AUDIT SUMMARY

Our audit of the **Department of Medical Assistance Services** for the year ended June 30, 1998, found:

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

- no material weaknesses in the internal control structure 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 for the findings listed on page 2 and detailed on pages 3-17.

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SYSTEMS UPDATE

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, MMIS operations, and maintenance and modification. It also provides for operation of specified programs such as the State and Local Hospitalization, the Long-Term Care Information System, Involuntary Mental Commitments, Budget Control, the Indigent Trust Fund, and managed care. The new MMIS will have two separate and distinct system platforms operating in a mainframe environment including (1) a Health Care Transaction Processing Platform and (2) a Health Care Information Retrieval Platform. The Department plans to implement the new system in early 2000.

Year 2000 Plans

DMAS has a plan to ensure the agency has Y2K compatible and operating systems. The Department appointed a Y2K project coordinator to develop a plan to identify and address critical business systems. The project coordinator has estimated costs to address Y2K corrections will total $4.2 million and identifies MMIS as DMAS' most critical system.

DMAS addressed Y2K compatibility for critical in-house systems by making program changes or upgrading software and had a contractor test the systems to ensure their Y2K compatibility. DMAS also developed a work-plan to address the agency's external interfaces with other entities. This work-plan identifies critical interfaces, assesses Y2K readiness, and identifies outside sources that are not Y2K compliant. The Department has developed contingency procedures to handle data exchange through these interfaces including the transfer of eligibility data with the Department of Social Services, payment of providers through the Department of Treasury, and exchange of data with the federal government.

DMAS is working with First Health to address Y2K compatibility for the current MMIS since the new system will be unavailable. First Health developed a detailed plan to make the current system Y2K compliant and began work in July 1998. First Health estimates completion of work by early April 1999 with full operational readiness by June 1, 1999. The Department is closely monitoring these efforts to ensure the works completion on schedule with proper testing. Again, for added assurance, the Department also plans to employ a contractor to monitor First Health's Y2K progress. The Department has developed contingency plans to ensure claims payment if First Health does not finish changes to MMIS on schedule and the system is not Y2K compliant.

Information Security

We noted the following security issues over the existing MMIS system. These issues are prior year audit findings.

Findings and Recommendations

Improve Medicaid Information Security Administration

Repeated findings in prior years indicated weaknesses in security controls. These weaknesses allowed one individual to have inappropriate update access to MMIS Geographic Fee File. The individual, assigned to cluster VAGRP72, has update capabilities to the VO2C screen, which updates National Drug Codes. Updates or changes to drug procedure codes is the most prevalent change made to the GEOFEE files.

The individual had this access in the prior year to help with a division backlog. In fiscal year 1998, the individual retained this capability however there was no indication of a division backlog. Inappropriate access is a result of the lack of review of user access. The Department continues exposing Medicaid data by allowing employees to maintain access that does not relate to their job duties.

RECOMMENDATION

DMAS should 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 responsibilities change.

The Department took considerable action to address security issues since our last review. This includes instituting a Security Committee to address issues involving security. Although the Committee identified a number of security control measures, there is no indication that these controls effected the current's year activities and security administration remains a problem.

Strengthen File Change Process

DMAS does not have specific processes to change drug procedure codes in the GEOFEE. Additionally, no one reviews such changes for accuracy, nor retains documentation for requested changes. Updates and changes to drug procedure codes are the most frequent changes made to GEOFEE.

GEOFEE contain the maximum fees and prices for individual procedure codes for each invoice type. Additionally, it provides information for the MMIS to automatically price invoices and check fee-for-service providers' service limitations.

The lack of specific procedures to change drug codes places DMAS at an unnecessary risk of making improper and inaccurate payments. During fiscal year 1998, DMAS paid over $220 million for drugs; almost ten percent of total Medicaid dollars. DMAS management can not rely on the surveillance and utilization system to identify and detect such errors without accurate drug procedure codes. Any change to the GEOFEE generates an *Online GEOFEE File Audit Trail* report that shows the record key, date, operator, and before and after fields. Some personnel receive the reports from the fiscal agent for review and verification. However, personnel responsible for changing drug procedure codes, do not receive this report.

Since our last review, the Department began reviewing a sample of the fiscal agent National Drug Code updates on a monthly basis, however, there is no review of changes made by the Department's pharmacy staff.

RECOMMENDATION

The Department should strengthen its file change and review process for drug procedure codes to minimize the risks of making improper Medicaid payments.

AGENCY HIGHLIGHTS

DMAS administers the Commonwealth's indigent health care financing programs, including Medicaid, State and Local Hospitalization, the Indigent Health Care Trust Fund, and the Involuntary Mental Commitments. Our report focuses on Medicaid, which makes up 96 percent of the Department's operating budget. In the sections below, we will describe the Medicaid process including procedures for determining recipients eligible, enrolling providers, and paying providers as well as internal controls to ensure payments are for covered and necessary services.

MEDICAID PROGRAM

Medicaid is an entitlement program that pays for necessary medical services provided to low income persons who are age 65 or over, blind, disabled, members of families with dependent children, qualified pregnant women, or children. The program receives joint funding from the Federal government and the Commonwealth. The Commonwealth must provide coverage to all individuals who apply for and meet specific Medicaid eligibility criteria. The Commonwealth operates under a federally approved State Plan for Medical Assistance administered by DMAS. The plan specifies covered services, eligibility requirements, payment procedures and rate setting methodologies. Medicaid operates as a vendor payment program with DMAS directly paying enrolled medical providers based on claims submitted for services rendered to eligible recipients. Medical providers must accept the Medicaid reimbursement level as payment in full.

Types of Services Covered

The Medicaid program covers medically necessary services rendered to eligible recipients using the State Plan for Medical Assistance. DMAS reimburses for services including physician visits, hospital care, nursing home care, home health rehabilitation, personal care, dental services, prescribed drugs, durable medical equipment, and transportation services. The state plan does not allow DMAS to cover services the plan does not consider medically necessary or reasonable such as experimental medical procedures, cosmetic surgery, and acupuncture.

Expenditures by Provider Type

	1998 (in millions)	1997 (in millions)	1996 (in millions)	1995 (in millions)	1994 (in millions)
Medicaid:					
Medicaid claim payments:					
Inpatient hospital	$ 490.9	$ 487.2	$ 488.5	$ 533.4	$ 459.3
Nursing facility	409.9	397.7	393.4	387.3	375.8
Physician	175.8	176.9	182.6	217.5	204.4
Outpatient hospital	110.3	107.5	107.8	122.3	116.1
Prescribed drugs (net of rebates)	220.0	201.3	178.1	179.1	141.6
Transportation	43.2	35.5	32.9	30.9	24.5
Other care services	126.6	126.2	119.1	122.6	100.3
Mental health services	386.6	344.7	351.8	307.4	279.7
Other long-term care	113.1	112.1	96.7	82.1	69.1
Total claim payments	2,076.4	1,989.1	1,950.9	1,982.6	1,770.8
HMO fees	191.7	193.2	146.7	16.3	-
Medicare insurance premiums	72.1	71.4	69.3	59.2	55.9
Administration	49.4	41.3	36.7	45.4	39.4
Other Medicaid payments	313.2	305.9	252.7	120.9	95.3
Total Medicaid payments	$ 2,389.6	$ 2,295.0	$ 2,203.6	$ 2,103.5	$ 1,866.1

Source: 1998 Virginia Medicaid Statistical Record CARS 1499 Report

Eligibility

The Department of Social Services (DSS) determines recipient eligibility for Medicaid benefits at its local social service agencies. Income and resources are recipient's primary consideration for eligibility. The Commonwealth must provide services to mandatory categorically needy and other required special groups including individuals receiving Aid to Families with Dependent Children (AFDC), Temporary Assistance for Needy Families (TANF), or Supplemental Security Income (SSI). Although new federal welfare reform law eliminates entitlement to welfare; children and parents who meet the State's old AFDC income requirements in place before the new law remain eligible for Medicaid even if they do not qualify under the new TANF requirements. DSS issues all recipient numbers and has responsibility for maintaining and controlling the recipient database.

DSS also administers a federally mandated quality control function over Medicaid eligibility determination. DMAS develops the sampling plan and DSS performs the quality control reviews of recipient cases to determine whether local eligibility workers are determining Medicaid eligibility in compliance with the requirements. We review and address the internal controls over Medicaid eligibility and the quality control function in our DSS audit report.

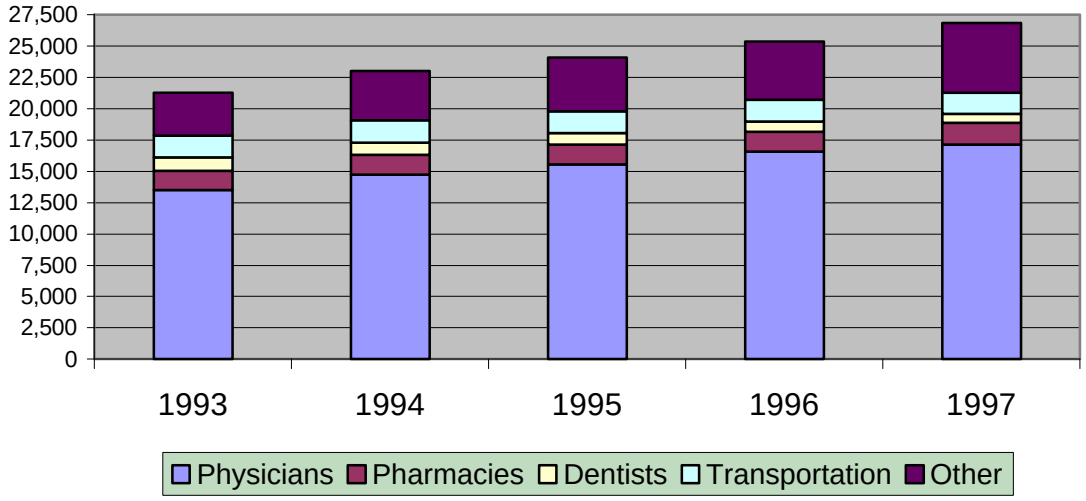
Provider Enrollment and Certification

DMAS contracts with First Health Services for enrolling providers into the Medicaid program. First Health's Provider Enrollment Unit enrolls providers and maintains the provider database in Medicaid Management Information System (MMIS). The Unit requires medical service providers sign a participation agreement and submit proof of licensure. For physicians and pharmacies, Provider Enrollment verifies the provider has an active and valid license through access to the Department of Health Professions. The Unit also verifies certification of nursing facilities with the Department of Health's Division of Licensure and Certification. The length of a provider's enrollment period depends on the type of provider.

All providers must re-certify at the end of their enrollment period by signing a new participation agreement. DMAS ends provider eligibility at the end of the enrollment period if they fail to re-certify and MMIS denies all payments to non-enrolled providers.

The Provider Enrollment Unit also reviews to ensure providers have not lost their license during their enrollment period. The Unit receives reports of sanctioned providers from U.S. Department of Health and Human Services, Virginia Departments of Health Professions and various medical boards. The Unit cancels provider eligibility as of the effective date of the sanction. DMAS' Division of Financial Operations initiates recovery of payments for services administered after the provider's termination from the program. Sanctioned providers may re-apply for inclusion in the Medicaid program after meeting their sanction.

ENROLLED MEDICAID PROVIDERS



Source: 1998 Virginia Medicaid Statistical Record. (1998 totals not available at time of audit.)

Payment for Services

During fiscal 1998, DMAS reimbursed medical service using the following three methodologies.

Fee for service - pays providers for each service based on a predetermined reimbursement rate. Providers receiving this type of payment include physicians, dentists, home health providers, laboratories, pharmacies, and transportation.

Per Diem\Cost Settlement – pays providers a per diem for services provided during the year. After year-end, DMAS and the provider negotiate a cost settlement considering the difference between actual costs of services and the amount reimbursed during the year. Providers receiving these include hospitals, nursing homes, rural health clinics, and federally qualified health clinics.

Capitated Rate - Managed Care Organizations receive a capped monthly rate for each enrolled recipient and agree to provide all health services for these recipients.

Providers subject to fee for service and per diem payment methods submit Medicaid claims to receive payment while managed care organizations bill monthly based on the number of enrolled recipients. Below, we describe DMAS procedures for processing Medicaid claims, negotiating cost settlements, and administering managed care programs.

Medicaid Claims Processing

DMAS contracts with First Health Services to process Medicaid claims and disburse funds to service providers. First Health enters claims received into the MMIS where the claims undergo a series of computer edits. The Department and First Health designed these edits to review claims for validity and approval by determining if the service falls within the criteria of the State Plan. These edits range from basic to complex depending on the type of service and provider. The system applies basic edits to all claims to verify the enrollment of the recipient and provider.

MMIS also subjects claims for each provider type to advanced edits that analyze claims data as well as recipient and provider historical data. These edits use recipient and provider background information to review for duplicate payments, determine validity of combined medical procedures, and determine reasonableness of services using available information. MMIS uses these computer edits to approve, reject, or hold the claim.

The system automatically pays approved claims and returns to the provider rejected claims with a reason for denial. The system refers held or pended claims to First Health or DMAS employees for manual review described later.

Our review found the system had appropriate edits with the exception of transportation claims. As noted in prior audits, the MMIS does not have edits to review arrival, departure, and wait times along with service date and mileage to identify questionable transportation claims. Although the information is available, MMIS does not record this data. Previous audits have included findings and questioned costs resulting from registered drivers and taxi providers overstating mileage, submitting duplicate and conflicting claims, not completing verification forms, recording unreasonable wait times and submitting split billings. DMAS has requested that First Health include additional edits to check this information, however, the First Health has not made the programming changes. In September 1998, DMAS began holding taxi claims exceeding 200 miles for further review before payment.

RECOMMENDATION

DMAS should improve controls in MMIS by developing adequate prepayment review procedures for registered driver and taxi provider claims. DMAS should work with First Health to expedite the programming changes to have sufficient claims processing edits for transportation providers.

Pended Claims Processing

First Health's Pend Resolution Unit initially receives all held or pended claims and generally resolves most of these claims for further processing. MMIS computer edits will "pend" many claims because of insufficient information. The Pend Resolution Unit resolves these claims manually by reviewing documentation submitted with the claim to locate missing information and resubmits the claim for payment processing.

DMAS also programs the system to automatically pend claims for specific services so its employees can manually review the claim. These "pend" claims include major medical procedures that require pre-authorization, weekend hospital admissions, and emergency room services. First Health forwards these claims to DMAS' Payment Processing Unit or to other applicable specialized areas within DMAS for resolution.

DMAS' Payment Processing Unit reviews claims against state plan requirements or established criteria to determine medical justification for the services. Unit technicians resolve pended claims by performing the following procedures.

- Review inpatient hospital stays to determine medical necessity and the reasonableness of the length of stay.
- Review emergency service claims to determine if the conditions meet the criteria of an emergency and if the emergency room was the appropriate place for treatment.
- Review claims for surgical procedures requiring additional authorization to determine he claim includes the appropriate medical documentation.

Based on the reviews, technicians may approve the claim as submitted, approve the claim with an adjusted payment amount determined appropriate for the services, or reject the claim.

Claim technicians at First Health and DMAS resolve pended claims by using technician codes to override system edits in MMIS that caused the claim to pend. Under this process, technicians can approve payment for claims by overriding edits that rejected payment. The Department assigns technician codes to all personnel with access to the MMIS resolution screens. These codes are the only control to identify individuals resolving claims.

As noted in the prior audit, the Department does not maintain adequate security to prevent unauthorized use of technician codes. The codes are not machine address or employee specific and do not have password protection. Additionally, we found that a number of individuals know the codes and anyone processing claims can readily see the codes. Finally, 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

The Department should implement security controls over technician codes to ensure accountability of all pend resolutions.

Cost Settlement

The Department has historically paid certain medical institutions such as nursing homes, hospitals, home health agencies, and rehabilitation agencies per-diem payments, which the Department calculates using annual cost reports. The Cost Report is the provider's annual report of its financial status and the level of its Medicaid activities.

Effective January 1, 1998, the Department's Cost Settlement and Audit Unit outsourced the review and settlement process to the same contractor who had been conducting cost report field audits. The contractor will review and audit cost reports for allowability of costs and set new prospective payment rate.

Monthly, DMAS reviews the contractor's progress on cost settlement through status reports and verification of projected versus actual work performed. The monthly reports provide the reviewer information by individual analyst and show which providers the contractor plans to settle during the next six months versus projected settlement levels.

The Department does not have a mechanism in place to ensure that all enrolled providers are submitting cost reports to the contractor. The Department's Provider Enrollment Division notifies the contractor of any additions or deletions to the enrolled list. However, the Department does not have procedures in place to update this information in the contractor's database and must rely on information from the contractor when performing monthly reviews.

RECOMMENDATION

The Department should assign the monitoring responsibilities to an agency employee. This employee should monitor the progress and completion of work and ensure that all provider cost reports are settled. The Department advertised to fulfill such a position on September 20, 1998.

Conversion To DRG Payments

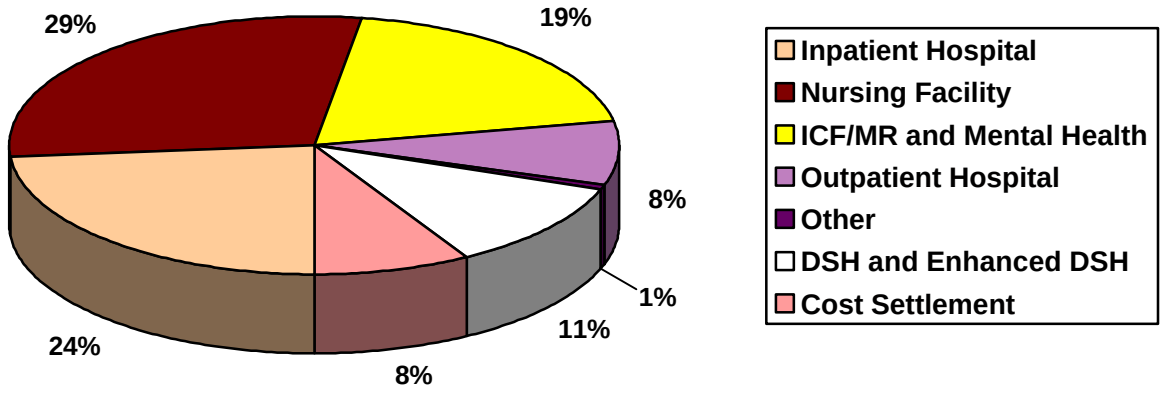
The Virginia Hospital Association (VHA) sued using the Social Security Act to allege that Medicaid's inpatient hospital payments were inadequate. DMAS settled out-of-court in December 1990. The settlement required that VHA and DMAS cooperatively develop a new payment system to be effective July 1, 1996. The Department adopted the Diagnosis Related Group (DRG) payment methodology and elected a two-year transition period, fiscal 1997 and 1998, from the old per diem methodology to DRGs. The DRG methodology provides consistency with Medicare claims already filed under the DRG methodology and eliminates the labor-intensive process of settling cost reports on a retrospective methodology. The Department expects it will convert all cost report provider payments to the DRG payment methodology by 2002, thus ending the need for the cost settlement function.

The Department had planned to begin paying hospitals using the DRG payments during fiscal 1997 and 1998. However, the failure of the EDS contract in April 1997 left the Department without the claims system capable of capturing DRG information and making payments. Because the Department could not capture and submit DRG claims data to approximately 100 providers, these providers could not submit cost reports to settle fiscal years 1996 and 1997.

After the EDS failure, the Department awarded a contract to First Health in October 1997 to develop the claims system on the old MMIS. Late July 1998, the Department submitted claims data to the hospitals and expects to begin settling the backlog of cost reports as early as October 1998 with the majority of the reports in January 1999. The Department also plans to implement the new claims system by January 1, 2000.

As seen below, cost settlement payments amounted to $113 million or 8% of the total amount paid under Medicaid. The Department also estimated cost settlement accruals based on outstanding cost settlements related to the switch from per diems to DRGs to be approximately $36.2 million.

1998 Cost Report Provider Payments (in millions)



Disproportionate Share

Hospitals that have a disproportionately higher level of Medicaid patients receive a special disproportionate share payment. This special payment considers the type of hospital and the utilization hospital's resources by Medicaid patients. Regular DSH payments amounted to $49 million in fiscal year 1998. State teaching hospitals receive an additional ***enhanced DSH*** payment, which totals approximately $70 million to the Medical College of Virginia and $35 million for the University of Virginia.

Managed Care

Enrolling Medicaid recipients into a managed care program continues as a Department priority. Managed care programs include of 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 a health maintenance organization (HMO) or a primary care provider (PCP). Virginia's three managed care programs include MEDALLION I, OPTIONS, and MEDALLION II. Medicaid recipients, not eligible for managed care, include the long-term care, waivered programs, dual eligible, foster children, certain aliens and refugees, and third party insured.

- **MEDALLION I** is Virginia's primary care case management program. The primary care provider (PCP) acts as a gatekeeper to either provide care or make the necessary referrals to coordinate care. Primary care providers may be general practitioners, pediatricians, gynecologists, or specialized clinics and receive payment according to traditional fee-for-service rates. The MEDALLION I program operates statewide and as of July 1998, included over 195,000 recipients.

- **OPTIONS** is Virginia's voluntary HMO program that allows Medicaid recipients to choose a health maintenance organization instead of a PCP. The program targets Richmond and enrolls TANF and Aged, Blind, and Disabled (ABD) persons. As of July 1998, the program enrolled 13,700 recipients. The Department paid $34 million to the HMOs in fiscal year 1998.

- **MEDALLION II** is Virginia's mandatory HMO program and began January 1, 1996 in the Tidewater communities. All recipients must select or receive assignment to one of four HMOs. As of July 1998, MEDALLION II included over 89,700 recipients. The Department paid $151.5 million in HMO payments in 1998.

Contracting

The Department uses a competitive procurement process when contracting with Medallion II HMOs and requires *all* HMOs to submit information related to administration, provider access, solvency, quality, member services, medical management and knowledge of Medicaid before selection.

The Options program differs from Medallion II in that all HMOs wishing to join the program must also submit an application. The Department's Operations Divisions evaluates each application for contract compliance before allowing an HMO to join the Options program.

Enrollment

The Department contracted with Benova, at an annual cost of $1,251,285, effective through July 2000. Benova, an independent enrollment broker, ensures Medicaid recipients receive sufficient information and education about the programs and enrolls clients with the most appropriate HMO or primary care provider. As an enrollment broker using the Department's guidelines, Benova secures and records enrollment choices, transfers and disenrolls individuals under the guidance of the Department.

Benova determines eligibility through the current Medicaid Management Information System. Monthly, the system generates a payment report that lists only those enrollees eligible by demographic information to ensure the correct payment rate for each recipient. First Health Services makes a monthly payment to the HMOs based on this report.

The Medicaid Management Information System also contains edit checks that serve as a control to prohibit payments to more than one HMO for the same recipient.

Quality Assurance and Monitoring

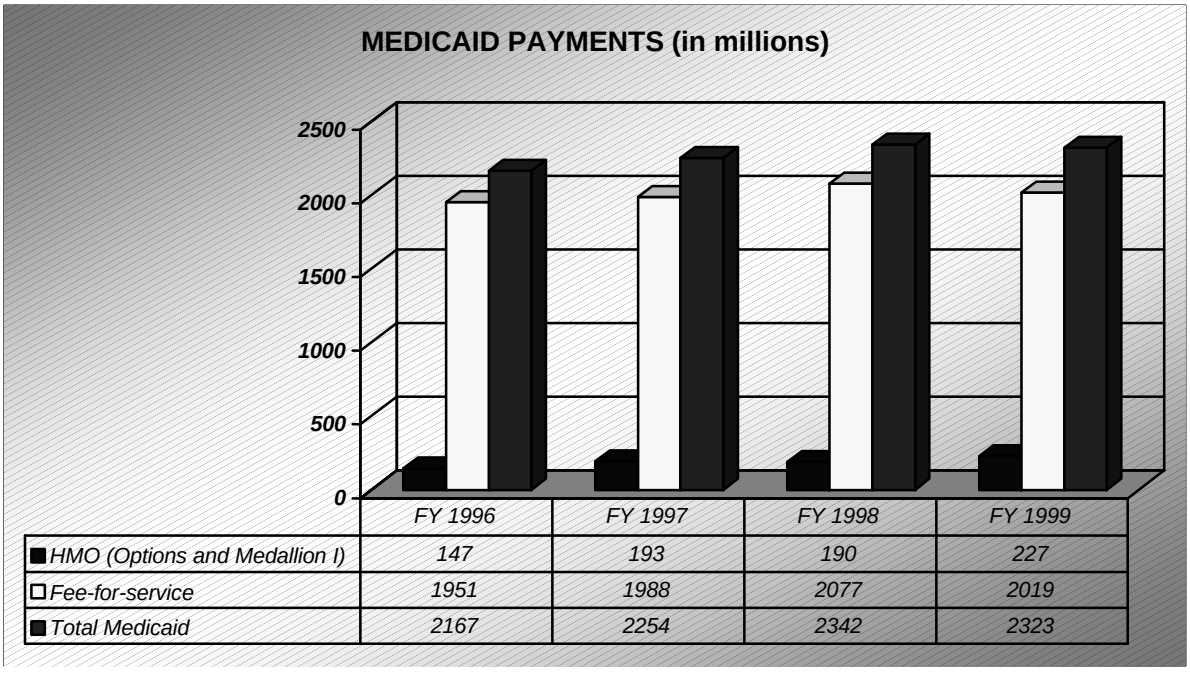
In November 1997, the Department entered a one-year contract with Keystone Peer Review Organization, at a cost of $445,983 to conduct medical reviews of sentinel events, validate encounter data, survey disenrolling clients, and conduct specific health care studies. The Department also has a quality assessment and improvement project contract with the Williamson Institute of VCU that continued during the year at a cost of $195,632. This project seeks to develop and pilot a quality assessment and improvement program that will improve the quality of healthcare for Medicaid managed care recipients.

The Annual 1997 Independent Assessment of Medallion II, also performed by the Williamson Institute, indicated general consensus among nearly all observers that the Medallion II implementation has gone much more smoothly than expected. Provider networks of participating health plans were inclusive and virtually all Medallion I primary care physicians were able to participate in one or more plans. The Institute also commented that DMAS needs to promote a long-term partnership relation with health plans.

As part of efforts to improve managed care policy and administration, the Department analyzes monthly enrollment and complaint reports submitted by Benova and meets quarterly with the HMOs at which time they address delivery and care of services. The Department also contracted with Birch and Davis to provide technical and managerial support. The contractor provides contract monitoring, financial operations, preparation of waivers; regulations and contract renewals, analysis of encounter data, and investigation of recipient complaints.

Managed Care Payments

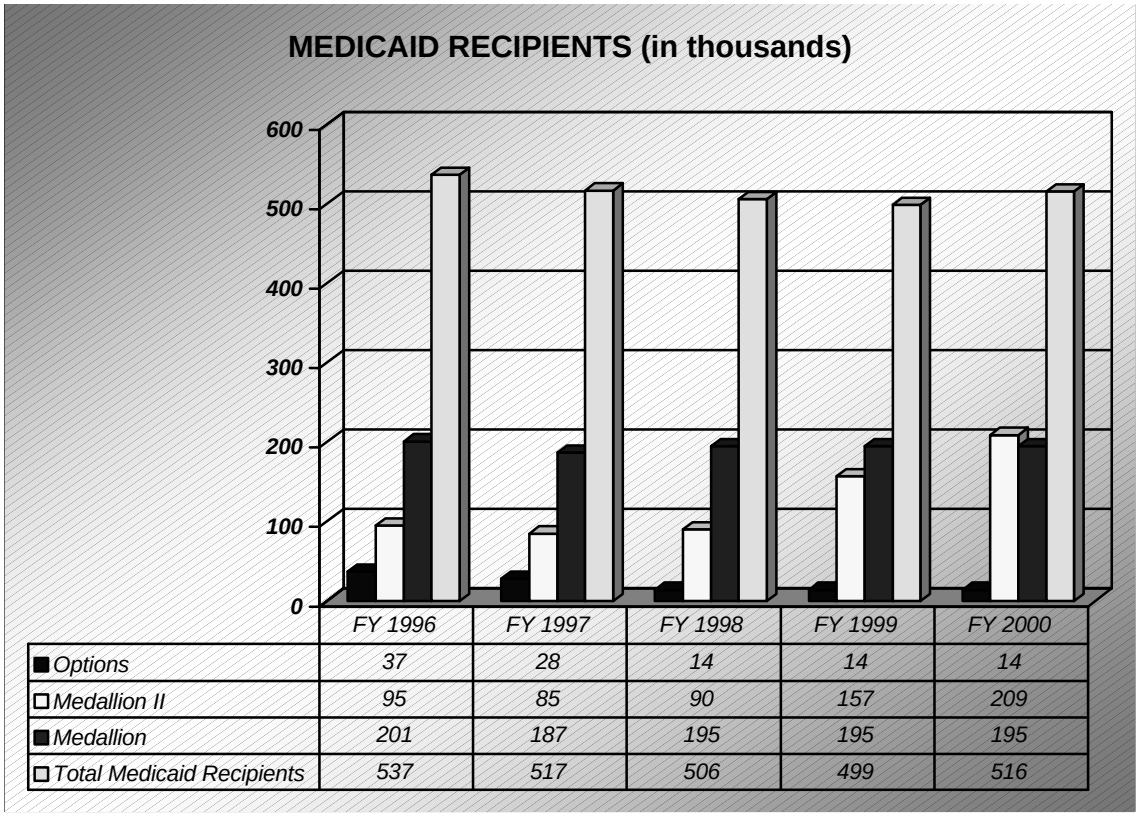
When compared to total Medicaid dollars, HMO capitated payments make up a small portion while fee-for-service still makes up the majority of Medicaid expenditures.



	FY 1996	FY 1997	FY 1998	FY 1999
HMO (Options and Medallion I)	147	193	190	227
Fee-for-service	1951	1988	2077	2019
Total Medicaid	2167	2254	2342	2323

Source: Expenditures Data from Individual Forecasts (1999)
Source: 1998 Virginia Medicaid Statistical Record (Annual Expenditures for Medical Services by HCFA Category and State Object Code 8-11) ** Does not include Administrative Expenditures

The chart below indicates the Department expects enrollment in Medallion II to increase approximately 74% FY 99 and 33% in FY 2000. This estimation is due to expansion of the program into the Richmond area in April 1999.



	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000
Options	37	28	14	14	14
Medallion II	95	85	90	157	209
Medallion	201	187	195	195	195
Total Medicaid Recipients	537	517	506	499	516

Source: 1998 Virginia Medicaid Statistical Record (Beneficiaries Enrolled in Medicaid Managed Care)
Source: Medicaid Program Budget Report and Projected Enrollment in Medicaid Managed Care (1999 and 2000)

Potential Future Changes In Medicaid Managed Care

In fiscal 1998, the Department attempted to expand its Medallion II program into the Northern Virginia area; however, these attempts were unsuccessful due to an inadequate number of offers. In the future, the Department will continue its efforts to expand managed care

Richmond is the next area scheduled for Medallion II expansion. The Department issued a request for proposal and responses are due October 1998. Existing Medallion II contracts require the Department to re-procure the Tidewater area in May 1999. At this time, the Department is considering ways to procure these services. However, the Department has not evaluated whether problems encountered in the Northern Virginia area will occur on a statewide level. Multiple year rates are also a future consideration when contracting. This concept provides stability to HMOs because rates are "locked–in" giving the HMOs a guaranteed minimum amount.

Beginning its third year of Medicaid Managed Care, the Department is closely monitoring capitated rates and expects most HMOs already within the program will remain and a few new ones will join. The Department's monitoring includes HMO cost and the service and financial activities of its participating HMOs.

Post-Payment Review Of Medicaid Providers And Recipients

DMAS has control measures to review Medicaid claims after payment to determine proper recipient and provider utilization and to detect fraud. The Provider Review Unit primarily monitors providers and the Recipient Monitoring Unit and Recipient Audit Unit review recipients. Other DMAS units perform additional reviews of certain types of providers.

DMAS uses the Surveillance Utilization Review System (SURS) to analyze Medicaid claims data quarterly and report on providers and recipients usage. SURS computes normal utilization levels for multiple criteria established for each provider and recipient category. DMAS establishes the criteria, such as number of times provider does a specific procedure or the number of recipient after hours office visits, using historical data and trends. SURS then analyzes individual provider and recipient totals for each criterion and registers an exception for any totals outside the computed normal parameters. After completing the analysis above, DMAS generates quarterly SURS reports ranking providers and recipients based on the number of exceptions. The review units use these reports to identify providers for audit.

Review of Medicaid Providers

The Provider Review Unit (PRU) reviews providers for frequency and appropriateness of medical care to determine validity of Medicaid claims. The Unit focuses primarily on fee for service providers and hospitals, selecting providers for review from the SURS ranking reports and complaints against providers.

PRU receives complaints against providers from help line calls, other providers, local DSS employees, and medical service confirmations returned by recipients. The unit does not track receipt or disposition of complaints, instead relying on informal procedures to review complaints and determine the need for follow-up. Because the PRU keeps no formal documentation, the unit cannot track the disposition of complaints to determine their resolution. DMAS is developing an Oracle application to track provider case reviews and plans to use this system to track complaints.

RECOMMENDATION

The Department should develop formal procedures to track receipt and disposition of complaints against Medicaid providers. The Department should complete development of the automated tracking system and use the application to record receipt and disposition of complaints against providers

Once PRU select a provider for review, the unit initially performs a desk audit using a limited sample of claims to detect inappropriate utilization or billings. If this process shows significant problems, PRU may open a full audit investigation. If PRU has findings, the reviewer issues an education letter addressing findings and corrective action and DMAS bills the provider for any Medicaid overpayments identified. During Fiscal 1998, DMAS identified approximately $2.7 Million in Medicaid overpayments.

PRU did not review any hospitals in fiscal 1998 because Virginia hospitals were the subject of a special audit by the United States Attorney's Office. DMAS has received approximately $400,000 in Medicaid overpayment recoveries from this audit. PRU plans to resume reviewing hospitals in fiscal 1999 and will have more detailed utilization data available for analysis with the conversion of hospitals from per diem to the Diagnosis Related Group (DRG) billing method. DMAS will be able to use SURS to analyze utilization trends for hospitals as it currently analyzes fee for service providers.

DMAS relies on other units to review nursing home and home health providers. The Cost Settlement Audit Unit reviews nursing home billing during the cost settlement process. The Long-term Care Unit reviews nursing homes to ensure recipients actually receive services and actually need services provided. The Department's Utilization Quality Management Unit reviews home health providers for compliance with federal requirements and appropriate billing of services.

Provider Fraud

PRU and other DMAS review units perform administrative reviews to identify improper utilization and billing but they do not perform fraud investigations. Although these units do not attempt to establish the existence of fraudulent activity, they do look for evidence that the provider may have intentionally defrauded the program. If a reviewer suspects fraud, DMAS refers the case to the Medicaid Fraud Control Unit at the Attorney General's Office. This Unit conducts investigations and gathers evidence to establish the existence of fraud. If this Unit discovers fraudulent activity, the Unit administers the case to prosecute the provider. DMAS cancels the enrollment of convicted providers as of their date of conviction. The Department referred twelve provider cases to the Medicaid Fraud Control Unit during fiscal 1998.

Review of Medicaid Recipients

Recipient Monitoring Unit

The Department's Recipient Monitoring Unit (RMU) reviews utilization of medical services by recipients to determine improper usage and abuse. RMU selects recipients for review using the SURS ranking reports and referrals received from other DMAS units. Analysts review SURS claims history reports detailing the recipient's type and frequency of services. Upon suspicion of inappropriate utilization patterns, the analyst may request medical records from providers to substantiate the recipient's abusive behavior. Typical findings include recipients consistently visiting multiple doctors for the same problem, visiting emergency rooms for non-emergency problems, or obtaining prescriptions at multiple pharmacies.

Some recipients are not necessarily intentional abusers but they are not using the program properly. The analyst can either send the recipient an educational letter explaining program rules or places the recipient in the Client Medical Management program. Analysts refer cases of suspected fraud to the Recipient Audit Unit.

Client Medical Management is a managed care program that requires the recipient to receive Medicaid services from one designated physician and pharmacist for three years. The recipient must obtain written referral from the primary physician to obtain services from other physicians. RMU analysts monitor the activity of recipients in the program monthly to gauge behavior and determine if the recipient should continue in the program at the end of the restriction period. The Department also enrolls mentally disabled recipients in Client Medical Management to provide the structure needed to manage their health care.

Recipient Audit Unit

The Recipient Audit Unit (RAU) investigates allegations of recipient eligibility fraud or abuse. The Unit receives most allegations from local social service agencies but also receives referrals from local health departments, law enforcement agencies, Medicare, family members, and other DMAS units. Investigators review eligibility records, financial statements, medical records and court documents to obtain evidence for criminal convictions, sanction from the program, and repayment for inappropriate services.

If the unit discovers fraud, it generally completes the investigation and refers the case to the applicable local Commonwealth's Attorney for prosecution. Fraudulent cases typically involve recipients who lied about their financial status to receive Medicaid assistance, didn't inform DSS of a change in financial status, or shared a Medicaid card with another person. DSS cancels eligibility for any recipient convicted of fraud and the recipient can not reapply for benefits for one year after the conviction date.

During fiscal 1998, the Recipient Audit Unit completed investigations for only 51 of 276 allegations against Medicaid recipients. The Unit attributes investigation delays to inadequate staffing caused by turnover and inability to recruit new staff. The unit has only one auditor. The Unit's failure to investigate complaints timely results in untimely identification and collection of Medicaid overpayments as well as potentially allowing ineligible recipients to continue to receive benefits.

RECOMMENDATION

The Recipient Audit Unit should 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.

Collection From Third Parties

Medicaid is the "payer of last resort" meaning that a recipient must exhaust all other resources before DMAS will make a payment. Third party liability (TPL) occurs when Medicaid pays for charges, when a recipient had others resource such insurance that could have paid a portion of the bill. The two components of the Third Party Liability sections are the Health Insurance Unit and the Casualty Unit.

Health Insurance Unit typically tries to obtain recoveries from Medicare, the recipient, estates, pharmacy, absent parents, and other insurers. The Casualty Unit deals with court proceedings for accident settlements, Workman's Compensation, assault restitution, and malpractice. In all cases, DMAS identifies the amount of the recovery and then bills the liable party.

Before the development of the Third Party Liability Recovery System (TPLRS), DMAS staff manually identified and billed all parties. The process was very inefficient and time consuming. Therefore, First Health developed the TPLRS to interact with the MMIS and an internal database daily. TPLRS' provides DMAS with automated third party identification and billing capabilities and generalized accounting functions.

NEW PROGRAMS

Comprehensive Services Act

The CSA (Comprehensive Services Act) requires the Department to reimburse therapeutic treatment foster care and residential treatment as a service under EPSDT (Early and Periodic Screening, Diagnosis and Treatment). The Department will begin to reimburse for therapeutic foster care and residential treatment in psychiatric facilities by January 1, 1999 and January 1, 2000 respectively.

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 EPSDT services.

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

Children's Medical Security Insurance Plan

The Commonwealth's new Children's Medical Security Insurance Plan, a program separate from Medicaid, expands child health assistance to uninsured, low-income children. The new program provides the Department with a greater flexibility within the broad parameters established in the federal legislation, including the capability of capping enrollment or targeting enrollment to specific groups.

The program requires the Federal government to pay approximately 2/3 of the program's cost ($63 million for 1998–2001). The Department will fund the remainder of the program through state special and general funds totaling approximately $7.5 million and $13 million through the year 2110 respectively.

OTHER COMPLIANCE ISSUE

Submit Federal Reports

The Department did not submit federal reports required for the Intensive Assisted Living Waiver for 1997. Agency officials did not submit the reports because necessary claims data could not be extracted from MMIS.

42 CFR 441.302 (h) requires that annually the state provide information on the cost of services provided. The cost data collected should demonstrate that average per capita costs of an individual in the waiver is less than or equal to the costs that would have been incurred had the individual received care in a hospital, nursing facility, or intermediate care facility.

RECOMMENDATION

The Department should develop MMIS programs to collect claims data related to the Intensive Assisted Living Waiver and submit required federal reports.

December 10, 1998

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, 1998. We conducted our audit in accordance with generally accepted government auditing standards. 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 control structure 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 an internal control structure and complying with applicable laws and regulations. The objectives of an internal control structure 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 the internal control structure or on overall compliance with laws and regulations. Because of inherent limitations in any internal control structure, errors, irregularities, or noncompliance may nevertheless occur and not be detected. Also, projecting the evaluation of the internal control structure 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 the internal control structure 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 the internal control structure 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
- Strengthen File Change Process
- Establish Controls Over Transportation Providers
- Develop Procedures to Monitor Tech 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 10, 1998.

AUDITOR OF PUBLIC ACCOUNTS

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jld:40