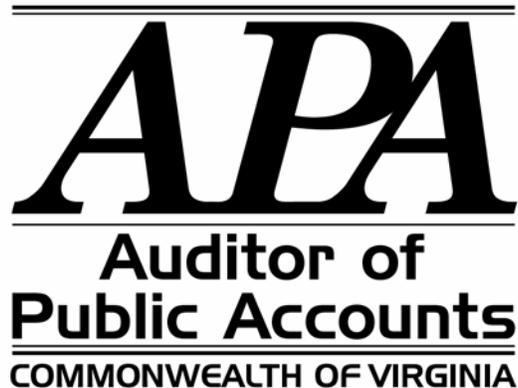


DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

**REPORT ON AUDIT
FOR THE YEAR ENDED
JUNE 30, 2005**



AUDIT SUMMARY

Our audit of the Department of Medical Assistance Services for the year ended June 30, 2005, found:

- proper recording and reporting of all transactions, in all material respects, in the Commonwealth Accounting and Reporting System and the Department's accounting records;
- weaknesses in internal controls that require management's attention and corrective action;
- no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards; and
- adequate corrective action for two of three prior year audit findings.

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INTERNAL CONTROL FINDINGS AND RECOMMENDATIONS

Implement System-wide Strategy for Utilization Units

The Department of Medical Assistance Services (Department) uses six Utilization Units (Units) to safeguard against unnecessary utilization of the Medicaid program, with the Units organized into two separate divisions: Program Integrity and Long-Term Care. Each of the Units, Long-term Care, Facility and Home-based, Waiver Services, Behavioral Health and Developmental Disabilities, Provider Review, and Recipient Audit, has their own area of responsibility within the Medicaid Program. Additionally, the Units collectively have the responsibility of identifying suspected fraud cases across the Medicaid Program. If one or more of the Units within the two divisions does not work as intended, it creates a gap within the Medicaid program where unnecessary utilization and/or fraud can occur and go undetected. The Units also ensure that the other controls surrounding the Medicaid program are working as intended to prevent improper payments.

During the audit, we reviewed how the Units prepare their annual work schedule, allocate resources for conducting and performing reviews, select providers for review, develop review plans, and prepare work paper documentation supporting the performance of provider reviews. We noted control weaknesses among the Units. Specifically, we found that the Units did not have sufficient resources to complete their plans due to loss of employees and changing priorities. Additionally, some of the review plans and work paper documentation did not contain sufficient information to determine what work the Units performed.

The Department has also had concerns about the Units' operations and meeting of their responsibilities. Management provided us with a plan to address these issues through a combination of Unit reorganization and selective outsourcing of aspects of the work required to support the identification of irregularities and for the maintenance of internal controls.

We agree with the Department's plan to address this matter, and plan to monitor its implementation. The Department should also consider establishing measurable performance expectations by which it can evaluate the effectiveness of the Units, individually and as a whole. Additionally, where the Department has provider types in which it does not review the population regularly, the Department should consider applying a risk assessment methodology and concurrent testing procedures to detect and monitor these providers and recipients groups.

Failure to Refund Federal Share of Medicaid Overpayments to Providers

Federal regulations require states to refund the federal share of Medicaid overpayments within 60 days after the date of discovery whether or not the state has recovered the payment. Bankruptcy or other matters that make the overpayment uncollectible remove the requirement to pay the federal government. To comply with federal regulations and respond to findings in the federal Office of the Inspector General audit on Medicaid overpayments in 2004 the Department revised its internal policies and procedures to require divisions to report overpayments to the Fiscal Division within two days after mailing the overpayment notice.

In our testing of the Units within the Program Integrity and Long-Term Care Divisions found four of the six cases involving overpayments not communicated to the Fiscal Division. This lack of communication between the divisions could cause delays in refunding the federal government.

We recommend that the Department communicate this federal requirement and the revised internal policies and procedures to all applicable divisions and ensure that appropriate oversights be initiated to ensure compliance.

Strengthen Case File Documentation

As reported last year, the Department's provider manual states that Services Facilitation (SF) providers must make in-home visits to recipients to observe, evaluate, and document the adequacy and appropriateness of the medical services provided to their client. Three of the seven cases reviewed for SF under the Elderly and Disabled with Consumer Direction (EDCD) Waiver did not have evidence supporting determination of adequacy and appropriateness of the medical services provided.

During fiscal 2005, the Department updated its provider manual and offered documentation training to providers that offer SF under the EDCD Waiver. However, because of the timing of these corrective actions and the noted exceptions, we are unable to determine the adequacy of the Department's corrective action plan related to last year's finding and will follow up next year.

AGENCY HIGHLIGHTS

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

The Medicaid program provides medical coverage to individuals who are aged, blind, or disabled and whose income do not exceed 80 percent of the federal poverty income guidelines (poverty guidelines); pregnant women (single or married) and children ages 0 through 5 whose family incomes are at or below 133 percent of the poverty guidelines; and eligible children ages 6 through 18 living in families with gross incomes below 100 percent of the poverty guidelines. FAMIS Plus provides coverage to children ages 6 through 18 in families with gross incomes in excess of 100 percent, but less than or equal to 133 percent of the poverty guidelines. FAMIS covers children from birth through 18 in families with gross incomes between 133 and 200 percent of the poverty guidelines.

2005 Poverty Guidelines

<u>Persons in Family Unit</u>	<u>48 Contiguous States and Washington D.C.</u>	<u>80 percent</u>	<u>133 percent</u>	<u>200 percent</u>
1	\$ 9,570	\$ 7,656	\$12,728	\$19,140
2	12,830	10,264	17,064	25,660
3	16,090	12,872	21,400	32,180
4	19,350	15,480	25,736	38,700
5	22,610	18,088	30,071	45,220
6	25,870	20,696	34,407	51,740
7	29,130	23,304	38,743	58,260
8	32,390	25,912	43,079	64,780
For each additional person, add	3,260	2,608	4,336	6,520

FINANCIAL INFORMATION

Tables 1 and 2 summarize the Department’s budgeted revenues and expenses compared with actual results and table 3 summarizes actual program expenses by fund source for the year ended June 30, 2005.

Table 1
Analysis of Budgeted and Actual Funding by Source - FY 2005

<u>Source</u>	<u>Original Budget</u>	<u>Adjusted Budget</u>	<u>Actual</u>
General Fund appropriations	\$1,947,986,146	\$1,990,510,079	\$1,990,510,079
Special revenue funds	56,013,154	80,121,717	67,818,022
Dedicated special revenue	306,182,711	306,182,711	313,626,580
Federal grants	<u>2,253,292,637</u>	<u>2,343,125,062</u>	<u>2,370,182,838</u>
Total	<u>\$4,563,474,648</u>	<u>\$4,719,939,569</u>	<u>\$4,742,137,519</u>

Source: Original Budget - Appropriation Act Chapter 951, Adjusted Budget - CARS 1419D1 Report, Actual - CARS 402 Report

The Department adjusted its original general and federal fund budgets primarily for inflation in Medicaid costs and for providing services to an increasing number of low-income children, elderly, and disabled persons. Revenue for federal grants exceeded their budget due to how the State Comptroller accounts for pass-through funds in the Commonwealth Accounting and Reporting System (CARS). The Department receives the funds as revenue then transfers the money to other agencies, such as the Department of Social Services, which budgets and spends the funds. During fiscal 2005, the Department received and transferred \$49 million in federal funding to the Department of Social Services for determining if individuals are eligible of the Medicaid program.

Virginia Health Care Fund

Funding for dedicated special revenue increased from \$14 million in fiscal 2004 to \$313 million in fiscal 2005 because of the establishment of the Virginia Health Care Fund (Fund). The Fund accounts for the collection and disbursement of state funds dedicated for the Medicaid Program. In fiscal 2005, the Fund had net expenses and revenues of \$283 million and \$299 million, respectively. The Fund received revenue from the following sources during fiscal 2005: tobacco tax, \$103 million; Intergovernmental transfers (IGT), \$95 million; master settlement agreement, \$52 million; Medicaid recoveries, \$46 million; and other, \$3 million.

Fiscal 2005 is the last year that the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) will allow IGT as a funding source. However, collections in the Fund should increase during fiscal 2006 as the excise tax on cigarettes will increase from one cent to one and one half cent per cigarette and the Tobacco Manufacturer Escrow Fund will become a new funding source for the Fund.

The Fund is a dedicated special revenue fund in the Appropriation Act and in this report. However, as required by the Code of Virginia, the Fund is part of the General Fund in the Comptroller's Commonwealth Annual Financial Report.

Table 2

Analysis of Budgeted and Actual Funding by Program - FY 2005

<u>Program</u>	<u>Original Budget</u>	<u>Adjusted Budget</u>	<u>Actual</u>
Medicaid	\$4,334,968,753	\$4,482,957,661	\$4,394,414,236
Administration and support services	75,913,771	82,962,906	79,174,694
FAMIS (includes administrative costs)	73,321,656	73,242,906	69,996,428
FAMIS Plus	43,994,654	43,994,654	42,701,473
Medical assistance services (nonMedicaid)	14,122,481	14,277,044	13,116,655
Appellate processes	10,254,550	11,468,660	8,026,081
Indigent Health Care Trust Fund	9,285,831	9,285,862	7,122,757
Continuing income assistance services	<u>1,612,952</u>	<u>1,749,876</u>	<u>1,387,605</u>
Total	<u>\$4,563,474,648</u>	<u>\$4,719,939,569</u>	<u>\$4,615,939,929</u>

Source: Original Budget - Appropriation Act Chapter 951, Adjusted Budget and Actual - CARS 1419D1 Report

Table 3

Analysis of Expenses by Program Funding Source - FY 2005

<u>Program</u>	<u>General Fund</u>	<u>Special Revenues</u>	<u>Dedicated Special Revenues</u>	<u>Federal Grants</u>
Medicaid	\$1,863,653,551	\$69,116,170	\$285,115,974	\$2,176,528,540
Administration and support services	31,183,701	284,916	-	47,706,077
FAMIS (includes administrative costs)	11,873,080	-	12,548,382	45,574,967
FAMIS Plus	14,936,676	-	-	27,764,797
Medical assistance services (nonMedicaid)	11,133,711	1,982,944	-	-
Appellate processes	8,026,081	-	-	-
Indigent Health Care Trust Fund	4,285,828	2,836,929	-	-
Continuing income assistance services	<u>1,387,605</u>	<u>-</u>	<u>-</u>	<u>-</u>
Total	<u>\$1,946,480,233</u>	<u>\$74,220,959</u>	<u>\$297,664,356</u>	<u>\$2,297,574,381</u>

Source: CARS 1419D1 Report

Administration and support services expenses decreased from \$120 million in fiscal 2004 to \$79 million in fiscal 2005. This \$41 million decrease results from the Department moving transportation costs from administration to the medical program for Medicaid. During fiscal 2005, the Department paid Logisticare, its statewide contractor, \$48 million for nonemergency transportation.

In fiscal 2002, the Department entered into a statewide contract for providing transportation and had to move the cost of this service from medical costs to administration. At that time, CMS, the federal agency that oversees the program required the Department to move the reporting of these costs from the medical program category to administration. Since then, CMS has removed this reporting requirement.

Total Department expenses for all programs amounted to \$4.61 billion in fiscal 2005. Approximately, 97.5 percent of this amount represents medical expenses attributable to the Medicaid, FAMIS, and FAMIS Plus programs. Another 1.8 percent of the total amount represents administrative expenses for these three programs.

Medicaid

The Department spent \$4.39 billion on Medicaid Assistance Services. The following table shows total medical expenses for the Medicaid program by provider type.

Table 4

Medicaid Expenses by Provider Type

	<u>2005</u>	<u>2004</u>	<u>2003</u>	<u>2002</u>	<u>2001</u>
Nursing facility	\$ 646,567,758	\$ 623,759,124	\$ 582,787,725	\$ 539,268,035	\$ 519,117,960
Managed care organizations	967,584,252	822,941,745	768,548,306	490,879,442	372,488,621
Prescribed drugs	611,762,626	568,887,798	498,672,240	445,195,673	412,672,142
Inpatient hospital - regular	524,024,992	483,247,785	402,014,317	401,859,141	426,261,052
Home and community-based waivers	446,368,368	401,779,716	352,596,635	318,007,100	287,562,995
ICF/MR public facilities*	195,854,274	193,136,174	178,053,785	218,492,490	179,127,169
Mental health facility	290,003,507	247,075,233	222,858,621	185,491,843	157,876,189
Inpatient hospital – enhanced disproportionate share	111,561,611	72,675,032	121,359,950	122,513,616	138,856,454
Physician	155,456,154	133,720,252	122,063,767	127,307,456	138,450,315
Outpatient hospital	126,288,370	99,455,728	111,118,885	107,438,441	114,226,353
Medicare premiums	133,112,503	119,820,296	90,894,139	97,298,222	80,885,022
Other care services	106,424,576	46,242,252	46,785,117	49,710,397	127,200,119
Clinic	36,767,116	33,659,555	33,846,096	34,756,028	35,876,395
ICF/MR private facilities*	34,036,235	25,460,429	21,127,148	18,299,608	19,292,971
Targeted case management	15,782,932	14,916,263	17,714,882	17,352,425	20,292,009
Lab and radiological	17,067,491	14,364,597	13,551,057	13,052,372	14,176,416
Dental	13,750,693	12,677,140	12,026,005	12,774,312	14,316,446
Other practitioners	13,651,485	12,348,782	13,072,417	12,562,381	11,777,207
Rural health clinic	8,668,652	11,086,814	9,163,116	8,066,079	8,933,928
Hospice benefits	16,023,355	9,514,896	9,613,604	7,045,884	5,921,051
Early and periodic screening, diagnosis, and treatment services	7,722,845	6,580,917	5,300,495	6,429,903	7,629,970
Home health	4,555,850	3,048,813	4,411,341	5,002,691	5,211,239
Prepaid health plans	3,959,700	3,596,304	3,722,002	2,811,449	3,025,300
Federally-qualified health center	7,066,424	3,409,375	1,915,894	1,940,064	2,074,675
Intergovernmental transfers	20,953,016	23,693,732	57,129,557	500,821,602	-
Drug rebates	<u>(120,600,610)</u>	<u>(91,636,289)</u>	<u>(73,263,453)</u>	<u>(65,610,593)</u>	<u>(70,691,112)</u>
Total	<u>\$4,394,414,175</u>	<u>\$3,895,462,463</u>	<u>\$3,627,083,648</u>	<u>\$3,678,766,061</u>	<u>\$3,032,560,886</u>

* Intensive care facility/mental retardation

Source: Department of Medical Assistance Services Accounting System and prior year report

Other care services increased because of the change in reporting of transportation cost discussed previously.

In addition to medical assistance services, the Department spent \$79 million on administrative costs. The schedule below summarizes the administrative expenses related to the Medicaid program.

Medicaid Administrative Expenses

Personal services	\$20,591,885
Contractual services and other	55,215,400
Supplies and materials	400,099
Indirect cost recovery and other	165,099
Rent and other continuous charges	1,796,163
Property, plant, and equipment	<u>1,006,048</u>
Total	<u>\$79,174,694</u>

Source: CARS

Contractual Service Payments

First Health services	\$25,285,359
West Virginia Medical Institute	5,544,234
Clifton Gunderson and Company	4,241,799
Other	<u>11,592,988</u>
Total	<u>\$46,664,380</u>

Source: Department of Medical Services' Accounting System

Of the \$46 million spent on contractual services for the administrative program, the Department paid its largest vendor and fiscal agent, First Health Services, \$25 million. First Health runs the day-to-day operation of the Medicaid program by processing claims and enrolling providers. First Health is also responsible for developing and maintaining the Department's Medicaid Management Information System and managing its preferred drug listing.

FAMIS

FAMIS' medical expenses amounted to \$65.5 million. Of this amount, \$48.6 million represents managed care organization payments, an increase of \$7.5 million from fiscal 2004. Administrative expenses totaled \$4.5 million with 75 percent paid for management services, which include consultant and contractor fees.

FAMIS Plus

Medical expenses for the FAMIS Plus program amounted to \$42.7 million. Of this amount, \$24.1 million represents managed care organization payments. The fiscal 2004 amount represents the first full year of the program's operation. The average monthly enrollment increased by 29.5 percent in fiscal 2005 due to continued outreach efforts.

New Initiatives

The Department developed several new initiatives during fiscal 2005 for implementation during fiscal 2006.

Smiles for Children Program - provides coverage for diagnostic, preventive, and restorative/surgical procedures, as well as orthodontia services for Medicaid, FAMIS, and FAMIS Plus-enrolled children. The program also provides coverage for limited medically necessary oral surgery services for adults (age 21 and older). Doral Dental USA, the single dental benefits administrator, will coordinate the delivery of all Smiles for Children dental services. Dental fees for providers and access to specialty providers were increased and more dental providers were enrolling in the program. This program went into effect July 2005 with a current enrollment of seven recipients.

Managed Care Expansion Programs - will include the Winchester Region as of December 2005. This expansion will provide recipients of Medicaid and FAMIS with a choice of Managed Care Organizations (MCOs). The Winchester Region includes the counties Frederick, Clarke, Warren Shenandoah, Rappahannock, and Page.

Day Support and Alzheimer's Waivers – The Department requested from CMS Day Support waivers in response to the existing waiting list for the Mental Retardation waiver. This waiver provides day support for eight hours per day, five days per week for a person at risk of institutionalization. As a cost containment measure, there is a limitation on the number of waiver slots available for services. The Day Support waiver was effective in July 2005 with 300 approved slots. CMS has also approved a Alzheimer's waiver for 200 slots, but has not yet taken effect. This waiver will focus on a small group with a high reimbursement rate. Individuals must meet nursing facility criteria for eligibility. DMAS is identifying and enrolling providers.

Disease Management (DM) Program - key goals of this program include preventive care, promotion of self-management and verification of appropriate use of medical services for recipients with asthma, congestive heart failure, coronary artery disease, or diabetes. The Department has contracted with the Health Management Corporation to implement the program in January 2006. The contractor has responsibility for providing outreach and education on the DM program, performing initial assessments, counseling and regularly assessing all program participants, and maintaining a 24-hour toll-free nurse call line for all program participants. The contractor will also monitor clinical health outcome measures and track changes in Medicaid and FAMIS expenditures for participants in the DM program.

FAMIS Moms Program - encourages pregnant women to get early and regular prenatal care to increase the likelihood for a healthy birth outcome. Recipients receive comprehensive health care benefits during and for two months following the end of the pregnancy. FAMIS MOMS also has a special program for women with high risk pregnancies. Mothers receive health care services through MCOs or fee-for-service, depending on where the recipients live. The program currently has 116 enrollees. FAMIS Moms took effect August 2005 and covers pregnant women from 133 to 150 percent of the federal poverty level, while Medicaid only covers pregnant women up to 133 percent. The application process requirements are the same as Medicaid and enrollment can occur over the telephone, by fax, on-line, and through the Department of Social Services. The Department estimated that the program will service 400 people and the Department will receive a 66 percent match of federal funds.

FAMIS Select Program - covers FAMIS enrolled children, allowing families flexibility and choice in providing health care coverage for their families. It will give families the choice of receiving coverage through FAMIS or through their private or employer-sponsored health plan. Families who choose to participate in FAMIS Select can receive a payment of \$100.00 per FAMIS enrolled child per month to assist with paying private health insurance premiums.

Previously, the FAMIS program allowed recipients to “buy-in” to their employer’s health insurance, which sometimes would cover the entire family. FAMIS Select replaces the Employee Sponsored Health Insurance Premium Assistance program.

The Department believes this program will reduce the Commonwealth’s cost, since FAMIS cost are normally more than \$100 per month. This program is also beneficial for the family because it allows them to use one health system. The Department expects the current enrollment of 100 children to increase to 500 as more families. The FAMIS Select program went into effect August 1, 2005.



Commonwealth of Virginia

Walter J. Kucharski, Auditor

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

November 21, 2005

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

The Honorable Lacey E. Putney
Chairman, Joint Legislative Audit
and Review Commission
General Assembly Building
Richmond, Virginia

We have audited the financial records and operations of the **Department of Medical Assistance Services** for the year ended June 30, 2005. We conducted our audit in accordance with Government Auditing Standards, issued by the Comptroller General of the United States.

Audit Objectives

Our audit's primary objectives were to evaluate the accuracy of the Department's financial transactions as reported in the Comprehensive Annual Financial Report for the Commonwealth of Virginia for the year ended June 30, 2005, and test compliance for the Statewide Single Audit. In support of these objectives, we evaluated the accuracy of recording financial transactions on the Commonwealth Accounting and Reporting System and in Department's accounting records; reviewed the adequacy of the Department's internal control; tested for compliance with applicable laws, regulations, contracts, and grant agreements; and reviewed corrective actions of audit findings from prior year reports.

Audit Scope And Methodology

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.

We gained an understanding of the overall internal controls, both automated and manual, sufficient to plan the audit. We considered materiality and control risk in determining the nature and extent of our audit procedures. Our review encompassed controls over the following significant cycles, classes of transactions, and account balances:

Accounts Payable	General System Controls
Accounts Receivable	Revenues
Expenditures	

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. Our audit procedures included inquiries of appropriate personnel; review of external audit reports; and inspection of documents including reconciliations, medical claims, records, contracts, and board minutes. We reviewed appropriate sections of Code of Virginia, the 2005 Acts of Assembly, and the Medicaid program. We also tested transactions and performed analytical procedures including trend analyses.

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 system. 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 require management's attention and corrective action. These matters are described in the section entitled "Internal Control Findings and Recommendations."

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

The Department has taken adequate corrective action in two of three audit findings reported in the prior year. We are currently unable to determine the adequacy of the corrective action with respect to the prior finding, "Strengthen Case File Documentation."

EXIT CONFERENCE

We discussed this report with management on December 15, 2005. Management's response is included at the end of 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 and its distribution is not limited..

AUDITOR OF PUBLIC ACCOUNTS

GDS/kva



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

December 20, 2005

PATRICK W. FINNERTY
DIRECTOR

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

RE: Response to Audit Findings

Dear Mr. Kucharski:

The following are our replies to the audit findings:

Strengthen Case File Documentation

We concur with the finding and with the APA's decision to extend its field work on this finding to next year.

The Division of Long-Term Care is setting in place plans to conduct a quality review on a statistically valid sample of consumers from all service facilitators within the Elderly and Disabled with Consumer Directed Waiver and take appropriate corrective action. This will serve as a follow-up to the training of 1,100 persons this year which included billing, covered services, service facilitator documentation and procedures.

Implement a System Wide Strategy for Utilization Units

The Department is in concurrence that improvements need to be made in the coordination of activities. This has been partially addressed by the Internal Audit Charter which coordinates activities with the department's management team in ensuring that internal controls are in place and that appropriate risk assessments, plans and processes are assessed and evaluated. As part of the process Internal Audit is working with both Program Integrity and Long Term Care in assessing their internal control processes. In terms of Program Integrity the annual plan for 2006 is being developed as well as a reorganization of staff and activities which include outsourcing some of the function to third party auditing vendors. The Department was selected as one of the first states for PERM project implementation which will aid in the identification of claims payment

errors and in their corrective actions. The goal is to have major initiatives in place by the second quarter of 2006 as part of a two year plan to strengthen the review process. The implementation of these activities will be tracked and documented and we are pleased that the APA has agreed to our two year plan of action.

Failure to Refund Ffderal Share of Medicaid Overpayment

The Department concurs with this finding and has addressed corrective action through staff education, workflow modification and coordination between the units to ensure that this weakness is addressed. The Department will be performing quality control checks in both Program Integrity and Long Term Care to ensure continuing compliance.

If you have any questions, please contact Charles Lawver, our Director of Internal Audit at 786-0241.

Sincerely,



Patrick W. Finnerty
Director

PWF/bws

cc: Charles Lawver
Cindi Jones
Manju Ganeriwala
Cheryl Roberts

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Patrick Finnerty
Agency Director

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