

STATE OF WEST VIRGINIA

SPECIAL REPORT

OF

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID PROGRAM

IMPLEMENTATION OF AUDIT RECOMMENDATIONS

FOR THE PERIOD

JULY 1, 1999 - JUNE 30, 2002



OFFICE OF THE LEGISLATIVE AUDITOR

CAPITOL BUILDING

CHARLESTON, WEST VIRGINIA 25305-0610

SPECIAL REPORT
OF THE
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
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FOR THE PERIOD
JULY 1, 1999 - JUNE 30, 2002

WEST VIRGINIA LEGISLATURE
Joint Committee on Government and Finance

Theodford L. Shanklin, CPA, Director
Legislative Post Audit Division
Building 1, Room W-329
1900 Kanawha Blvd., E.



Area Code (304)
Phone: 347-4880
Fax: 347-4889

CHARLESTON, WEST VIRGINIA 25305-0610

April 15, 2003

The Joint Committee on Government and Finance:

In compliance with the provisions of Chapter 4, Article 2, we have examined the implementation of audit recommendations regarding the Medicaid Program of the West Virginia Division of Health and Human Resources (WVDHHR) as contained in audits performed by other independent auditors engaged to audit the processing of transactions for user organizations of the State of West Virginia Medicaid Management Information System (MMIS), such audits having been performed on behalf of ACS State Healthcare Services (ACS), who acts as the third-party claims processor for the Medicaid Program of the WVDHHR. Also, we have examined the implementation of audit recommendations contained in audits performed by the Office of Inspector General of the United States Department of Health and Human Services.

Our examination covers the period July 1, 1999 through June 30, 2002. The results of this examination are set forth on the following pages of this report.

Respectfully submitted,


Theodford L. Shanklin, CPA, Director
Legislative Post Audit Division

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID PROGRAM

IMPLEMENTATION OF AUDIT RECOMMENDATIONS

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WEST VIRGINIA DIVISION OF HEALTH AND HUMAN RESOURCES

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EXIT CONFERENCE

We held an exit conference on April 30, 2003 with the Secretary of the West Virginia Department of Health and Human Resources and other department representatives and all issues contained in the Special Report were reviewed and discussed. The Department's responses are included in bold and italics in the Summary of Audit Recommendation and Implementation Actions and after each finding in the General Remarks section of this report.

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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INTRODUCTION

Medicaid was created by Title XIX of the Social Security Act in 1965 and is a Federal/State program administered by the States and funded in West Virginia by a combination of Federal and State funds. Under Title XIX, Medicaid is operated as an entitlement program for individuals which means anyone who meets certain specified eligibility criteria is "entitled" to receive Medicaid services. While most Americans recognize Medicaid as the nation's leading source of funding for health care of low-income Americans, Medicaid actually has three distinct facets: 1. A health insurance program for low-income parents (primarily mothers) and children - over one-third of all births nationwide are covered by Medicaid; 2. A long-term care program for the elderly - nearly 70 percent of all nursing home residents nationwide are Medicaid beneficiaries; and, 3. A significant funding source for services to people with disabilities - Medicaid pays one-third of the cost of national services for the disabled in America.

The Medicaid Program is based on a sharing of costs between the Federal Government and the several States. In terms of program administration costs, the Federal Government contributes 50% for each State. For covered medical services, the Federal Medical Assistance Percentage (FMAP) or Federal matching rate, varies among the States, ranging from 50% to 80%, based on per capita income. Under Federal law, the States choose whether to participate in Medicaid which provides substantial financial incentives to aid the States in covering the costs of health services for

those persons traditionally unable to pay for such services. People covered by Medicaid may totally lack health insurance or their health insurance plans may not cover certain needed medical services. As a technical matter, the State of Arizona is the only State which does not have a Medicaid Program; however, Arizona operates an unique managed care program utilizing a Medicaid 1115 Demonstration Waiver granted in 1982. Under the auspices of this waiver, the State of Arizona receives Federal Medicaid matching dollars for the purpose of matching State funds to provide low-income persons with medical services.

As a general rule, Medicaid covers low-income mothers and children, elderly people who need long-term care services and people with disabilities. Nationwide, children make up half of the Medicaid population and the elderly and persons who are blind or have other disabilities account for roughly 27 percent of the Medicaid population. However, only 16 percent of the Medicaid budget nationally is spent on children, in comparison to the approximately 73 percent of the budget spent on the elderly and persons who are blind or have other disabilities. Based on Federal law, the West Virginia Medicaid Program must cover the following eligibility groups:

1. "Section 1931" populations based on Temporary Assistance to Needy Families (TANF).
2. Persons who receive Federal Supplemental Security Income (SSI).
3. Pregnant women whose family income is up to 133 percent of federal poverty guidelines (\$11,425 for an individual in 2001) for pregnancy-related services, through about 60 days after delivery.
4. Infants born to Medicaid-eligible pregnant women. The eligibility of such infants must continue throughout the first year of life as long as the infant remains in the mother's household and the mother remains eligible or would be eligible if she were still pregnant.

5. Children under age 6 whose families earn up to 133 percent of poverty (\$19,458 for a family of three in 2001).
6. Older Children defined as children born after September 30, 1983, who are over age 5 and live in families with income up to the poverty level (\$14,630 for a family of three in 2001).
7. Children who receive adoption assistance or foster care.
8. Certain Medicare recipients who are eligible to have the Medicaid Program pay their Medicare premiums, deductibles and copayments for elderly people and people with disabilities who have incomes below the poverty level.
9. Certain Special Protected Groups which include short-term coverage for people who lose TANF or SSI cash assistance because of increased wages or Social Security payments.

Additionally, States are permitted to cover 18 additional groups under the Medicaid Program, mostly consisting of additional children and pregnant women, as well as, other persons whose medical expenses reduce their income to the State's ceiling to qualify as being medically needy.

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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ADMINISTRATIVE OFFICERS AND STAFF

JUNE 30, 2002

Paul L. Nusbaum Cabinet Secretary

Phillip A. Lynch Deputy Cabinet Secretary

Danny Franco Assistant Secretary for Finance

Larry W. Arnold General Counsel

Edgar D. VanCamp Inspector General

Nancy V. Atkins Commissioner - Bureau for Medical Services

Frederick D. Boothe Commissioner - Bureau for Children and Families

Leonard C. Kelley Bureau for Medical Services
Chief Operating Officer

Eric Cole Bureau for Medical Services
Chief Financial Officer

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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SUMMARY OF AUDIT RECOMMENDATIONS AND IMPLEMENTATION ACTIONS

**Office of Inspector General - U.S. Department of Health and Human Services
Followup Audit of West Virginia Medicaid Payments for
Clinical Laboratory Services (A-03-01-0022) April 2002**

1. The Office of Inspector General - U.S. Department of Health and Human Services (OIG-DHHS) conducted an audit of Medicaid payments made during Calendar Years 1999 - 98 for outpatient clinical laboratory services.

Recommendations by OIG-DHHS

The OIG-DHHS recommended the West Virginia Department of Health and Human Resources (WVDHHR) do the following: 1. Install and revise edits to detect and prevent payments for unbundled and duplicated services; 2. Either provide CMS evidence of the Federal share refund related to the clinical laboratory overpayment recovery of \$995,083 or make an adjustment for the Federal share of \$521,660 of laboratory overpayments on its Quarterly Report of Expenditures to the CMS; and, 3. Refund the Federal share of overpayments related to 1993 and 1994 unbundling overpayments totaling \$1,047,789 as identified in the OIG-DHHS' prior report.

WVDHHR's Response

The WVDHHR has taken appropriate action to address the issues raised by the OIG and we have reached a settlement totaling \$600,000 to settle the laboratory unbundling issue which has been refunded to the Centers for Medicare and Medicaid Services (CMS). (See pages 9-12)

**Office of Inspector General - U.S. Department of Health and Human Services
Review of Pharmacy Acquisition Costs for Drugs Reimbursed Under the
Medicaid Prescription Drug Program of the West Virginia Department of
Health and Human Resources (A-06-01-00007) December 2001**

2. The OIG-DHHS conducted an audit of pharmacy acquisition costs for drugs reimbursed under the West Virginia Medicaid Prescription Drug Program incurred in CY 1999 with the objective of the audit being to develop an estimate of the discount below the average wholesale price (AWP) at which pharmacies purchase brand name and generic drugs.

Recommendations by OIG-DHHS

The WVDHHR should consider the difference between Average Wholesale Price and pharmacy acquisition costs in setting pharmacy reimbursement policy, as well as, the effects of Federal upper limit amounts on generic drug reimbursement or usual and customary charge limitations when setting pharmacy reimbursement policy.

WVDHHR's Response

Currently, West Virginia Medicaid reimburses pharmacies at the lower of (1) their usual and customary charge to the general public; (2) the Federal Upper Limit cost plus a dispensing fee of \$3.90; or (3) the Estimated Acquisition Cost defined as AWP minus 12 percent plus a dispensing fee of \$3.90. (See pages 12-16)

State of West Virginia Medicaid Management Information System Service Auditor's Report (2001)

3. The 2001 annual audit of compliance with procedures used in processing of claims by ACS State Healthcare Services (ACS), the fiscal agent for the West Virginia Medicaid Program revealed a total of six findings which were not immediately addressed by ACS. Specifically, (1) No disaster recovery testing was performed in the Charleston, WV office of ACS; (2) A system override is provided to circumvent the system control regarding validation of current licensure for medical providers; (3) Restrictions on physical access at the Charleston, WV office were not being consistently complied with because the door to the computer area was not locked during the day; (4) Certain quality control unit personnel had update capabilities which were incompatible with their assigned job duties with respect to suspended claims; (5) The Medicaid Management Information System (MMIS) included stale-dated checks and undeliverable checks as representing claims which had been paid which meant that upon resubmission by a medical provider, the claim would be automatically rejected as having already been paid; and, (6) The contractual requirement to microfilm all paper claims upon submission was not complied with in a timely fashion.

Recommendations by Service Auditor

Ethridge & Miller, PC in their capacity as independent Certified Public Accountants engaged by ACS recommended corrective actions be taken with respect to these six findings summarized above.

WVDHHR's Response

All of the six recommendations outlined in the report by the Service Auditor have been implemented, except for Item 2 regarding licenses for medical providers. Because State licensing boards issue licenses retroactively on a routine basis, it renders this feature of the MMIS inoperable. (See pages 16-20)

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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GENERAL REMARKS

INTRODUCTION

We have completed a Special Report designed to review the audit reports and attending audit recommendations made by independent auditors who conducted annual audits of the West Virginia Medicaid Program's third-party claims processor (ACS State Healthcare Services). The purpose of these annual audits was to assess whether the internal control structure policies and procedures of ACS were being complied with and whether such policies and procedures were suitably designed to achieve their objectives. In addition, we reviewed several audit reports of various types of Medicaid payments which were made by the Office of Inspector General - United States Department of Health and Human Services. The purpose of this special report is to summarize the audit findings contained in these various reports of other auditors and to ascertain the corrective actions, if any, initiated by the West Virginia Department of Health and Human Resources in response to the audit findings.

OVERVIEW

During the course of our planning for the current ongoing post audit of the Medicaid Program of the State of West Virginia, we became aware of various audits of Medicaid functions which had been performed by other auditors during the period July 1, 1999 - June 30, 2002. In the course of documenting the accounting procedures used by the Medicaid Program, we likewise noted

apparent weaknesses in the internal control structure. At that point, we determined that conducting an in-depth review of the various audits and making a formal inquiry of the management of the West Virginia Department of Health and Human Resources (WVDHHR) asking what steps had been taken to address the various audit findings was appropriate. During the aforementioned period, July 1, 1999 - June 30, 2002, the following independent audits were reviewed by us:

1. Office of Inspector General - U.S. Department of Health and Human Services - Followup Audit of West Virginia Medicaid Payments for Clinical Laboratory Services (A-03-01-0022), April 2002.
2. Office of Inspector General - U.S. Department of Health and Human Services - Review of Pharmacy Acquisition Costs for Drugs Reimbursed Under the Medicaid Prescription Drug Program of the West Virginia Department of Health and Human Resources (A-06-01-00007), December 2001.
3. State of West Virginia Medicaid Management Information System - Service Auditor's Report (2001).
4. State of West Virginia Medicaid Management Information System - Service Auditor's Report (2000).
5. State of West Virginia Medicaid Management Information System - Service Auditor's Report (1999).

The remainder of this report sets out the relevant findings of the various reports and the WVDHHR's response outlining corrective actions taken to address the audit issues raised in these various reports.

Office of Inspector General - U.S. Department of Health and Human Services
Follow-up Audit of West Virginia Medicaid Payments for
Clinical Laboratory Services (A-03-01-0022) April 2002

The Office of Inspector General - U.S. Department of Health and Human Resources (OIG-DHHS) conducted an audit of medicaid payments made during Calendar Years (CY) 1996 - 1998 for outpatient clinical laboratory services with the objective of this audit being to determine the

adequacy of the West Virginia Medicaid Program's controls over claiming Federal Financial Participation (FFP) for Medicaid payments to providers for the aforementioned services. This particular audit was performed by the OIG-DHHS as a follow-up to the audit of West Virginia Medicaid clinical laboratory claims (CIN A-03-96-00203) which had shown the West Virginia Medicaid Program had overpaid clinical laboratory claims totaling \$1,378,601 (FFP \$1,047,789) during CY 1993 and 1994. The follow-up audit contained the following findings:

“... The State agency still lacked adequate controls to prevent claiming FFP for Medicaid clinical laboratory payments in excess amounts paid by the Medicare program, as required by Section 6300 of the State Medicaid Manual. In this regard, Medicare regulations provide that claims for laboratory services in which a provider bills separately for tests, that are available as part of a panel, should be paid at the lesser amount for the panel. Additionally, services that duplicate one another should not be billed on the same day by the same provider for the same patient...”

In addition, the OIG-DHHS noted the following observations:

“The State agency reimbursed providers for laboratory services for chemistry, hematology and urinalysis claims for services that were not grouped together (bundled into a panel) or duplicated other paid services. We estimated that the State agency overpaid providers \$711,323 (Federal share \$521,660) for laboratory services during CY 1996, 1997, 1998. The State agency has recovered laboratory unbundling overpayments of \$995,083 related to services from 1996 and 1997. However, we can not determine that they refunded the Federal share of these overpayments. Additionally, no overpayments were refunded.”

The OIG-DHHS recommended the following corrective actions:

- “1. Install and revise edits to detect and prevent payments for unbundled and duplicated services.**
- 2. Either provide CMS evidence of the Federal share refund related to the clinical laboratory overpayment recovery of \$995,083 or make an adjustment for the Federal share of \$521,660 of laboratory overpayments on its Quarterly Report of Expenditures to the CMS.**

3. Refund the Federal share of overpayments related to 1993 and 1994 unbundling overpayments totaling \$1,047,789 as identified in our prior report (CIN A-03-96-00203).” (Emphasis added)

WVDHHR's Response

At the time of the original audit, Medicare had bundling software so providers were accustomed to billing laboratory profiles, panels and other tests “unbundled” as Medicare bundled prior to payment. The Bureau for Medical Services (Bureau) sent the enclosed Program Instruction MA-97-19, March 1997, to alert providers that they cannot unbundle and bill individual laboratory tests as opposed to bundling and billing a comprehensive code.

By way of background: the process utilized by the Office of Inspector General (OIG) for a Medicaid review is to submit a draft report to the State for comment and then submit a final report. The Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)) then initiates enforcement action, if necessary; the OIG takes no enforcement action. In the Bureau’s response to the 1993-94 laboratory audit, the Bureau had substantial issues with the audit including the sampling method utilized, the methodology, the time period that tied to payments, and that the underlying assumptions were based on flawed clinical interpretations.

As the Bureau received no notice of any enforcement action from HCFA, other than the subsequent post-payment review of “unbundled” laboratory claims, the Bureau took no further action on the audit report.

The Bureau was surprised and dismayed to find that when the OIG appeared for the 2002 audit, they did not consider this matter closed and, in fact, re-opened the 1993-94 audit. Due to the passage of time, the Bureau was at a disadvantage for the 1993-94 audit.

To address the issue of unbundling of laboratory panels, the Bureau has taken a two-step approach to prevent future overpayment of these services. To address overpayments due to unbundling of organ and disease panels, the Bureau has contracted with a vendor to perform post payment reviews of claims paid in which the individual components were billed separately. These claims are rebundled and priced for the appropriate panel performed with the resultant overpayment recouped from the provider. To address overpayments due to Medicare's pricing guidelines in which deleted panels are used to rebundle and reprice claims, the Bureau is working with a software development contractor and the Bureau's current claims fiscal agent to develop software that will incorporate Medicare's pricing methodology in the front end of claims processing to prevent future overpayments. Because this pricing methodology represented a change in current program policy, Program Instruction MA-02-53 was released in October 2002 to notify providers of the revised payment provision. Until the software is operational, providers were notified that post payment review of all claims subject to repricing would be reviewed by the Office of Surveillance & Utilization Review.

Copies of the Bureau's response to both audits have previously been provided. The Bureau and CMS agreed to settle both laboratory unbundling audit periods for \$600,000 which has been refunded via the Quarterly CMS-64 report.

Office of Inspector General - U.S. Department of Health and Human Services
Review of Pharmacy Acquisition Costs for Drugs Reimbursed Under the
Medicaid Prescription Drug Program of the West Virginia Department of
Health and Human Resources (A-06-01-00007) December 2001

The OIG-DHHS conducted an audit of the pharmacy acquisition costs for drugs reimbursed under the West Virginia Medicaid Prescription Drug Program incurred during CY 1999 with the objective of the audit being to develop an estimate of the discount below the average

wholesale price (AWP) at which pharmacies purchase brand name and generic drugs. The audit was conducted as part of nationwide review of pharmacy acquisition costs. The audit contained the following conclusions regarding brand name drugs:

“We estimated that the invoice price for brand name drugs was 21.71 percent below AWP. The estimate combined all pharmacy categories except non-traditional pharmacies and was based on the comparison to AWP of 2,728 invoice prices received from 29 pharmacies. The standard deviation for this estimate was 0.52 percent..

The estimated difference between AWP and Invoice Price by individual categories for brand name drugs are summarized in the following table:

<u>Category</u>	<u>Percent Below AWP (Point Estimate)</u>	<u>Standard Deviation</u>	<u>Sample Pharmacies</u>	<u>Drug Prices Reviewed</u>
Rural-Chain	22.43	3.16	6	808
Rural-Independent	21.44	0.88	8	369
Urban-Chain	21.88	2.64	8	1,132
Urban-Independent	19.99	2.69	7	419
Non-Traditional	23.86	16.69	7	228
Overall (Exc. Non-Trad)	21.71	0.52	29	2,728”

In addition, the audit had the following findings with respect to generic drugs:

“We estimated that the invoice price for generic drugs was 68.92 percent below AWP. Once again, the estimate combined all pharmacy categories except non-traditional pharmacies. The estimate was based on the comparison to AWP of 1,507 invoice prices received from 29 pharmacies. The standard deviation for this estimate was 1.84 percent...”

The following table summarizes the results by category for generic drugs by showing the estimated difference between AWP and Invoice Price for Generic Drugs:

<u>“Category</u>	<u>Percent Below AWP (Point Estimate)</u>	<u>Standard Deviation</u>	<u>Sample Pharmacies</u>	<u>Drug Prices Reviewed</u>
Rural-Chain	73.48	7.51	6	462
Rural-Independent	68.47	5.94	8	185
Urban-Chain	70.29	10.52	8	689
Urban-Independent	54.94	21.99	7	171
Non-Traditional	61.38	14.82	8	152
Overall (Exc. Non-Trad)	68.92	1.84	29	1,507”

The OIG-DHHS reached the following conclusions and recommendations with respect to the Medicaid Prescription Drug Program:

“Based on our review, we determined that there was a significant difference between AWP and pharmacy acquisition costs. The difference between AWP and pharmacy acquisition costs was significantly greater for generic drugs than for brand name drugs. We recognize that acquisition cost is just one factor in pharmacy reimbursement policy and that any change to that policy should also consider the other factors discussed in the SCOPE section of our report.

Additionally, the effect of Federal upper limit amounts on generic drug reimbursements or usual and customary charge limitations should be taken into consideration. However, a change in any of the factors affecting pharmacy reimbursement could have a significant impact on expenditures because of the size of the program. We believe that the difference between AWP and pharmacy acquisition costs as determined by our review was significant enough to warrant consideration by the State in any evaluation of their Medicaid drug program. Therefore, we recommended that the State Agency consider the results of this review as a factor in determining any future changes to pharmacy reimbursement for Medicaid drugs.”

WVDHHR’s Response

The summary of the findings of the OIG’s Pharmacy Acquisition Costs for Drugs (A-06-01-00007, December 2001) states that overall, pharmacies located in West Virginia can

purchase brand-name drug products at an average of 21.71 percent below the average wholesale price (AWP) and generic drug products at an average of 68.92 percent below the AWP. Similar findings were generalized for the nation overall when the participating states' data were combined.

Following the release of this OIG report, the National Association of Chain Drug Stores (NACDS), the National Community Pharmacists Association (NCPA), the West Virginia Pharmacists Association (WVPA), and other groups representing retail pharmacies across the nation responded that errors were made in the methodology used by the OIG auditors while conducting their survey and that pharmacies could not purchase drugs at the prices proposed by the OIG. The Bureau for Medical Services met with leaders of the pharmacy community in West Virginia to respond to their concerns that West Virginia Medicaid would adopt these recommendations and reduce reimbursements to pharmacies. They predicted that pharmacies, particularly small independent ones, would be forced to close. They also reiterated that the OIG audit survey contained gross errors.

As a result of the national attention, the OIG agreed to address the concerns that had been raised and again analyze the data. Another report (A-06-02-00041) was released in September 2002, which further stratified the discounts as follows:

- Single source innovator drugs - pharmacies purchased drugs at an estimated 17.2 percent below AWP*
- All drugs without Federal Upper Limits (FUL) - pharmacies purchased drugs at an estimated 27.2 percent below AWP*
- Multiple source (generic) drugs without FULs - pharmacies purchased drugs at an estimated 44.2 percent below AWP*

- *Multiple source drugs with FULs - pharmacies purchased drugs at an estimated 72.1 percent below AWP*

Currently, West Virginia Medicaid reimburses pharmacies at the lower of (1) their usual and customary charge to the general public; (2) the Federal Upper Limit cost plus a dispensing fee of \$3.90; or (3) the Estimated Acquisition Cost defined as AWP minus 12 percent plus a dispensing fee of \$3.90.

As outlined in the OIG's survey narrative, reimbursement to pharmacies is based on two factors - the purchase price of drug products and a reasonable dispensing fee. The dispensing fee covers the pharmacies' cost of doing business, such as rent, utilities, salaries, etc. Therefore, any reduction in the reimbursement for the drug component would have to be balanced by an assessment of the cost of doing business, which was not a part of the OIG survey. The Bureau has not yet investigated this issue and cannot make adjustments in reimbursement until this can be conducted.

However, in response to the availability of low pricing for generic drugs, the Bureau is in the process of procuring a vendor to assist in a "State Maximum Allowable Cost" (SMAC) program. Utilizing a list of commonly used generic drugs that currently do not have a Federal Upper Limit, the vendor will ascertain the price that pharmacies generally pay for these generic drugs. Once this is accomplished, the Bureau will adopt these prices and reduce the overall reimbursement for generic drug products.

**State of West Virginia Medicaid Management Information System -
Service Auditor's Report (2001)**

ACS State Healthcare Services (ACS) headquartered in Atlanta, Georgia has a contract to act as the Fiscal Agent for the State of West Virginia Medicaid Program. As a part of

their contract with the West Virginia Department of Health and Human Resources, ACS processes approximately 15 million West Virginia Medicaid claims per year received from roughly 17,000 Medicaid service providers engaged in providing Medicaid-covered services to over 200,000 West Virginia recipients. Under the contract between ACS and the WVDHHR, the claims processing system for Medicaid, the Medicaid Management Information System (MMIS), is required to undergo an annual audit. As a part of our work, we have reviewed the Service Auditor's Report for 2001. We noted the Service Auditor's Report performed by Ethridge & Miller, PC, Certified Public Accountants set out the following testing procedures which they performed and highlighted the results of such testing as set forth below:

1. **"Testing Performed** - Reviewed restart and recovery procedures for evidence of current revisions and completeness.

Results of Testing - Exceptions noted. While the Atlanta data center performed disaster recovery testing, no local area network disaster recovery testing is performed in Charleston."

2. **"Testing Performed** - Tested a sample of claims utilizing override codes and reviewed for appropriate processing. Reviewed the Quality Control department review of all file update requests for the reference subsystem.

Results of Testing - Exceptions noted. The provider subsystem has the capability to populate a field noting license expiration date of a provider that has a licensing requirement. The system generates a letter sixty days prior to expiration of the license notifying the provider to submit new license information. After thirty days, the system generates a second letter reminding the provider of the need for current license information. If the information is not received prior to the license expiration date, the system places the provider on a hold for license renewal status and does not process any claims for that provider. During the audit period, providers with an expired license were not able to submit claims. To overcome this system control, BMS updated the license "through to" date to 2050 to allow providers to submit claims without regard to their license status. Manipulation of a system control should not be performed unless the control should not exist."

3. **“Testing Performed** - Observed the physical access controls in place and made inquiries of data center personnel to determine that access was restricted to authorized personnel according to job function.

Results of Testing - Exceptions noted. It was noted that the door to the computer area was not locked during the day thereby allowing unrestricted access.”

4. **“Testing Performed** - Reviewed a sample of access authorities granted to system users. Noted list of authorized users with update capabilities.

Results of Testing - Exceptions noted. Certain quality control unit personnel have update capability to the exam entry and claims correction screens in the claims processing subsystem. This allows the individual to enter claims and correct suspended claims in the system. Quality control personnel should not have update capability in this area. Update capability for these individuals have now been revised.”

5. **“Testing Performed** - Reviewed a sample of historical claims noting proper resolution of claims utilizing appropriate edit checks. Reviewed procedures for processing of adjudication and payment cycle reports.

Results of Testing - Exceptions noted. Stale dated checks and undeliverable checks that not valid live checks are voided by the State. However, the claims that created the payment are not voided in the system. Therefore, the MMIS is incorrect since the system indicates those claims that were paid by the voided check are still reflected as a paid claim. If a provider resubmitted these claims, they would be denied as a duplicate claim. The State should provide a detail listing of all claims supporting the voided check so a history only mass adjustment could be processed to correct the MMIS allowing the provider to resubmit the unpaid claims....”

6. **“Testing Performed** - Observed the receipt of paper claims in the mailroom and sorting of claims by type noting attachments. Examined a sample of claims for the assignment of a transaction control number by the microfilm machine. Reviewed batch cover sheets for accuracy of information. Selected a random sample of claims in the mailroom before microfilming and assigning control number and tested ability to locate claims several weeks after receipt.

Results of Testing - Exceptions noted. Based on the BMS quality control review of the contractual requirement to have claims keyed into the system within fifteen days from the date of microfilming, the contractual requirement was not met for several weeks at the beginning of the audit period. ACS set up an exam entry unit at one of their other facilities to relieve the backlog of claims in order to meet contractual requirements. The fifteen-day contractual requirement was met for the remainder of the audit period.

There were consistent problems with the filming of paper claims during the audit period. Poor image quality made it necessary for ACS to institute an in-house review of all processed film that resulted in a refilming of many claims. In one instance whole days of certain types of claims had to be refilmed. In some cases, the poor image quality was detected by State personnel attempting to review claims on microfilm. In a few instances, the filming machine issued duplicate transaction control numbers on paper claims being filmed.”

WVDHHR's Response

1. *Disaster recovery testing was performed on the LAN in the local Charleston office on December 14 and 15, 2000. Daily backups to an offsite facility are being performed on PC personal files and emails.*
2. *Since the State licensing boards issue licenses retroactively on a routine basis, it renders this feature of the MMIS inoperable.*
3. *Staff were temporarily located in the computer room area prior to remodeling the facility. The door was often open due to the nature of the staff duties which required them to have frequent access to the claims storage shelves that were just outside the door. Unauthorized staff is no longer permitted access to the area and the door remains secured at all times.*
4. *This issue was resolved during the FY 2000 Audit period and noted in the FY 2000 Audit response.*
5. *According to State Code, all providers had to become EFT (electronic funds transfer) by July 2002. There are now very few checks generated to providers. When one is returned for an incorrect address, the provider's accounts payable is put on hold so that no more checks are generated. Payments can be reissued to the provider by the process of a gross adjustment once he has notified provider enrollment of his new address.*

6. *There were consistent problems with the filming of paper claims during the audit period. Poor image quality made it necessary for ACS to institute an in-house review of all processed film that resulted in a refilming of many claims. In one instance whole days of certain types of claims had to be refilmed. In some cases, the poor image quality was detected by State personnel attempting to review claims on microfilm. In a few instances, the filming machine issued duplicate transaction control numbers on paper claims being filmed.*

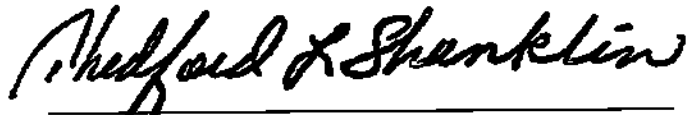
In 2002, ACS began a new imaging process for claims. Claims are now photo quality and can be easily accessed through password protected internet access. This has eliminated the need to make copies of claims from fiche.

STATE OF WEST VIRGINIA

OFFICE OF THE LEGISLATIVE AUDITOR, TO WIT:

I, Thedford L. Shanklin, CPA, Director of the Legislative Post Audit Division, do hereby certify that the Special Report of audit appended hereto was made under my direction and supervision, under the provisions of the West Virginia Code, Chapter 4, Article 2, as amended, and that the same is true and correct copy of said Special Reprt.

Given under my hand this 8th day of June, 2003.



Thedford L. Shanklin, CPA, Director
Legislative Post Audit Division

Copy forwarded to the Secretary of the Department of Administration to be filed as a public record. Copies forwarded to the Secretary of the Department of Health and Human Resources; Attorney General; Governor; State Auditor; and, Director of Finance Division, Department of Administration.