

- no instance of noncompliance with the laws and regulations that are required to be reported; and

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

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AGENCY HIGHLIGHTS

Medicaid Management Information System

The Department continues its development of the Medicaid Management Information System (MMIS). In doing so, it must incorporate the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which standardizes certain electronic transactions and establishes national identifiers for providers, employers, health plans, and individuals. In addition, HIPAA establishes standards for the security of data processing systems and for privacy of individuals' health data. The Department has estimated the MMIS implementation to occur during the fourth quarter of fiscal year 2002.

Accounting System

Oracle Governmental Financials is the Department's internal financial accounting software used for reporting Medicaid information to the federal and state governments. Oracle has informed the Department that they must upgrade this software since the company does not plan to continue providing maintenance and support for the version that the Department is currently using. The Department of Information Technology conducted a study of the Department's use of Oracle Government Financials and as a result, the Department decided to upgrade the system. However, due to the time constraints that the new MMIS development has put on the information management division, the Oracle upgrade will not occur until fiscal year 2003. Vendor error correction support is scheduled to end on December 31, 2002 and extended assistance support will end on December 31, 2005.

CHILDREN'S INSURANCE (CMSIP)

Program Information

The Virginia Children's Medical Security Insurance Plan (CMSIP) is an insurance plan that provides coverage to uninsured, low-income children. CMSIP provides comprehensive health care benefits to children of working families who earn too much income to qualify for Medicaid and too little income to afford health insurance. Since approval on October 22, 1998, by the Health Care Financing Administration, CMSIP has enrolled 46,042 children.

Children under the age of 19 may be eligible for CMSIP if their families have incomes up to 185 percent of the federal poverty level. The Department of Social Services, through the local offices, determined eligibility and enrolled children who are eligible for Medicaid, as well as those who are eligible for CMSIP. At least once a year, local social workers review cases and determine continued eligibility.

CMSIP provides health care services through the Medicaid program's managed care delivery system. Managed care consists of prepaid health plans (HMOs) that manage and deliver health care for enrollees for a monthly capitation rate. The Department uses its utilization controls to monitor CMSIP.

Family Access to Medical Insurance Security

On August 1, 2001, CMSIP became the Family Access to Medical Insurance Security (FAMIS) Plan. The Department sought the General Assembly's approval to change the plan, because management believed that this would improve the public's perception and acceptance of the children's insurance program. The Department hopes to increase its enrollment of uninsured children by simplifying and accelerating the enrollment process and by providing enrollees with a larger selection of providers through private-sector health insurance programs.

Instead of providing coverage to children in families with incomes up to 185 percent of the federal poverty level, FAMIS extends coverage to children under the age of 19 in families with incomes up to 200% of the Federal Poverty Level. Children enrolled in CMSIP automatically became eligible to participate in FAMIS.

FAMIS provides comprehensive health care benefits such as well-child and preventative services; medical, dental, vision, mental health, and substance abuse services; and physical and occupational therapy, speech pathology and skilled nursing for special education purposes. The Department contracted with various health insurers, such as HMOs, preferred provider organizations, and managed care entities, to provide a comprehensive health benefits plan.

While Social Services performed the eligibility determination and enrollment functions for CMSIP, the Department has contracted with Benova, Inc. to perform these functions for FAMIS. Benova will establish a central processing site in Richmond for the receipt and review of applications and for making eligibility determinations. The central processing site will receive applications from numerous sources such as local social service departments, providers, and health plans. Applicants can apply for FAMIS by mail, telephone, facsimile, the Internet, or in person. In contrast with CMSIP requirements, applicants will not need to have a face-to-face interview or contact with an eligibility worker. Children determined to be eligible for FAMIS will have their cases maintained at the central processing site.

FAMIS requires families to assist with premium payments and co-payments. There is no co-payment requirement for well-baby, well-child, and other preventive services, including age-appropriate immunizations. The co-payment requirement will cover outpatient services, prescription drugs, inpatient services, and non-emergency use of emergency rooms. Families will contribute $15 per child each month, with a monthly maximum of $45 per family and there are no deductibles or co-insurance. Total cost sharing will not exceed five percent of the family's income.

Currently, there are 36,064 children enrolled in the FAMIS program. The rate of enrollment of eligible, uninsured children in the program has decreased over the past five quarters (see table below). If the Department expects to meet its goal of 61,500 enrolled children by September 30, 2002, it must enroll approximately 5,000 children for each of the six remaining quarters. Since the inception of the CMSIP program, quarterly enrollments have ranged from 1,577 to 5,128 children. The most successful quarters occurred during the first year of the program.

CMSIP/FAMIS Enrollment – Fiscal Years 2000 – 2001

Fiscal Year	Quarter	Date Ending	Enrollment	Increase	Percent Increase
2000	3rd	March 31, 2000	21,092	n/a	n/a
2000	4th	June 30, 2000	24,680	2,778	12.7
2001	1st	September 30, 2000	27,550	2,870	11.6
2001	2nd	December 31, 2000	29,515	1,965	7.1
2001	3rd	March 31, 2001	31,092	1,577	5.3
2001	4th	June 30, 2001	32,526	1,434	4.6

CMSIP Expenditures – Fiscal Years 1999 - 2001

Fiscal Year	Fee for Service	HMO	Administrative	CMSIP
1999	$ 3,510,541	$ 304,223	$ 200,008	$ 4,014,772
2000	16,279,066	4,899,339	1,713,750	22,892,155
2001	23,710,786	9,214,189	8,829,823	41,754,798

MEDICAID PROGRAM

Medicaid is an entitlement program that serves approximately 616,000 recipients across Virginia. Medicaid expenditures for fiscal year 2001 totaled $3,100,057,518.

The table below lists the categories of services provided to recipients and the per recipient cost for each service.

Medicaid Services Cost-Per-Person – Fiscal Years 1997 - 2001

Services	1997	1998	1999	2000	2001
Lab and x-ray services	$ 81	$ 70	$ 90	$ 93	$ 94
Family planning services summary	99	98	118	122	115
Screening services	104	92	98	101	104
Dental services	129	131	210	215	235
Other practitioner services	131	117	107	104	112
Physician services	369	384	410	431	553
Outpatient hospital services	428	453	476	495	514
Other care summary	582	619	570	667	823
Prescribed drugs	605	714	850	1,091	1,234
Home health services	1,109	1,112	1,108	1,111	1,068
Managed care programs *	-	-	1,086	1,539	1,690
Clinic services	1,492	1,805	525	643	791
Mental health facility services *	-	-	2,585	2,806	3,066
Personal care support services *	-	-	3,324	2,224	1,839
Inpatient hospital services	3,156	3,303	3,421	3,466	3,760
Nursing facility services	14,171	14,149	14,447	16,359	18,222
Home/Community-based waiver services *	-	-	23,074	24,972	27,045
Mental Retardation services	60,259	64,749	73,999	80,895	83,221

* Costs for fiscal years 1997 and 1998 not available

Health Maintenance Organizations

In order to improve the quality and access of medical care for its Medicaid recipients, the Department launched the Medallion II program on January 1, 1996. In its Medallion II program, a mandatory Health Maintenance Organization (HMO) program, the Department contracts with managed care organizations (MCOs) to provide medical services covered by Medicaid. These MCOs provide medical services within their provider network for a set capitation rate based on each recipient enrolled and pay for their own administrative costs.

Medicaid recipients in Virginia must participate in the Medallion II program unless they receive a specific exclusion. Excluded groups include recipients who are in long-term care facilities, enrolled in home and community-based waiver programs, participating in foster care, or enrolled in Medicare. Benova, Inc., a

contractor, enrolls recipients and is responsible for patient education and basic member services. Benova verifies that the recipient is eligible for HMO enrollment through Social Services.

Six managed care organization (MCO) partners serve the Medallion II program:

- Trigon Healthkeepers Plus (by Healthkeepers)
- Trigon Healthkeepers Plus (by Peninsula Health Care)
- Trigon Healthkeepers Plus (by Priority Health Care)
- Sentara Family Care
- Southern Health CareNet
- Virginia Premier

The Medallion II program originally covered Medicaid populations in the Tidewater area and then expanded into Eastern Virginia in 1997 and Central Virginia in 2000. The program currently covers 55 localities and serves 157,000 recipients.

In December 2000, the Health Care Financing Administration (HCFA) approved the Department's plan to expand the Medallion II program to additional Virginia localities. The Department has postponed the initial date of November 1, 2001, for its expansion into the following localities in Northern Virginia:

- The counties of Fauquier, Loudoun, Prince William, Arlington, and Fairfax
- The cities of Manassas, Manassas Park, Alexandria, Falls Church, and Fairfax

The Department has set December 1, 2001, for expansion of the Medallion II program. In addition to moving into Northern Virginia, the expansion will include 48 new cities and counties in the Charlottesville, Roanoke Valley, and the Central Virginia areas.

Waivers

Medicaid Waivers totaled $301,919,270 which represents approximately 9 percent of fiscal year 2001 total Medicaid expenditures. Waivers allow exceptions to state plan requirements, enabling the state flexibility to try different approaches to improve the efficiency and cost-effectiveness of the delivery of health care services.

States request waivers, which allow exemption from certain federal program requirements that they feel may hinder the development of Medicaid community-based treatment alternatives. The Department has six such Home & Community Based Services Waivers, which receive initial approval for three years and must undergo renewal every five years.

The six waiver programs include the AIDS Waiver, which provides for the care of individuals diagnosed with AIDS or AIDS-related conditions. The Elderly and/or Disabled Waiver provides care for individuals who are age 65 or older or disabled. The Consumer-Directed Attendant Services Waiver provides care for individuals who are age 65 or older or disabled and have no cognitive impairments. The Technology-Assisted Waiver provides care for individuals who need both a medical device and substantial and continuous skilled nursing care. The Mental Retardation Waiver provides care for individuals with mental retardation. The Individual and Family Developmental Disabilities Support Waiver provides care to individuals who are six years of age and older with a condition related to mental retardation, but without a diagnosis of mental retardation.

The Department assures the federal government that the cost of providing home and community-based services will not exceed the cost of providing institutional care. The state must also assure HCFA that there are safeguards to protect the health and welfare of recipients

Waiver Payments and Claims – Fiscal Years 2000 - 2001

	Payments to Providers		Number of Claims	
Waivers:	FY2000	FY2001	FY2000	FY2001
AIDS	$ 1,259,283	$ 1,936,616	12,583	16,246
Elderly and Disabled	88,627,135	90,937,204	165,107	250,271
Consumer-Directed Attendant Services	680,249	618,843	3,595	3,607
Technology Assisted	18,616,771	20,608,513	13,665	51,266
Mental Retardation	155,186,738	187,804,947	206,654	251,921
Individual/Family Development Disabilities Support *	-	3,147	-	128
TOTAL	$264,370,176	$301,919,270	401,604	573,439

* Payments and claims not applicable for fiscal year 2000.

Utilization and Review

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

- Recipient Monitoring Unit
- Recipient Audit Unit
- Provider Review Unit
- Facility and Home-Based Services Unit
- Developmental Disabilities and Behavioral Health Unit
- Waiver Services Unit

The Recipient Monitoring Unit (RMU) monitors the activities of Medicaid recipients to identify individuals who are using services at a frequency or amount that would appear medically unnecessary. RMU initially reviews all cases to analyze the recipient's claims history for a specified period to identify inappropriate utilization patterns. RMU then reviews medical records to substantiate the need for services. If the review determines the recipient's activity is abusive, the Department may restrict the recipient to one provider and track the individual's future use of medical services for three years. RMU refers cases of apparent illegal drug activity to the appropriate law enforcement agency and cases of suspected fraud to the Recipient Audit Unit.

The Recipient Audit Unit (RAU) investigates referrals of recipient 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. The RAU performs a cursory review to determine the validity of the allegation. If valid, investigators gather claims and other evidence to determine the period of the recipient's ineligibility.

If the investigator decides the recipient misunderstood or was unaware of the existence of income, RAU refers the case to the eligibility worker at the local social service office to correct the error. If the investigator decides the recipient intentionally misrepresented the information provided to eligibility workers, RAU refers the case to the Commonwealth Attorney for criminal prosecution or to the Attorney General for civil litigation. Convicted recipients have no Medicaid access for 12 months.

The Provider Review Unit (PRU) monitors the activities of service providers to identify abusive billing practices and misspent funds. Typical abusive patterns may include billing multiple service units, billing lab tests individually rather than as panels, performing procedures unrelated to diagnosis coding, and excessive orders for laboratory procedures per client. The Department bills the provider for any identified Medicaid overpayments. In the event that the PRU believes it can prove fraud, they refer the case to the Medicaid Fraud Control Unit at the Attorney General's Office.

Before enrollment, First Health's Provider Enrollment Unit manually checks providers' names, licenses, and addresses against the DHHS/OIG List of Excluded Individuals and Entities (LEIE), a nationwide database which lists over 17,000 ineligible providers. Though while the unit performs provider eligibility checks, it does not document these activities and therefore, leaves an insufficient audit trail.

The Facility and Home-Based Services Unit performs on-site reviews to ensure that providers are giving the appropriate level of authorized care. The unit reviews nursing homes and providers of home health care services, rehabilitative services, durable medical equipment, and hospice care. The concentration of the reviews may depend on complaints received by the Attorney General's office, the Medicaid Fraud Unit, or the Provider Review Unit.

The Developmental Disabilities and Behavioral Health Unit performs utilization reviews of the waivers for Mental Retardation, Individual and Families Developmental Disabilities and Support, and Mental Health SPO Services. The Unit also case manages the high cost cases for Individual and Families Developmental Disabilities and Support.

The Waiver Services Unit performs reviews to ensure that providers are complying with the terms of the Department's six waivers. Waivers allow exceptions to state plan requirements, enabling the flexibility to try different approaches to improve the efficiency and cost-effectiveness of the delivery of health care services.

Medicaid Eligibility Quality Control

The federal government requires each state to operate an approved Medicaid Eligibility Quality Control (MEQC) system. The MEQC system re-determines eligibility for Medicaid and projects the number and dollar impact of payments to ineligible recipients. The Department is participating in the MEQC Pilot project that differs from the traditional system. The MEQC Pilot provides each state an opportunity to address its unique problems. By establishing the MEQC Pilot Program, the Department reduces the risk of federal fiscal sanctions, which can occur if the state's error rate exceeds a set percentage.

The Department administers the MEQC Pilot project in conjunction with the quality control staff at Social Services. The Department selects a monthly sample for testing by Social Services' regional quality

control reviewers. Every six months, the Department prepares and submits to the federal government a detailed statewide summary report of findings and a corrective action plan.

Phase One of the pilot, which ran from April 1999 through March 2000, focused on the Commonwealth's seven most problematic Social Services localities with the objective of identifying cases in which Medicaid eligibility errors occurred. From April through September 1999, Social Services identified 114 error cases out of the 840 cases selected for review (13.8 percent). From October 1999 through March 2000, Social Services identified 43 error cases out of the 660 cases selected for review (6.5 percent).

Phase Two will review all long-term care cases for which the Department seeks to identify instances where Medicaid has overpaid or underpaid a provider for services. The Department will prepare a statewide summary report for Phase Two for the period ending in August 2001.

Administrative Costs

The administrative costs for fiscal year 2001 totaled $67,406,614. The majority of these costs paid for contractual services, data processing services and payroll expenses. The Department records all administrative costs in the Commonwealth Accounting and Reporting System (CARS) and its internal accounting system. The chart below shows the various categories of administrative expenses, but excludes the federal and state funds allocated to various state agencies that assist the Department in administering Medicaid.

Administrative Costs – Fiscal Years 1995 - 2001

Expenditures:	1997	1998	1999	2000	2001
Fringe benefits	$ 2,380,501	$ 2,513,266	$ 2,442,135	$ 2,880,161	$ 3,555,251
Salaries	10,400,930	10,508,580	9,903,661	10,956,380	12,613,582
Printing and distribution	2,972,800	2,875,954	2,728,858	2,912,107	3,409,571
Data processing	2,760,097	4,609,343	8,296,582	7,739,784	15,215,745
Medical services	1,400,593	1,640,302	1,130,493	1,694,161	1,572,175
Contracted services	9,200,991	13,609,174	18,809,403	19,772,636	17,441,368
Telecommunications	586,881	501,894	560,219	510,858	489,620
Supplies	394,257	700,782	691,359	596,351	674,645
Travel and education	236,349	233,262	175,730	255,525	272,005
Awards and claims	26,891	5,447	3,742	3,547	9,192
Insurance	39,094	35,807	43,193	73,262	18,602
Rent	1,470,482	1,476,865	1,561,044	1,431,158	1,320,401
Memberships and reference materials	53,022	39,498	57,979	77,380	58,725
Equipment and structures	33,056	70,299	18,176	290,360	370,573
Subtotal DMAS	31,955944	38,820,473	46,422,574	49,193,670	57,021,455
Interagency Transfers and other	703,647	1,387,757	1,227,491	1,151,310	327,129
Claims processing	8,723,835	9,276,487	11,743,318	9,800,474	10,058,030
Total	$41,383,426	$49,484,717	$59,393,383	$60,145,454	$67,406,614

The Department has interagency agreements with various state agencies that assist in administering Medicaid to recipients. The Department allocated a total of $43,058,549 to the Departments of Rehabilitative Services, Social Services, Health, and Mental Health, Mental Retardation, and Substance Abuse Services.

These agencies provide services such as eligibility, rehabilitative services, maternal outreach, prescreening, and teenage pregnancy programs. The following chart illustrates the amounts provided to these agencies.

Administrative Funds Provided to Other Departments

	Totals
Departments:	
Rehabilitative Services	$ 523,218
Health	1,496,339
Social Services	39,912,161
Mental Health, Mental Retardation, and Substance Abuse Services	1,126,831
Total	$43,058,549

INTERNAL CONTROL FINDINGS AND RECOMMENDATIONS

Strengthen Contract Manager Oversight

The Procurement Unit has responsibility for the purchase of goods, services, and supplies needed by the Department. This includes the administration and processing of Requests for Proposals (RFP) and the management of all contracts and interagency agreements.

Payments to contractors make up approximately 41percent of the total administrative expenses for the Department. The contracted services at the Department range from audits of Medicaid costs reports and recipient enrollment services to the implementation of the new Medicaid Management Information System (MMIS).

The Department maintains a database of all contracts and interagency agreements. The contract manager is responsible for maintaining contracts and interagency agreements and communicating changes to Internal Audit who updates the contract database. However, not all contracts are in the database because Management is executing contracts and modifications without the contract manager's review. Also, Management is not notifying the contract manager of changes, such as a newly designated contract administrator. In addition, the contract manager did not have current agreements for two of the three selected interagency agreements.

While some of the agreements are small, the Department spent over $31 million on contractual services from July 1, 2000 through February 28, 2001, which represents an increase of almost $10 million more than the previous year. Contracting initiatives and costs continue to increase and it is important that the Department maintain the contract database with all pertinent information to ensure proper management of contracts and interagency agreements.

The contract manager should review all contractual obligations before execution. In addition, management should involve the contract manager in changing existing contracts and agreements.

Implement Contract Review Recommendations

The Department has contractual obligations of over $200 million. Due to increased contracting initiatives, coupled with the amount of the Department's contracting, a comprehensive contract monitoring and administration program is important. Such a program ensures that the Department would receive the appropriate deliverables or services in accordance with terms and conditions of the final contracts and agreements.

The Department conducted a control self-assessment for the contract management business process on July 25, 2001 and September 10, 2001, and identified numerous deficiencies, many of which we identified earlier in this report. We have reviewed the draft of the Department's report and concur with the proposed recommendations in this report.

Management should develop a plan to implement these recommendations and obtain adequate resources to enhance contract administration and oversight.

Review Fiscal Agent Contract Management Oversight

The Department's contract monitor for the fiscal agent contract has not performed onsite compliance reviews since May 1999. These reviews would include audits of the contractor's claims resolution process. In addition, there was only a limited review for compliance with other contract requirements such as the timely processing of claims. During the first eight months of fiscal year 2001, the Department paid more than $11 million to the fiscal agent, which represents more than a third (37 percent) of all contractual expenses.

Since the Department has expanded the scope of the contract over the years, management should also determine if the contract administrator should expand the scope of the review to include the additional services added to the existing contract. The size and scope of this contract makes performing timely reviews essential to its oversight.

We recommend that the Department improve oversight of the fiscal agent contract and determine if the contract monitor should expand the scope of the review to include the additional services added to the existing contract.

Implement Sanctioned Medicaid Recipient Fraud Precautions

The current MMIS system lacks a program edit that would prevent recipients convicted of Medicaid fraud from reenrolling for Medicaid within the 12-month sanction period. Management has decided not to implement this edit into the current system; however, it plans to add it to the new MMIS system. The Department does have a manual procedure to contact local social services offices, who do eligibility, and request that they remove recipients from the program. Additionally, the manual process follows up to ensure that the recipient is removed from the program.

The original date set for implementation of the new MMIS system was June 30, 2001. Currently, the expected MMIS implementation is June 20, 2002, which causes the potential occurrence of sanctioned recipient fraud to continue to be a risk until the new MMIS system is implemented.

We recommend that the Department's Recipient Audit Unit begin efforts to work with the local social service agencies in identifying and properly coding sanctioned recipients to ensure that these recipients cannot re-enroll in the program during the sanctioned period. These efforts should continue until the implementation of the new MMIS system.

Commonwealth of Virginia

Walter J. Kucharski, Auditor

Auditor of Public Accounts
P.O. Box 1295
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November 1, 2001

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, 2001. We conducted our audit in accordance with Government Auditing Standards, issued by the Comptroller General of the United States.

Audit Objectives, Scope, and Methodology

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 Payable	General System Controls
Revenues	Accounts Receivable	

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 generally accepted accounting principles. 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. Reportable conditions are described in the subsection titled "Internal Control Findings And Recommendations." We believe that none of the reportable conditions is a material weakness.

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

The Department has not taken adequate corrective action with respect to the previously reported finding, "Implement Sanctioned Medicaid Recipient Fraud Precautions." Accordingly, we included this finding in the subsection entitled "Internal Control Findings and Recommendations." The Department has taken adequate corrective action with respect to audit findings reported in the prior year that are not repeated in this report.

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.

EXIT CONFERENCE

We discussed this report with management at an exit conference held on December 6, 2001.

AUDITOR OF PUBLIC ACCOUNTS

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