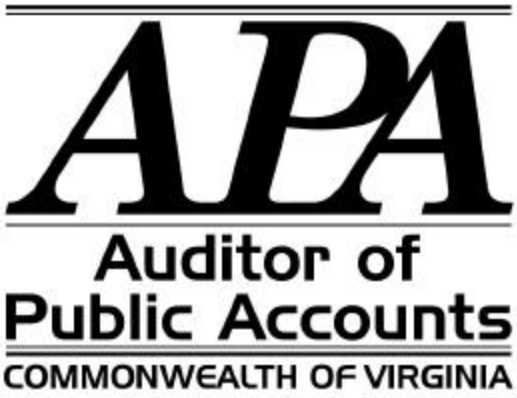
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

RICHMOND, VIRGINIA

REPORT ON AUDIT

FOR THE YEAR ENDED

JUNE 30, 2002



AUDIT SUMMARY

Our audit of the Department of Medical Assistance Services (the Department) for the year ended June 30, 2002, 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;

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

- inadequate corrective action for one prior audit finding which is addressed in two separate findings in this report entitled "Enhance Interagency Agreements Administration" and "Enhance Monitoring of Fiscal Agent Contract."

- T A B L E O F C O N T E N T S -

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), the Indigent Health Care Trust Fund, Income Assistance for Regular Assisted Living, Involuntary Mental Commitments, and other medical assistance services like HIV Assistance and State and Local Hospitalization.

We begin our discussion with an agency highlight section that addresses the impact of statewide budget cuts on the Department, status of the development of the new Medicaid Management Information System, and other system initiatives. The next section of the report addresses agency operations. It includes a discussion of the administration of the Department's two largest programs, Medicaid and FAMIS.

AGENCY HIGHLIGHTS

During fiscal year 2002, the Department had two priorities; addressing statewide budget reductions and developing the new Medicaid Management Information System. Although budget reductions did not impact this system development project, it did impact several other administrative activities.

Budget Reductions

To comply with statewide budget cuts, the Department reduced its administrative budget by 3 percent or $4.8 million (including $3.3 million of federal funds) in fiscal year 2002. To absorb these cuts, the Department renegotiated its brokered transportation services contracts with Logisticare and DynCorp. These contractors coordinate and monitor non-emergency transportation services, and received $32 million in their first year of service. The Department was able to reduce the contract amount without reducing services by simply accounting for the reduction in fee-for-service enrollment. Additionally, the Department captured a significant savings ($2.8 million) from the delay in the implementation of the new Medicaid Management Information System. Lastly, State and Local Hospitalization balances that the Department historically kept and used to offset the locality's cost of the program, were reverted back to the General Fund of the Commonwealth.

Budget cuts for the 2003-2004 biennium total 19 percent, resulting in an additional administrative cut of $20.0 million (including $10.2 million of federal funds). Like the transportation contracts, the Department's renegotiated its contract with West Virginia Medical Institute for pre-authorization services to also account for the reduction in fee-for-service enrollment. In addition, the Department is enforcing stricter application of nationally recognized standards to determine the medical necessity of inpatient hospital admissions. The Department estimates that it will save approximately $800,000 with this strategy. And lastly, the Department has re-bid its Medicaid managed care enrollment broker contract and awarded it to Maximus, who will replace Concera (formerly Benova) for a lower contract amount.

To date, Medicaid and FAMIS are exempt from statewide budget cuts. However, it is important to note that contractors primarily service these programs. Therefore, continued reductions in administration may impact service delivery.

Medicaid Management Information System

In February 1998 the Department contracted with First Health Services Corporation to develop a new Medicaid Management Information System (MMIS). The new system is essential because the Department questions whether the federal government will continue to re-certify the current system. The current system

cannot easily accommodate programmatic and legislative changes brought on by the introduction of waiver services, FAMIS, cost savings initiatives, the Health Insurance Portability and Accountability Act (HIPAA) and other situations that require changes to the MMIS. In addition, the current system lacks certain capabilities, which require the Department to perform many processes manually. The Department agreed to pay First Health Services $15.5 million to develop the new system. First Health Services agreed to deliver the system by January 1, 2000.

The Department did not receive the new system on the original delivery date due to First Health Services staffing issues, Y2K, and other contractual disagreements between the Department and First Health Services. The Attorney General's Office assisted in settling these disputes, and in September 2000, a settlement agreement established June 30, 2001, as the systems new delivery date. In exchange, the Department paid an additional $10 million to adequately compensate First Health Services for changes in the scope of the work.

Once again, First Health Services did not meet the delivery date. As a result, in January 2002 First Health Services assigned a new project manager to improve relations and to meet the goal of developing the new system. At this point, a new project schedule was developed and the Department procured the services of consultants including CACI, ACS (formerly Birch & Davis), and the Department of Information Technology (DIT) to perform risk assessments and other analysis of the project. CACI is assisting the Department with project management and HIPAA requirements. ACS is managing testing of the new system to ensure that it meets program and contractual requirements. DIT is providing technical expertise on the system architecture and performance.

In April 26, 2002, the federal government approved a new development plan with June 27, 2003, as the revised completion date, and increased funding to $39 million. Then, in November 2002, the federal government approved yet another funding increase, which results in total funding of $61 million. The Department anticipates that payments to First Health Services will total approximately 72 percent ($43.8 million) of this budget, while payments to consultants will total 28 percent ($17.2 million). As of September 2002, the Department's expenses were $24.5 million.

In accordance with Federal Regulations, the MMIS must be HIPAA compliant by October 16, 2003. HIPAA is a federal law that affects the entire healthcare industry. HIPAA requires that healthcare systems be able to accept and produce electronic transactions in a standard national format. The Act also requires that healthcare entities meet certain security and privacy standards. Penalties for noncompliance with any provisions of HIPAA include civil fines of up to $100 per occurrence.

Currently, the Department appears on schedule to have the system HIPAA compliant and completed by June 27, 2003. However, Medicaid providers across the state will also have to comply with HIPAA requirements. Providers are awaiting guidance from the Department for changes impacting Medicaid claims submission. The Department distributed a letter to providers in October 2002 informing them of training sessions on HIPAA and the new MMIS in June 2003. The Department also informed providers that the new HIPAA compliant MMIS will allow for the submission of claims using the current coding structure until October 16, 2003, then the Department will accept only HIPAA compliant electronic transactions and paper claims. The Department plans to distribute additional notification to providers in December 2002.

Other System Initiatives

Oracle Governmental Financials is the agency's financial accounting system that reports Medicaid information to the Federal government and the Commonwealth. Oracle recommended that the Department upgrade its software because it does not plan to continue to provide maintenance support for the version that the Department is currently using. In addition, the Department of Information Technology conducted a study

of the Department's use of Oracle Government Financials and also concluded that the Department should upgrade. The Department will upgrade its system. However, due to the time and resource constraints caused by the MMIS development, the Department is not sure when the upgrade will occur. Oracle extended its assistance support until June 2003. However, Oracle has informed the Department that it is considering extending this date.

AGENCY OPERATIONS

This section of the report includes a discussion about Medicaid and FAMIS. Medicaid 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 covers children in families with gross income between 100 and 200 percent of the federal poverty level. While Medicaid covers more than 500,000 individuals, FAMIS has not yet met its enrollment projections.

MEDICAID

Program Administration

Medicaid administrative costs for fiscal year 2002 totaled $105.5 million; of this amount, $82.5 million was paid to contractors. The Department contracts with several vendors and state agencies to administer the Medicaid program. These contractors perform a variety of functions including fiscal agent duties, enrollment services, quality control, non-emergency transportation services, and systems development.

First Health Services Corporation is the Department's largest vendor. The Department paid First Health over $21 million in fiscal year 2002. In addition to developing the Department's new MMIS, First Health also serves as the Department's fiscal agent. As fiscal agent, First Health processes claims and pays providers for medical services rendered to eligible recipients. First Health is also responsible for maintaining MMIS, which incorporates the surveillance utilization review subsystem (SUR). The Department uses SUR to evaluate program integrity. Additionally, through a recent contract modification, First Health enrolls medical providers into the Medicaid program and evaluates their enrollment status annually. The growth of the responsibilities of First Health has significantly increased the reliance of the Department on this single vendor.

Enhance Monitoring Of Fiscal Agent Contract

The First Health Services contract impacts practically every division of the Department's operations. The Department designated a Data Processing manager as the contract administrator; however, persons in various divisions were delegated some contract monitoring responsibilities such as approving invoices, completing semi-annual contractor evaluations, and providing documentation of the contractor's performance. However, these responsibilities are not designated in writing, resulting in some tasks not performed. For example, there are 15 individuals in at least six different divisions of the Department that were delegated the responsibility to monitor portions of the contract, however, we found that only four individuals were actually performing any contractor evaluations.

To better administer the contract the Department should:

- Assign an overall administrator of the contract. This person will receive reports from other designated administrators and ensure proper tracking of the contract is performed.
- Assign "in writing" administrators for the various parts of the contract in each of the divisions where First Health provides services.

- Provide each administrator with guidance as to how to monitor deliverables for their part of the contract; address contractual issues; and provide feedback to the contractor and to the Department's management on their portion of the contract.

Formalizing this designation of duties will ensure thorough contract monitoring and proper assignment of responsibility for the many parts of the contract.

While First Health Services plays a key administrative role in the operation of the Medicaid program, the Department also depends on the following thirteen state agencies to facilitate the administration of Medicaid. The Department paid other state agencies $2.5 million in fiscal year 2002. These agencies perform a wide variety of activities including eligibility determination, provider licensure, case management, and legal representation.

Department of Rehabilitative Services
Department of Social Services
Department of Health
Attorney General's Office
Department of Aging
Department of Education
Department of Mental Health, Mental Retardation, and Substance Abuse Services
MCV/UVA Hospitals
Supreme Court of Virginia
Department of Health Professions
Department of State Police
Virginia Employment Commission
Department of the Blind and Visually Handicapped

The Department uses interagency agreements to define each agencies responsibility; however, we found that the Department did not adequately monitor the implementation of these agreements.

Enhance Interagency Agreement Administration

The Department maintains over 115 interagency agreements with other state agencies and with local governments to administer and deliver services to the citizens of the Commonwealth. The Department's Purchasing Manual requires monitoring interagency agreements in the same manner as any contract, which includes designation of the responsibilities of the agreement administrator in writing and the regular evaluation of the agreement by the administrator. There is no written assignment of interagency agreement administrators nor does anyone conduct formal performance evaluation.

The letter of designation is an essential document for interagency agreement administration, since it provides the administrator key information concerning the most important elements of the agreement. The letter should explain the terms of the agreement, provide responsibilities of each of the participants in the agreement, inform the administrator if there are any miscellaneous duties, and course of action to follow if

the contractor does not perform. The letter also establishes a reporting procedure to keep management apprised of the agency's performance and any difficulties in the contract.

Many agreements have been in force for many years without substantial change or review. The Department's programs change and evolve due to changes in legislative initiatives and improved technology. Because of these changes, there should be a system to review interagency agreements on a regular basis in order to ensure the coordination of services with other agencies.

Medical Claim Payments

Medicaid is an entitlement program jointly funded by the Commonwealth of Virginia and the U.S. Department of Health and Human Services. Federal funding ranges from 51.45 percent to 90 percent of allowable expenditures depending on the type of activity. In fiscal year 2002, medical assistance payments for Medicaid made up 94 percent of the Departments total budget at $3.7 billion. The Department classifies medical assistance payments into the following provider categories.

	1999	2000	2001	2002
Nursing Facility	$ 424,175,594	$ 470,879,131	$ 519,117,960	$ 539,268,035
Intergovernmental Transfers*	-	-	-	500,821,602
Managed Care Organizations (MCO)	222,337,808	326,812,417	372,488,621	490,879,442
Prescribed Drugs	322,927,888	373,858,267	412,672,142	445,195,673
Inpatient Hospital-Regular	388,887,748	401,947,640	426,261,052	383,046,988
Home/CBC Waivers	212,624,777	252,668,172	287,562,995	318,007,100
ICF/MR/Public Facilities	171,963,182	180,850,661	179,127,169	218,492,490
Mental Health Facility	118,247,483	127,125,782	157,876,189	185,491,843
Inpatient Hospital-DSH	100,199,790	122,530,789	138,856,454	141,325,769
Physician	159,222,745	143,739,484	138,450,315	127,307,456
Outpatient Hospital	118,366,874	111,660,045	114,226,353	107,438,441
Health Insurance Premiums	74,461,562	77,000,649	80,885,022	97,298,222
Other Care Services	81,437,297	91,523,525	127,200,119	49,710,397
Clinic	38,055,584	37,073,008	35,876,395	34,756,028
ICF/MR/Private Facilities	14,611,345	16,064,302	19,292,971	18,299,608
Targeted Case Management	2,679,100	4,944,857	20,292,009	17,352,425
Lab and Radiological	15,280,922	14,097,176	14,176,416	13,052,372
Dental	15,805,587	13,687,482	14,316,446	12,774,312
Other Practitioners	11,299,569	10,052,182	11,777,207	12,562,381
Rural Health Clinic	7,373,164	8,139,382	8,933,928	8,066,079
Hospice Benefits	3,129,907	4,590,423	5,921,051	7,045,884
EPSDT Screening	8,273,876	7,942,717	7,629,970	6,429,903
Home Health	7,051,662	6,707,635	5,211,239	5,002,691
Prepaid Health Plans (PHP)	2,159,311	2,517,971	3,025,300	2,811,449
Federally Qualified Health Center	1,562,438	1,492,971	2,074,675	1,940,064
Drug Rebates	(60,522,588)	(75,477,394)	(70,691,112)	(65,610,593)
Total Medical Service Expenditures	$ 2,461,612,625	$ 2,732,429,274	$ 3,032,560,886	$3,678,766,061

**Intergovernmental Transfers represent enhanced Medicaid payments to nursing homes owned and operated by local governments.*

The Commonwealth has revised its reimbursement methods over the years in an effort to control medical costs. The Department processes Medical claims through MMIS either as fee-for-service, capitated-rate, per-diem/cost settlement basis, or diagnosis related groupings. Below is a description of each reimbursement method.

Fee-for-Service

Under fee-for-service, recipients manage their own health care, and physicians and drug providers individually bill for services and prescriptions. This method has the most expensive medical claims per person. Recipients decide the frequency of services and the physician that provides the service. Fee-for-service providers include a wide variety of physicians, dentists, laboratories, and pharmacies. The Department, with guidance from the federal government, sets rates of pay for each service.

Capitated Rate

In order to improve the quality and access of medical care, as well as control cost, the Department launched the Medallion II program on January 1, 1996. Medallion II is 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 the number of recipients enrolled and their administrative costs. In fiscal year 2002, the Department paid $490.9 million to these organizations.

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. Concera, a contractor (formerly known as Benova), enrolls recipients and is responsible for patient education and basic member services.

The Medallion II program currently covers 103 localities and serves approximately 234,000 recipients. The Medallion II program covers the following regions: Tidewater, Central Virginia, Allegheny/Winchester, Far Southwest, and Lynchburg. Hybrid regions exist in Northern Virginia, Roanoke, and Halifax in which the recipients can choose between Medallion and Medallion II programs.

The following 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

Per Diem

The per diem billing method pays for long-term care facilities and inpatient psychiatric and rehabilitation hospitals. Per diem is a pre-authorized reimbursement amount based on the cost of providing services on a daily basis. Providers submit cost reports annually in order to establish the per diem payment rates.

Diagnosis Related Groupings(DRG)

Currently, only hospitals providing Inpatient Acute Services use the DRG method to bill Medicaid. DRGs are pre-authorized reimbursements for groups of similar services. The DRG payments to hospitals are equal to the DRG case weight multiplied by the hospital specific operating rate per case.

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS)

FAMIS provides medical coverage for children up to the age of nineteen, when they are in families with gross incomes at or below 200 percent of the federal poverty level and not insured or have not had comprehensive health insurance in the past six months. Most families eligible for FAMIS make too much money to qualify for Medicaid and too little to afford adequate health insurance.

FAMIS makes up 2 percent of the Departments total budget at $50.1 million. The federal government and the Commonwealth jointly fund these expenses at 66 percent and 34 percent, respectively. The Department classifies medical assistance payments into the following nineteen provider categories for federal reports.

	1999	2000	2001	2002
Managed Care Organizations (MCO)	$ 304,223	$ 4,899,216	$ 10,239,616	$ 24,773,225
Prescribed Drugs	605,156	2,957,894	5,122,356	4,598,479
Physician and Surgical Services	685,800	3,567,139	5,173,969	3,819,816
Inpatient Hospital Services	853,668	3,331,940	4,707,620	3,348,616
Outpatient Hospital Services	427,051	2,048,637	2,962,178	2,636,029
Dental Services	357,187	1,722,928	2,598,733	2,036,432
Outpatient Mental Health Facility Services	100,754	612,109	1,377,010	1,602,435
Clinic Services	105,698	384,519	605,683	675,829
Therapy Clinic Services	69,755	483,122	679,274	529,178
Screening Services	67,296	397,204	577,076	466,083
Laboratory and Radiological Services	53,070	255,587	378,371	298,639
Other Practitioner's Services	38,488	185,527	348,799	278,119
Vision Services	63,857	222,716	301,689	276,949
Durable and Disposable Medical Equipment	29,461	171,719	218,812	208,280
Case Management	36,831	153,822	217,687	155,976
Medical Transportation	9,514	52,647	142,750	38,201
Home Health	6,358	18,772	39,577	29,900
Nursing Care Services	430	4,642	24,513	5,980
Home/CBC Services	-	17,338	-	(48,897)
Total Medical Service Expenditures	$ 3,814,597	$21,487,478	$ 35,715,713	$ 45,729,269

Administrative expenses for the FAMIS program totaled about $5 million for fiscal year 2002. The Department contracted with Concera, Inc. (formerly Benova) to determine eligibility. Concera serves as the

central site for receipt and review of FAMIS applications. Concera also performs enrollment and customer service functions.

The Department is required to administer FAMIS in accordance with a State Plan approved by Department of Health and Human Services Center for Medicare and Medicaid Services (CMS).

Modify the FAMIS State Plan

The Department omitted the fee-for-service benefit package from its Title XXI (FAMIS) state plan. According to the plan, the Department will offer Primary Care Case Management (PCCM) and Managed Care Organization (MCO) benefit packages. The Department anticipated having either a PCCM or MCO benefit package in all regions serving FAMIS recipients. However, in some regions, the Department could not obtain providers to enroll in either a PCCM or MCO. As a result, of approximately 32,000 FAMIS enrollees, over 7,100 participate in a fee-for-service benefit package although this is not part of the Commonwealth's approved state plan.

The Department should identify its program needs, revise its current plan to meet those needs, and obtain approval from CMS to execute the revised plan. The Department plans to submit revisions to CMS in fiscal year 2003.

Enrollment Status

The Department's goal is to enroll 61,500 children in FAMIS. At June 30, 2002, FAMIS enrollment was only 32,314 and the Department expects further decreases in enrollment as it attempts to clean up the system. The Department is aware that they have children enrolled in FAMIS twice or enrolled in FAMIS and Medicaid. In addition, the Department will begin dropping children from the program if they fail to submit re-determination information after receiving five requests from the Department.

New Initiatives

To improve enrollment, the Department will implement several programmatic changes. These changes seek to improve coordination between the Medicaid and FAMIS programs and streamline the application process.

- Adopt one application
- Implement uniform income verification for Medicaid and FAMIS
- Suspend monthly premium payments

In addition, the Commonwealth's 2003-2004 biennium budget provides for the following:

- Children ages 6 through 19 whose family income is 100 percent to 133 percent of the federal poverty level, now qualify for Medicaid. The Department estimates that 8,000 children fit this criterion. Although this may have a negative impact on FAMIS enrollment figures, it satisfies the overall goal to insure Virginia's children. According to the Department, the Commonwealth will also continue to

receive FAMIS enhanced federal funding (66 percent) versus the Medicaid federal match of only 51 percent.

- In addition, the Department of Planning and Budget can transfer funds from the Medicaid (state) budget to FAMIS. The Department intents to use these funds for administrative purposes.

QUALITY CONTROL

The Department has 48,582 eligible providers in the Medicaid/FAMIS network. The Federal government requires that each state have methods and procedures to safeguard against unnecessary use of care and services. The Department split this responsibility between its contractors, and several utilization and review units found within the Department. Below is a list of these units/contractors and the types of providers that they are responsible for monitoring.

The Provider Review Unit (PRU) focuses primarily on fee-for-service providers, selecting providers for review using the MMIS SURS ranking reports and referrals and complaints against providers. The 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, procedures unrelated to diagnosis coding, and high numbers of laboratory procedures per client. The Department bills the provider for any Medicaid overpayments identified. In the event that the PRU believes they can prove fraud, they refer the case to the Medicaid Fraud Control Unit at the Attorney General's Office.

The 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 depends on complaints received by the Attorney General's Medicaid Fraud Unit or the PRU.

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.

First Health Services' manually checks providers' names, licenses, and addresses with the Department of Health and Human Services, Office of Inspector General List of Excluded Individuals and Entities, a nationwide database listing over 17,000 ineligible Medicaid providers.

Delmarva, a contractor, performs quality reviews and monitoring of the overall performance and contractual compliance of each MCO participating in the Medallion II program.

Clifton Gunderson examines and audits the applicable records of DRGs and per diem providers of Medicaid services. The firm performs on-site examinations to determine if the cost report submitted by the provider complies with state and federal requirements. Clifton Gunderson reports to the Department any matters that would affect the allowable and reimbursable costs reported by the providers.

OTHER INTERNAL CONTROL FINDINGS

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. Historically, the Commonwealth has reported a 3 percent error rate, which met federal standards. As a result of this 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.

By establishing a pilot, the Department can experiment with alternative testing methods without risk of federal sanctions. The Department has initiated three pilots. The first pilot focused on the eligibility determination function. The second pilot focused on long-term care recipients. The third pilot focuses on the medically indigent.

Develop Correction Action Plans For Medicaid Eligibility Quality Control Reviews

The Department instituted the MEQC pilot program approximately three years ago; however, to date it has not developed corrective action plans for errors identified during the various MEQC pilot projects. The Department has an interagency agreement with the Department of Social Services (DSS) to perform the quality control reviews. DSS is extremely behind in completing the reviews and reporting results to the Department. On the other hand, the Department has not enforced compliance with its interagency agreement. As such the Department has not devised a plan to address eligibility errors for the first pilot, which ended in fiscal year 2000. Although the identification and correction of individual errors is important, the Department should also be proactive in identifying the cause of the errors and devising corrective action plans to prevent similar errors from reoccurring in the future.

The Commonwealth of Virginia and the U.S. Department of the Treasury developed an agreement to comply with the Cash Management Improvement Act of 1990. The agreement sets interest accrual provisions for the Commonwealth to address the timing differences between the receipt of Federal funds and their related disbursement. The agreement includes specific funding techniques used for federal programs, methods used for check clearance patterns, and methods used for calculating applicable interest accrual.

Comply with the Cash Management Improvement Act (CMIA) Agreement

The Department did not use the correct check clearance pattern as stated in the Cash Management Improvement Act (CMIA) agreement section 6.2.2.4 for fiscal year 2002. For approximately ten months of the fiscal year, the Department used the incorrect clearance pattern to drawdown funds from the federal government, which could affect the Commonwealth's interest liability. The Department alone makes up approximately 70 percent of the Commonwealth interest liability to the federal government.

We recommend the Department review and comply with the CMIA agreement to ensure the Commonwealth minimizes the interest liability to the federal government.

Commonwealth of Virginia

Walter J. Kucharski, Auditor

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

November 15, 2002

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

The Honorable Kevin G. Miller
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, 2002. 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	General System Controls
Revenues	Accounts Payable	

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. Reportable conditions are included in the Agency Operations section of the report. 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 two 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 "Review Fiscal Agent Contract Management Oversight", which is included in two separate findings in the Agency Operations section of this report. 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 19, 2002.

AUDITOR OF PUBLIC ACCOUNTS

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DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Richmond, Virginia

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