STATE OF WEST VIRGINIA

AUDIT REPORT

OF

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID PROGRAM

FOR THE PERIOD

JULY 1, 2000 - JUNE 30, 2002

OFFICE OF THE LEGISLATIVE AUDITOR

CAPITOL BUILDING

CHARLESTON, WEST VIRGINIA 25305-0610

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID PROGRAM

FOR THE PERIOD

JULY 1, 2000 - JUNE 30, 2002

WEST VIRGINIA LEGISLATURE

Joint Committee on Government and Finance

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CHARLESTON, WEST VIRGINIA 25305-0610

The Joint Committee on Government and Finance:

In compliance with the provisions of Chapter 4, Article 2, we have examined the accounts of the Medicaid Program of the West Virginia Division of Health and Human Resources (WVDHHR).

Our examination covers the period July 1, 2000 through June 30, 2002. The results of this examination are set forth on the following pages of this report.

Respectfully submitted,

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

TLS/gkc, ela, jdb

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID PROGRAM

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EXIT CONFERENCE

We held an exit conference on October 9, 2003 with the Secretary of the West Virginia Department of Health and Human Resources and other representatives of the Department of Health and Human Resources. All findings and recommendations were reviewed and discussed. The Department's responses are included in bold and italics in the Summary of Findings, Recommendations and Responses and after each finding in the General Remarks section of this report.

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID PROGRAM

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 six 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 five 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	Chief Operating Officer Bureau for Medical Services
Eric Cole	Chief Financial Officer Bureau for Medical Services

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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SUMMARY OF FINDINGS, RECOMMENDATIONS AND RESPONSES

Lack of Effective System of Internal Controls

1. During the course of our examination, it became apparent to us, based on the observed noncompliance with the West Virginia Code, the West Virginia Department of Health and Human Resources did not have an effective system of internal controls in place over the Medicaid Program to ensure compliance with applicable State laws, rules and regulations. We believe an effective system of internal controls would have alerted management to these violations at an earlier date and allowed more timely corrective action.

   Auditors' Recommendation

   We recommend the DHHR comply with Chapter 5A, Article 8, Section 9 of the West Virginia Code, as amended and establish a system of internal controls that will serve to alert management to areas of noncompliance with the West Virginia Code and other applicable rules and regulations.

   Agency's Response

   No response by the West Virginia Department of Health and Human Resources. **(See pages 14 and 15)**

Drug Rebates Due from Drug Manufacturers

2. The DHHR had total drug rebates due from various drug manufacturers totaling $2,457,406.06 as of May 2, 2003 of which $1,285,240.86 was more than 1 year and 278 days old which is the time limit recommended in the Dispute Resolution Process guidelines of the Centers for Medicare and Medicaid Services (CMS).

Auditors' Recommendation

We recommend the DHHR comply with the Drug Rebate Program Guide of the CMS (formerly HCFA), in collections of drug rebate amounts and use the available steps contained in the CMS Dispute Resolution Guide to collect overdue receivables.

Agency's Response

By February 2004, BMS expects to be able to track and become more efficient in reviewing data and ultimately collecting rebates in a more timely and effective fashion while continuing to reference the guidelines set forth by CMS. **(See pages 15-24)**

Internal Control Procedures for Non Emergency Transportation Payments

3. Cimarron Coach received payments for Non-Emergency Medical Transportation of at least $779,904.67 during the period July 1, 2000 through June 30, 2003 and we believe these payments included estimated overcharges totaling approximately $21,300.00.

Auditors' Recommendation

We recommend the DHHR review all payments made to Cimarron Coach during the period July 1, 2000 through June 30, 2003 and identify all instances of overpayments and request refunds for any overpayments identified. Also, we recommend the DHHR comply with

Chapter 5A, Article 8, Section 9 of the West Virginia Code, as amended; Chapter 19, Section 19.3, Subsection C of the West Virginia Income Maintenance Manual; and, Chapter 600 of the Medicaid Regulations.

Agency's Response

We believe the new claims processing and fiscal agent contract scheduled to be implemented in February 2004 will prevent the reoccurrence of the kind of enrollment error typified by this finding. **(See pages 24-32)**

Special Handling of State Warrants

4. During Fiscal Year 2003, after the effective date of provisions of State law requiring all payments to be made using electronic funds transfers (EFTs), the DHHR still made payments totaling $78,995,044.51 using State warrants rather than EFTs. State warrants were used to pay State Facility Disproportionate Share Income payments to State health care facilities; make payments to medical providers whose payments had been ordered to be intercepted by court order as part of the State's lien collection responsibilities and to make payments to some in-home care providers who lacked bank accounts.

Auditors' Recommendation

We recommend the DHHR comply with Chapter 12, Article 3, Section 1a of the West Virginia Code, as amended.

Agency's Response

The DHHR is forced to continue to make payments for the reasons specified in the audit finding. **(See pages 32-36)**

Copies of Files, Professional Licenses and Certifications and other Supporting Documents

5. Local county DHHR offices and the BMS Provider Enrollment Unit were unable to provide us with several files and supporting documents. As a result, we were unable to perform tests regarding some recipient's eligibility status, some medical service provider's eligibility for participation in the Medicaid Program and some Non Emergency Medical Transportation (NEMT) payments in order to determine if the DHHR was in compliance with the West Virginia Code and other rules, regulations and agency procedures. In addition, the BMS was unable to provide us with copies of the current professional licenses or certifications for 34 active Medicaid service providers.

Auditors' Recommendation

We recommend the DHHR comply with Chapter 5A, Article 8, Sections 9 and 17, of the West Virginia Code and the Provider Enrollment Application, by ensuring that all providers with licensing requirements have current license(s)/certification(s)/approval(s) on file at all times. We also recommend the BMS enter the actual expiration dates in the MMIS provider enrollment subsystem. We also recommend the DHHR maintain an effective system of managing Medicaid beneficiary files as required by the aforementioned sections of the West Virginia Code.

Agency's Response

The DHHR's new fiscal agent contract will require the fiscal agent to address the problem areas noted in this audit finding. **(See pages 37-42)**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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GENERAL REMARKS

INTRODUCTION

We have completed a post audit of the Medicaid Program of the State of West Virginia as administered by the West Virginia Department of Health and Human Resources (DHHR). This audit covered the costs of the Medicaid Program related to Medicaid Recipient Eligibility, Medicaid Provider Enrollment and Non-Emergency Medical Transportation. The audit covered the period of July 1, 2000 through June 30, 2002.

GENERAL REVENUE ACCOUNTS

General Revenue moneys are used to fund a portion of West Virginia State matching moneys for the Medicaid program. Contingent on both the timing of tax collections and the quarterly appropriation allotments, these funds are transferred as needed to the Medical Services Program Account (5084-999). These State matching moneys are appropriated through the following general revenue account:

ACCOUNT NUMBER	DESCRIPTION
0403-189	Medical Services

Also, appropriations are made to cover the health care costs incurred by the surviving former patients of the now closed Colin Anderson Center. State matching moneys are appropriated from the State General Revenue Fund and DHHR's Office of Behavior Health Services (OBHS) is invoiced for

the actual State share of costs incurred by the DHHR's Bureau for Medical Services(BMS). These State matching moneys are appropriated to OBHS through the following general revenue account:

ACCOUNT NUMBER	DESCRIPTION
0525-803	Colin Anderson Community Placement

SPECIAL REVENUE ACCOUNTS

In addition to the appropriations made from the State General Revenue Fund, a portion of the State of West Virginia's share of costs for the Medicaid program are also paid from the following special revenue accounts:

ACCOUNT NUMBER	DESCRIPTION
5084-999	Medical Services Program Fund Account
5090-999	Medicaid State Share Account
5185-999	Medicaid Services Trust Account
5405-539	Lottery Net Profits Account - Title XIX Waiver for Senior Citizens
5405-871	Lottery Net Profits Account - Senior Services Medicaid Transfer
5065-999	Human Services Personal Services Account
5072-999	Employee Benefits Account
5362-999	Human Services Administrative Expense Account

In accordance with Chapter 11, Article 27, Section 32 of the West Virginia Code, the Department of Tax and Revenue collects taxes that are assessed on various health care providers (Provider Tax). The collections of the Provider Tax are deposited by the Tax Department into the Medicaid State Share Account (5090-999). The Tax Department retains $200,000 each fiscal year for administrative expenses and the remaining monies, except for amounts needed for allowable refunds, are transferred

approximately once each week to the Medical Services Program Fund Account (5084-999) as funds become available.

Also, in accordance with Chapter 29, Article 22, Section 18 of the West Virginia Code, certain lottery profits are transferred from the Lottery Account (7202) to the Bureau for Senior Services' Lottery Net Profits Account (5405). Some of the monies transferred to the Lottery Net Profits Account are appropriated for use as State matching funds for the Medicaid Program. Transfers are made subject to appropriations on a quarterly basis from the Lottery Net Profits Account to the Medical Services Program Fund Account (5084-999).

FEDERAL REVENUE ACCOUNT

The drawdowns of Federal Medicaid matching funds are deposited into the following account prior to transfer to the Medical Services Program Fund Account (5084-999):

ACCOUNT NUMBER	DESCRIPTION
8722	Federal Funds Account

COMPLIANCE MATTERS

Chapter 9, Articles 4, 4A, 4B, and 4C of the West Virginia Code generally govern the West Virginia Medicaid Program. We tested the above plus general State regulations and other applicable chapters, articles and sections of the West Virginia Code as they pertain to financial matters. Our findings our discussed below:

Lack of Effective System of Internal Controls

During the course of our post audit, it became apparent to us, based on the observed noncompliance with the West Virginia Code and other rules and regulations, the Department of Health and Human Resources (DHHR) did not have an effective system of internal controls in place to ensure compliance with applicable State laws, rules and regulations.

Chapter 5A, Article 8, Section 9(b) of the West Virginia Code, as amended, states in part:

> "The head of each agency shall:. . .
> (b) Make and maintain records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures and essential transactions of the agency designed to furnish information to protect the legal and financial rights of the state and of persons directly affected by the agency's activities. . . ."

This law requires the agency head to have in place an effective system of internal controls in the form of policies and procedures set up to ensure the agency operates in compliance with the laws, rules and regulations which govern it.

During our audit of the DHHR Medicaid Program , we found the following instances of noncompliance with State laws or other rules and regulations: **(1)** Approximately $1.285 million in drug rebate receivables were outstanding more than one year and 278 days which is the time limit recommended by the Centers for Medicare and Medicaid Services (CMS). **(2)** DHHR did not follow it's own payment procedures in paying Cimarron Coach a total of $779,904.67 during fiscal years 2001, 2002 and 2003 for Non Emergency Medical Transportation (NEMT) resulting in estimated overcharges of approximately $21, 300.00. **(3)** The DHHR made payments to medical services providers totaling approximately $79,000,000 in Fiscal Year 2003 using State warrants even though State law calls for payments to be

made using electronic fund transfers. (4) Local county DHHR offices and the Bureau for Medical Services (BMS) Provider Enrollment Unit were unable to provide us with several files and supporting documents. As a result, we were unable to perform tests on transactions supported by these documents to determine if the DHHR was in compliance with the West Virginia Code and other rules, regulations, and agency procedures, and the BMS Provider Enrollment Unit was unable to provide copies of current professional licenses or certifications for 34 active providers and the Enrollment Unit manipulated the expiration dates entered in the MMIS so system controls designed to prevent payments to providers with expired licenses were inoperative.

We recommend the DHHR comply with Chapter 5A, Article 8, Section 9 of the West Virginia Code, as amended, and establish an effective system of internal controls that will serve to alert management to areas of noncompliance with the West Virginia Code and other applicable rules and regulations.

Agency's Response

No response by the West Virginia Department of Health and Human Resources.

Drug Rebates Due from Drug Manufacturers

During our review of the West Virginia Medicaid Drug Rebate Program, we noted the records of the Bureau for Medical Services showed $2,457,406.06 in total drug rebates due from various drug manufacturers were outstanding as of May 2, 2003 with $1,285,240.86 of these receivables older than the one year and 278 day time limit that is recommended in the Dispute Resolution Process guidelines designed by the Centers for Medicare and Medicaid Services (CMS). The details of the drug rebates receivable are reflected in the following schedule:

Period Covered	Amount of Invoiced Rebates	Amount of Rebates Collected	Receivable Amount as of May 2, 2003
10/01/2002 - 12/31/2002	$ 16,772,418.94	$ 16,323,605.18	$ 448,813.76
07/01/2002 - 09/30/2002	12,911,582.07	12,802,871.46	108,710.61
04/01/2002 - 06/30/2002	19,100,987.52	18,908,910.90	192,076.62
01/01/2002 - 03/31/2002	15,697,256.92	15,446,506.46	250,750.46
07/01/2001 - 12/31/2001	27,267,104.48	27,095,290.73	171,813.75
Subtotal:	**91,749,349.93**	**90,577,184.73**	**1,172,165.20**
MORE THAN 1 YEAR AND 278 DAYS OLD:			
01/01/2001 - 06/30/2001	27,554,546.75	27,288,269.61	266,277.14
01/01/2000 - 12/31/2000	47,801,166.26	46,782,373.08	1,018,793.18
01/01/1999 - 12/31/1999	40,915,437.03	40,915,266.49	170.54
Subtotal:	**116,271,150.04**	**114,985,909.18**	**1,285,240.86**
TOTALS	**$208,020,499.97**	**$205,563,093.91**	**$2,457,406.06**

The Medicaid Drug Rebate Program came about through an amendment to Title XIX of the Social Security Act, which requires Medicaid participating drug companies to offer rebates to the Medicaid programs of the various States for covered outpatient drugs (i.e., those drugs which may be dispensed only upon prescription). In general, in order for Federal Medicaid matching funds to be made available to the States for covered outpatient drugs, the Labeler (drug manufacturer) must enter into and have in effect a Rebate Agreement with the United States Government's Centers for Medicare and Medicaid Services (CMS). The Agreement requires the Labeler to provide certain pricing information to CMS to enable it to calculate a per Unit Rebate Amount (URA) for each covered outpatient drug. These

URAs are provided to both the administering Medicaid agencies of the various states and the participating Labelers. The Labelers receive information from the various agencies of each State responsible for administering the Medicaid Program of that particular State reflecting the total number of dosage units of each covered outpatient drug (utilization data) paid during a given calendar quarter. At the conclusion of every calendar quarter, the DHHR's Bureau for Medical Services (BMS) uses the URAs and utilization data to calculate drug rebates due from each labeler with an effective rebate agreement with CMS and whose drug products have been reimbursed by the West Virginia Medicaid Program. BMS then invoices each labeler for the amount due for that calendar quarter.

According to the BMS Registered Pharmacist, who is responsible for the invoicing and collecting of quarterly drug rebate amounts, the BMS has neither an automated rebate system nor a formal, State-written, procedure for following up on overdue drug rebate balances. However, BMS does follow a basic procedure of sending out reminder letters to manufacturers with outstanding drug rebate or interest amounts.

The BMS does have the full authority granted by the CMS Dispute Resolution Process to resolve disputed items and collect corresponding amounts due. According to the BMS Pharmacist, efforts to resolve disputed drug rebate receivables have extended to working with the manufacturers through an exchange of information and informal negotiation only. However, the BMS Pharmacist told us she does not schedule hearings or use any other settlement options, such as: mediation review, non-binding arbitration, binding arbitration, administrative review, or State hearings, all of which are avenues afforded the BMS under the CMS Dispute Resolution Process as shown below.

Specifically, Section K, of the CMS Dispute Resolution Process, of the Drug Rebate Program Guide, states in part:

> "After the labeler has reviewed the State's invoice(s) and, as necessary, has attempted an immediate resolution of any invoice item discrepancies, the labeler must notify the State of any remaining utilization data it wishes to dispute. This notification to the State begins the official dispute resolution process and must be given no later than 38 days after the utilization data is sent by the State. Labelers may dispute **ONLY THE NUMBER OF UNITS** reported by the State. Other items on the invoice for which the labeler disagrees, e.g., RPU [rebate per unit], reimbursed amounts, are not subject to dispute under the Dispute Resolution Process. This policy is consistent with the terms of the National Rebate Agreement.
>
> ... This process applies if immediate resolution of utilization data is not accomplished by the 38th day after the State sends its utilization data to the labeler. The Dispute Resolution Process is designed to provide general guidelines and associated time limits. HCFA [Health Care Finance Administration] continues to stress the importance of open communication between labelers and States, and of keeping the HCFA Regional Office Drug Payment Coordinators involved in the process.
>
> **PHASE I - EXCHANGE OF DATA TIME PERIOD**
>
> Phase I of the process begins after the State receives the labeler's notification of dispute (no later than the 38th day after the State utilization data is sent) and involves a period for both parties to seek resolution of the dispute through exchange of information and informal negotiations. . . .
>
> **PHASE II - FORMAL REVIEW**
>
> Phase II of the Dispute Resolution Process is initiated when the dispute has not been resolved using the steps in Phase I. The State or the labeler may proceed to phase II if either party has not fulfilled its obligations under any step in phase I of the process.
>
> **Within 30 days from the end of Phase I,** the State must schedule a hearing that must be conducted no later than one year from the 240th day after the State receives the labeler's dispute. The State and the labeler

may continue to attempt resolution of disputes before the hearing is conducted by considering the settlement options described below.

A. Mediation Review - . . . .
B. Non-Binding Arbitration - . . . .
C. Binding Arbitration - . . . .
D. Administrative Review - . . . .
E. State Hearing - . . . ."

The West Virginia Medicaid Drug Rebate Program can not benefit from the rebate amounts that remain uncollected. Therefore, other revenue sources will have to be used to fund the outpatient drugs dispensed to Medicaid beneficiaries through the program. When we asked about the efforts to collect outstanding drug rebate receivables, the BMS Pharmacist told us that because of other duties and responsibilities at BMS, she has not been able to spend as much time as she would like in collecting overdue receivables. In addition, this pharmacist is the only staff person available to work with the drug manufacturers on dispute resolution.

We recommend the DHHR comply the Drug Rebate Program Guide of the CMS (formerly HCFA), in collections of drug rebate amounts and use the available steps contained in the CMS Dispute Resolution Guide to collect overdue receivables.

Agency's Response

According to the preliminary draft of the post audit of the DHHR Medicaid Program, several instances of "noncompliance with State laws or other rules and regulations" were discovered. The recommendation was that DHHR needed to comply with the CMS Drug Rebate Program Guide in the collection of drug rebate amounts and use the available steps contained in the Guide to collect overdue receivables.

It should be clarified that the "Amount of Invoiced Rebates" includes the original amount of the invoice plus adjustments to the invoice. For example, for 4Q02, the original invoice amount was $16,168,012.83. There were adjustments that netted $604,406.11 for a total amount of $16,772,418.94, which was listed on the draft as "Amount of Invoiced Rebates." The amount of rebates collected for this quarter totaled $16,323,605.18. Also, it should be noted that the Medicaid Rebate Program collected 98.8% of the "Amount of Invoiced Rebates" in the period covered by the audit. If the "Original Amount Invoiced" is considered in regards to the amount collected, then the rebate program has collected 106.2% of the amount invoiced. Since the beginning of the Medicaid Drug Rebate Program in 1991, collected rebates amount to 99.2% based on the "Amount of Invoiced Rebate" or 100.7% based on the "Original Amount Invoiced."

It is stated in the draft that BMS uses data to calculate drug rebates due from "each labeler participating in the West Virginia Medicaid Program." It is true that BMS uses the unit rebate amounts from the CMS tape and the Medicaid drug utilization data to invoice the drug labelers for rebates, but the labelers must enter into and have in effect a rebate agreement with the Federal government, not the State government. This agreement requires the labeler to pay each State a quarterly rebate for their covered outpatient drugs paid by the State during that particular quarter.

Another statement included in the draft claims that, according to the BMS rebate pharmacist, BMS "has neither an automated system nor a standard procedure for following up on overdue drug rebate balances." The West Virginia Medicaid Rebate Program has historically been performed through a manual process using guidelines set forth by CMS. Dispute resolution

is typically a very time consuming and cumbersome process. The rebate staff resolves disputes as best as possible using their available staff resources. Just recently, we contracted the services of a new fiscal agent, Unisys, and we will be utilizing their Pharmaceutical Rebate Information Management System (PRIMS) starting in February 2004. We are very excited about this new venture and hope that it will allow us to have more control over our rebate program. PRIMS has many features that will help our program become more efficient. In addition, the accounting position in the Office of Accounting is being moved to the Bureau for Medical Services' Rebate Program Unit. The staff person in this position will be trained on PRIMS and be responsible for the accuracy of the rebate accounting. Once PRIMS is loaded and functioning, the rebate payments will be reconciled on a National Drug Code (NDC) level for the first time in West Virginia. This will also increase the efficiency of the program. The Medicaid Rebate Program does not have a "standard" written procedure for collecting overdue or unpaid invoice amounts or interest, but it is routine practice for the rebate staff to mail out notices to the labelers that rebate or interest amounts are past due. In addition, the staff communicates daily with the drug labelers via telephone and email regarding disputes and unpaid rebate amounts. Since the Rebate Program is currently undergoing changes in staffing responsibilities and duties and a new rebate computer system is being acquired, many of the current procedures will be changing. However, staff are drafting a new policy and procedure manual. Appropriate sections will be written and added as the new rebate system is put into place and procedures are defined. Once the manual is completed, it will be presented to management for review and approval. Changes and updates will be made to the manual as required to provide guidance to current staff, as well

as a transitioning and learning tool for new employees. This should help maintain continuity in the program.

According to the CMS Dispute Resolution Process, Phase I of the process begins after the State receives the labeler's notification of dispute, which is supposed to be no later that 38 days after the invoice is sent by the State. Within 90 days after the receipt of the labeler's dispute, the State discusses the units dispensed and the reasons for the dispute. The State then presents the labeler with a preliminary response for dispute resolution. The labeler and the State have to discuss and consider resolution only on paid units. Labeler/State settlements proposed on rebate amounts based solely on a dollar amount or a percentage of the disputed dollar amount are "unacceptable and NOT endorsed by HCFA" (CMS), according to the CMS rebate guide. Within 150 days after the receipt of the labeler's dispute, the State takes steps to resolve the questionable data, and the labeler can request more documentation from the State. If their differences remain unresolved, the labeler can request the State to perform random sampling of the pharmacy providers, and the State can request the labeler to validate data. Within 240 days after the receipt of the labeler's dispute, the State can cease the dispute resolution process if the disputed amount is both under $10,000 per labeler code and under $1,000 per product code. However, the state can maintain the discretion to continue the resolution process if cases fall below these thresholds. West Virginia Medicaid chooses to continue the process. Another option that can be used to facilitate the resolution within 240 days after receiving the labeler's dispute is a settlement based on utilization data that has been corrected by the State or other valid documentation that has been accepted and affects the drug utilization data. According to the

CMS guide, if the State and labeler are unable to reach an agreement, they proceed to Phase II- Formal Review Process. Within 30 days from the end of Phase I, (270 days after the receipt of the labeler's dispute), the State must schedule a hearing that must be conducted no later than one year from the 240th day after the State receives the labeler's dispute. A CMS rebate staff person was contacted on October 7, 2003 by BMS rebate staff inquiring about the Formal Review Process (Phase II). CMS staff communicated that they were not aware of any state that had ever conducted a formal hearing as a result of the Dispute Resolution Process. This statement was also made at a recent rebate meeting held in Boston, Massachusetts, in September 2003. CMS does hold yearly dispute resolution meetings if states and labelers want to attend, but it is completely on a voluntary basis.

The Bureau for Medical Services recognizes the usefulness of audits and the recommendations that come from them. The Rebate Program staff strives to comply with the Medicaid Drug Rebate Operational Training Guide and "Medicaid Drug Rebate Program Releases" prepared by CMS, since rebate agreements are between the labelers and the federal government. The Rebate Program staff acknowledge the Dispute Resolution Process and use many of the available steps included in the Process, as well as the suggested steps outlined in CMS' Best Practices Guide for Dispute Resolution Under the Medicaid Drug Rebate Program, to resolve disputed rebate units. As stated in the CMS Dispute Resolution Process, the Process is "designed to provide general guidelines and associated time limits." With the current changes that the Rebate Program is undergoing in staffing responsibilities and in contracting to obtain a new rebate computer system that will be functional in February 2004, BMS expects to be able

to track and become more efficient in reviewing data and ultimately collecting rebates in a more timely and effective fashion while continuing to reference the guidelines set forth by CMS.

Internal Control Procedures for Non Emergency Transportation Payments

The Department of Health and Human Resources (DHHR) failed to follow it's own internal control procedures when paying a transportation provider who transported Medicaid Program beneficiaries. This particular transportation provider, Cimarron Coach of Virginia, Inc. (Cimarron Coach) is a Specialized Multi-Passenger Van Provider, for Non Emergency Medical Transportation (NEMT). At a minimum, Cimarron Coach was paid $779,904.67 for improperly submitted claims for fiscal years 2001, 2002 and 2003 resulting in estimated overcharges totaling approximately $21, 300.00. While the claims were paid for services which legitimately benefitted Medicaid Program beneficiaries, these claims were improperly paid through the DHHR Local Office Recipient Automated Payment and Information Data System (RAPIDS) rather than though the Bureau for Medical Service's Medicaid Management Information System (MMIS) as they should have been. Our evaluation of the internal control structure of the DHHR indicates NEMT payouts processed through the MMIS system are subjected to scrutiny by employees who are generally more familiar with the NEMT Program requirements than employees in the Local County DHHR offices. More importantly, almost all of the payments made to Cimarron Coach which were examined by us indicated the provider had been overpaid for the transportation services provided. We believe processing these NEMT payments through RAPIDS rather than the MMIS, system may have contributed to the overcharges not being discovered.

Specifically, we believe Cimarron Coach was overpaid $139.75 for nine payments examined by us as shown in the following schedule:

Invoice Number	Actual Vendor Charges	Authorized Tariff Charges	(Undercharge)/ Overcharge
MCDHIC0500	$1,067.00	$1,101.25	($ 34.25)
MERMI0502	965.25	958.75	$6.50
MERPAL0502	630.00	660.00	(30.00)
MERCER0201C	530.73	487.75	42.98
MCDCCAM0101	531.60	485.00	46.60
MCDTHOM0701	482.78	457.50	25.28
MERCER0301K	377.73	365.78	11.95
MCDOWELL0500AE	240.10	210.50	29.60
MCDOWELL0601AP	291.09	250.00	41.09
TOTALS	$5,116.28	$4,976.53	$139.75

As shown in the schedule above, Cimarron Coach should have been paid $4,976.53 for these nine payments; however, records indicate Cimarron Coach was actually paid $5,116.28 which means the provider received excess payments of $139.75. At our request, utility analysts with the Public Service Commission of West Virginia reviewed the invoices reflected in the schedule above and concurred with our finding that Cimarron Coach generally charged amounts in excess of the authorized tariff rates. Projecting the net overcharges from the schedule to the total payments made to Cimarron Coach results in possible overcharges of approximately $21,300.00 during the period July 1, 2000 through June 30, 2003. Based on the documentation available to us, we were generally unable to trace the rates charged

by Cimarron Coach to any approved tariff rate schedule; however, we were able to determine Cimarron Coach was charging for time spent waiting for Medicaid beneficiaries to receive medical services which would not be an authorized charge for this type of provider. According to an HHR Senior Specialist for Office of Family Support, the administering agency for the DHHR Local Offices, employees at local DHHR county offices would not know the rate which should be charged by commercial carriers for transporting Medicaid beneficiaries which would indicate a lack of internal controls at the county level for monitoring NEMT payments to commercial carriers.

Chapter 600-C-2 of the Medicaid Regulations (Medicaid Program Instruction MA-01-02) states in part:

> "...**Specialized Multi Passenger Van Providers will be reimbursed at $20.00 base rate, $.75 per mile after the first 30 miles per round trip,** per patient, when transporting Medicaid eligible individuals to and from Medicaid covered scheduled medical appointments. When a patient is picked up at his/her home, transported to scheduled medical service, and returned to his/her place of residence, this constitutes one (trip). **This category of service provider will be enrolled for direct submission of claims to the Bureau for Medical Services..." (Emphasis added).**

The Bureau for Medical Services standard letter of notification to Specialized Multi-Passenger Provider states in part:

> "...**You are enrolled as a SPECIALIZED MULTI-PASSENGER VAN SERVICE, with a per trip, per passenger reimbursement rate of $20.00 base, and $ .75 per mile after the first 30 miles.** Provider type 903, SPECIALIZED MULTI-PASSENGER VAN SERVICE, must submit claims on paper claim forms WVMMIS-131, accompanied by the certification form signed by the transportation provider, the Medicaid eligible recipient, and the medical service provider, verifying attendance of the eligible recipient at schedule medical services....**Claims will be submitted directly to the West Virginia Medicaid claims processor** Consultec, Inc. P.O. Box 3768 Charleston, West Virginia 25337, accompanied by the above identified attachments..." **(Emphasis added).**

The DHHR file for Cimarron Coach indicated the provider applied for approval as a Specialized Multi Passenger Van Provider; however, Cimarron Coach failed to submit a copy of their Certificate of Convenience and Necessity (CON) issued by the Public Service Commission of West Virginia (PSC). At a later date, after Cimarron Coach failed to respond to a request for a copy of the CON, DHHR representatives apparently contacted the PSC directly and were told Cimarron Coach did have the required CON. The DHHR at that point approved Cimarron Coach's application. Based on our discussions with the PSC, we believe the DHHR may have been incorrectly told the required CON was on file with the PSC because Cimarron Coach has several different CON's approved by the PSC. The Bureau for Medical Services Provide Enrollment Unit's additional criteria required for enrollment of a Specialized Multi-Passenger Van Provider states in part:

> ". . . Specialized Multi-Passenger Van Service
>
> Attach:
> 1. Vehicle Registration
> 2. Business License
> 3. Driver(s) CPR and First Aid Certification
> 4. Proof of Liability Insurance in an Amount Not Less Than $100,000.00 Per Person, $500,000.00 Per Accident Which Is In Full Force and Effect.
> 5. **PSC Certificate for Convenience and Necessity from the Public Service Commission.**
> 6. CP-575 Form.-. ." **(Emphasis added)**

We believe the DHHR should review all payments made to Cimarron Coach during the period July 1, 2000 through June 30, 2003 and identify all instances of overpayments and request refunds for any overpayments identified.

In addition, we noted another transportation provider, a taxi company, (Tranportation Provider #1) provided transportation services to two different Medicaid beneficiaries; however, we could not determine if prior approval was actually given by the local DHHR County Office for use of this-provider by the Medicaid beneficiary. We were told by a DHHR Senior Specialist for the Office of Family Support that DHHR county office workers are not required to physically document instances of prior approval, but may provide such approval orally. According to DHHR policy, in the event that prior authorization is not given for travel and the Medicaid beneficiary uses a common carrier to make the trip, the Medicaid beneficiary must be able to show that automobile transportation by private car was not available, otherwise, reimbursement will be made at the current State mileage reimbursement rate instead of the actual taxi fare charged. Since no prior approval was evidenced in the records available to us, we determined Transportation Provider #1 was overpaid $205.47 for the two trips in question.

Chapter 19 Section 19.3, Subsection C of the West Virginia Income Maintenance Manual states in part:

> "... Whenever patients/applicants use more expensive transportation than the private auto mileage rate **without prior authorization,** they must show that only the more expensive transportation was available when the trip was taken. **If the patient/ applicant, for example, uses a taxi to make the trip but is unable to show that automobile transportation was not available, reimbursement will be at the current mileage rate instead of the taxi fare. . . . (Emphasis added)**

Chapter 600-C-2 of the Medicaid Regulations (Medicaid Program Instruction MA-01-02) states in part:

> "... **Common Carrier Services: Preauthorized transportation of Medicaid beneficiaries as approved by the local DHHR office.** This level of service is reimbursed through the Non-Emergency Medical

> Transportation Program (NEMT), administered by the Department of Health and Human Resources' County Office, to public railways, buses, cabs, airlines or other common carriers, at rates established by the West Virginia Public Service Commission or applicable Federal Regulatory Agency . . ." **(Emphasis added)**

Chapter 5A, Article 8, Section 9 of the West Virginia Code, as amended, states in part:

> "The head of each agency shall:
> (b) . . . **Make and maintain records** containing adequate and proper documentation of the organization, functions, policies, decisions, procedures and essential transactions of the agency designed to furnish information to protect the legal and financial rights of the state and of persons directly affected by the agency's activities . . ." **(Emphasis added).**

We believe the DHHR should review the requirements of Chapter 19, Section 19.3, Subsection C of the West Virginia Income Maintenance Manual and Chapter 600-C-2 of the Medicaid Regulations and determine an appropriate method for documenting instances of prior approval for use of certain transportation providers.

We recommend the DHHR review all payments made to Cimarron Coach during the period July 1, 2000 through June 30, 2003 and identify all instances of overpayments and request refunds for any overpayments identified. Also, we recommend the DHHR comply with Chapter 5A, Article 8, Section 9 of the West Virginia Code, as amended; Chapter 19 Section 19.3, Subsection C of the West Virginia Income Maintenance Manual; and, Chapter 600 of the Medicaid Regulations.

Agency's Response

The draft report states that the Department of Health and Human Resources (DHHR) failed to follow its own internal control procedures in paying a transportation provider,

specifically Cimarron Coach, who transported Medicaid Program beneficiaries to West Virginia Medicaid covered medical services. The issue cited in the report revolves around the fact that Cimarron Coach is both a common carrier, as certified by the Public Service Commission, with a Public Service Commission approved tariff or rate, and a Medicaid enrolled provider, classified as a specialized multi-passenger van provider for non-emergency medical transportation, authorized to submit claims directly to the Medicaid Program's MMIS Claims Processing System for reimbursement at the Department established rate for that service and that category of providers. The reimbursement for multi-passenger van services is a $20.00 base rate, plus 75¢ per mile after the first 30 miles. The Public Service Commission approved tariff or rate for common carrier is significantly higher.

The West Virginia Medicaid Program Regulations for Transportation Services recognizes two categories of non emergency transportation for which claims may be submitted directly to the MMIS System and reimbursed through that system to providers. Those are the specialized multi-passenger transport which is operated by an emergency medical services agency, and the specialized multi-passenger van transport which may be owned and operated by any private or non profit entity which meets the provider participation criteria and is enrolled with the program.

Those regulations also recognize two categories of transportation services which are authorized and administered at the local level by the county offices. Those two categories of transportation are: [1] reimbursement at the state employee mileage rate and for meals to friends, neighbors, relatives, and volunteers who transport Medicaid eligible individuals to

covered medical services, and [2] the use of common carriers, taxis, buses, airlines, etc., which may be authorized by county office staff to provide transport services and reimbursed at the prevailing rates established by the regulatory agency which controls that particular common carrier, in those situations in which other transportation resources are not available or are not appropriate.

It is the Department's position that the reimbursements made to Cimarron Coach, as authorized by county offices and reimbursed at the Public Service Commission approved rate, were appropriate and permissible within the Department's guidelines and within the administrative authority of the DHHR local office. There are many organizations, both private and public, which operate numerous related and/or different businesses under one corporate umbrella. The fact that an organization such as C & H Taxi might operate a yellow cab in addition to a Medicaid certified multi-passenger van service does not, on the face of it, preclude Medicaid utilizing and appropriately reimbursing either or both services.

The draft report does point out a weakness in the provider enrollment process, in that it does correctly point out that the Department of Health and Human Resources, Bureau for Medical Services, enrolled Cimarron Coach as a multi-passenger van service, based on a verbal assurance from the Public Service Commission that the entity did have the required certificate of need. In retrospect, we would agree that the Bureau should have required a copy of the CON prior to enrolling the provider. Had that procedure been followed, the Bureau would have been able to ascertain the appropriateness of the CON at issue, and whether or not it met the Bureau's Provider Enrollment criteria.

By way of corrective action, we would point out that the Department of Health and Human Resources, Bureau for Medical Services, has issued a contract to a new claims processing and fiscal agent, which is scheduled to be implemented in February 2004. Part of the responsibility of the provider under that new contract will be to perform provider enrollment, including assembling and maintaining all required provider credentialing. The internal controls, which will be implemented with the revised claims processing system, should prevent reoccurrence of the kind of enrollment error typified by this finding.

Special Handling of State Warrants

Chapter 12, Article 3, Section 1a, of the West Virginia Code, as amended, states in part:

> **"... That after the first day of July, two thousand two, the state auditor shall cease issuing paper warrants except for income tax refunds. After that date all warrants, except for income tax refunds, shall be issued by electronic funds transfer:** *Provided, however,* That the auditor, in his or her discretion, may issue paper warrants on an emergency basis: *Provided further,* That the treasurer and the auditor may contract with any bank or financial institution for the processing of electronic authorizations." **(Emphasis added)**

During our review of Medicaid provider payments made from the Medical Services Account (5084) during fiscal years 2002 and 2001, we learned $766,050,589.93, consisting of $339,070,246.03 and $426,980,343.90 in Fiscal Years 2002 and 2001, respectively, was paid to providers by use of "special handled" State warrants. During Fiscal Year 2003, after the effective date of the aforementioned provisions of State law, the DHHR still made payments to medical providers totaling $78,995,044.51 using State warrants rather than electronic fund transfer (EFT) payments. Generally, State warrants are mailed directly to vendors from the State Treasure's Office; however, when such State

warrants are designated for "special handling", the State warrants are returned or picked-up by the DHHR and mailed by them. Therefore, there is an increased risk State warrants may be lost or stolen when State warrants are designated for "special handling".

The State warrants processed for Medicaid by the State Treasurer are picked up by a BMS runner and delivered to the DHHR Bureau for Medical Services (BMS) Fiscal Agent Monitoring Unit. Employees of the BMS Fiscal Agent Monitoring Unit will locate and remove the State warrants that are to be redeposited by the BMS because such State warrants have become the subject of liens as set out below. All other State warrants are sent to the post office and mailed to the providers by BMS employees.

Considering the large volume of State warrants which were "special-handled" traditionally by the DHHR, we inquired through a memorandum dated January 27, 2003 as to the current policy of the DHHR in paying providers via "special handled" State warrants following the effective date for implementation of the requirement for EFT payments. The DHHR Assistant Secretary for Finance provided responses to our questions in a memorandum dated February 4, 2003, which states as follows:

> "... In 2001, the Bureau for Medical Services developed a plan to have all paper warrants direct mailed by the WV State Treasurer. **However, they soon learned that the Treasurer was unable to pull the warrants which needed to be cycled through the State Auditor's Office due to various liens. Accordingly, all paper warrants were required to be "special handled" in order to be able to honor the State's lien collection responsibilities. Any provider who is normally paid by EFT and is found to have an official lien recorded in the WV State Auditor's Office must be converted to a paper warrant payment. The State Auditor is currently unable to intercept EFT payments through his lien software package . . ." (Emphasis added)**

State warrants issued to Medicaid providers with liens attached represent a small percentage of the total State warrants processed. According to DHHR personnel, it may be possible to process State warrants for providers with liens separately from other providers paid by State warrant and, therefore, permit State warrants without liens to be mailed directly from the State Treasurer's Office.

Also, we noted all of the Non-Emergency Medical Transportation (NEMT) payments initiated by the local DHHR County Offices, which totaled $18,042,082.22, consisting of $9,855,818.84 and $8,186,263.38 in Fiscal Years 2002 and 2001, respectively, were paid by "special handled" State warrants. During the fiscal year ended June 30, 2003 (fiscal year 2003), NEMT payments continued to be made using State warrants and totaled $9,160,990.38. According to DHHR personnel, NEMT payments were "special handled" so remittance advices could be included with those payments made to vendors as explained in DHHR's memorandum to us dated February 4, 2003:

> "...Separate mail of the remittance advice has been considered for the NEMT payments. There is a small additional administrative cost to both the Treasurer (process two files - one for mail outs and one for "special handle") and DHHR (send a person to pick up checks) to "special handle" the small number of NEMT checks that we process. The Treasurer could also offer a lower cost of postage if they were mailed out directly. However, the additional postage costs plus the added confusion to the providers due to timing problems and inability to match the checks with the remittance advice (which would result in telephone response costs) caused us to conclude that "special handling" was the correct path. The vendors involved in the provision of transportation services to our clients typically do not have sophisticated accounts receivable processes..."

On August 12, 2003, we held a meeting with DHHR personnel with the purpose of obtaining further clarification on the DHHR's use of special handled warrants for paying medical services providers. During the meeting, we were told State Facility Disproportionate Share Income (DSH)

payments were paid using special handled checks since the DHHR's Medicaid Management Information System (MMIS), the primary accounting system for Medicaid provider payments, will not interface with the State's accounting system, WVFIMS, to permit the processing of intergovernmental transfers of funds. The DSH payments represent moneys due the State health care facilities which have been earned through providing medical services to Medicaid beneficiaries. Also, we were told segregating State DSH payments from the normal on-line processing of provider payments, is difficult, time-consuming and labor intensive process. As a result, the DHHR to overcome the weaknesses in the current system of processing DSH payments has continued to designate such payments to be made using special handled State warrants which are intercepted at the DHHR headquarters and deposited to the credit of the State health care facility which is due the money.

Department of Health and Human Resources representatives also told us that DHHR had conducted some preliminary discussions during the middle 1990's with the Information Services and Communications Division (IS&C) of the Department of Administration regarding interfacing DHHR'S MMIS with WV FIMS. However, those preliminary discussion were not followed up on and, as a result, State Facility DSH payments are still required to be processed through the use of "special handed" State warrants.

In addition, we were told some medical service providers who provide in-home care for Medicaid beneficiaries do not have bank accounts into which EFT payments can be wired. Therefore, according to DHHR personnel, these providers are required to continue to be paid by the use of State warrants. We believe the DHHR should work closely with the State Auditor, and State Treasurer, and the Information Services and Communications Division (ISCD) of the Department of Administration to develop

a system for payments which meets the requirements of Chapter 12, Article 3, Section 1a of the West Virginia Code, as amended and minimizes the use of paper State warrants and the "special handling" of such warrants.

We recommend the DHHR comply with Chapter 12, Article 3, Section 1a, of the West Virginia Code, as amended.

Agency's Response

The Bureau for Medical Services implemented policy changes on January 22, 2002 to comply with Chapter 12, Article 3, Section 1a, of the West Virginia Code which resulted in a decrease in provider payments made by paper warrants from $339,070,246.03 in SFY 2002 to $78,995,044 during SFY 2003. However, the Bureau for Medical Services has been forced to continue to make payments utilizing paper warrants rather than electronic fund transfer (EFT) for the following reasons:

[1] The State facility disproportionate share income payments are made via paper warrants due to the inability of the current Medicaid Management Information System (MMIS) and the West Virginia Financial Information Management System (WVFIMS) to have an electronic interface.

[2] Paper warrants are required in order for the Bureau for Medical Services to honor the State's lien collection responsibilities since the Auditor's office is currently unable to intercept EFT payments through the current lien software package.

[3] A small number of medical providers currently enrolled in the Medicaid Program do not have bank accounts into which EFT payments can be made.

Copies of Files, Professional Licenses and Certifications and other Supporting Documents

Local county DHHR offices and the BMS Provider Enrollment Unit were unable to provide us with several files and supporting documents. As a result, we were unable to perform tests on transactions supported by these documents regarding some recipient's eligibility status, some medical service provider's eligibility for participation in the Medicaid Program and some Non Emergency Medical Transportation (NEMT) payments to determine if the DHHR was in compliance with the West Virginia Code and other rules, regulations, and agency procedures. The files and documents which we were not provided are detailed as follows:

Medicaid Recipient Eligibility:

1. Local county offices were unable to provide us with two client files supporting medical assistance determinations, as well as, other assistance program eligibility decisions made. Since the files were not provided, we could not conclude if Medicaid eligibility decisions for these two cases were correct.

2. Although the DHHR Local County Offices provided us with the case files, the particular applications and other documents requested supporting three Medicaid eligibility determinations in our sample could not be located in these files. Therefore, we could not determine if Medicaid eligibility decisions for these three cases were correct.

3. One instance where documentation supporting the verification of income; one instance where documentation verifying the identity of two people in a case; and, one instance where documentation verifying the value of a vehicle were not found in the local county office case files.

Non Emergency Medical Transportation(NEMT):

1. Local county offices were unable to provide us with NEMT applications supporting nine transportation payments totaling $1,391.09. Therefore, we were unable to determine if payments were made in conformity with the policies and regulations governing NEMT.

2. A local DHHR county office was unable to provide us with documentation indicating prior approval was granted by the BMS Case Planning Unit, as required for NEMT regulations for an out-of-state trip. A total of $653.00 was paid for this trip to Mount Dora, Florida, made by a Medicaid client and her mother.

Provider Enrollment:

1. The Bureau for Medical Services Provider Enrollment Unit was unable to provide us with four provider files that had an "active" status in the Medicaid Management Information System (MMIS) during our audit period. Two of the four providers remained active in MMIS as of the date of this report. However, according to a MMIS payment history report, none of these providers were paid for claims during or subsequent to our audit period.

2. Also, during our review of provider files, we could not locate several documents required by the Provider Enrollment Application and/or Provider Manuals as follows:

   - A comprehensive waiver agreement for an aged/disabled waiver chore service provider,
   - A Public Service Commission Certificate of Convenience and Necessity for a multi-passenger van service provider,
   - A Certificate of Clinical Competence for an audiology provider,
   - A Bureau of Senior Services Letter of Approval for an aged/disabled waiver home care provider,
   - A West Virginia Emergency Medical Service's Medical Ambulance Certificate for an ambulatory provider,
   - The Business Ownership and Controlling Interest section of an enrollment application.
   - Two instances of pharmacists' professional licenses by pharmacy providers,
   - Three instances of tax Form W-9 used for tax reporting purposes, and
   - Four instances of a current West Virginia Business License for West Virginia-based providers.

   Chapter 5A, Article 8, Section 9, of the West Virginia Code, states in part:

   "The head of each agency shall: . . .
   (b) Make and maintain records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures and essential transactions of the agency designed to furnish information **to protect the legal and financial rights of the state and of persons directly affected by the agency's activities."** **(Emphasis added.)**

In additions, Chapter 5A, Article 8, Section 17 of the West Virginia Code, states in part:

> "Except as provided in section seven-a, article one, chapter fifty-seven of this code, **no record shall be destroyed or otherwise disposed of by any agency of the state,** unless it is determined by the administrator and the director of the section of archives and history of the division of culture and history that the record has no further administrative, legal, fiscal, research or historical value. . . ." **(Emphasis Added)**

Lastly, Chapter 19.3-B-2 of the Income Maintenance Manual states:

> "All requests for out-of-state transportation and certain related expenses **must have prior approval** from the Bureau of Medical Services, Case Planning Unit . . ." **(Emphasis Added).**

We were unable to determine why the aforementioned Medicaid eligibility client files and supporting documents could not be provided by local county offices. A Health and Human Resources (HHR) Senior Specialist for the Office of Family Support, the administering agency for the local county DHHR offices, told us it was the policy of Braxton, Nicholas, Webster, and Clay Counties, to purge NEMT Application/Verification of Attendance Forms after one year. We were unable to determine why two NEMT applications from McDowell County were not provided.

Also, the Supervisor for the BMS Provider Enrollment Unit said the four provider case files had been archived and the company who provides DHHR's archival services could not locate them. However, the Unit could not provide documentation indicating that these particular files had in fact been archived and forwarded to the archival company's custody. The Unit provided no explanation for the other missing documents in the provider files.

In addition, the Bureau of Medical Services was unable to provide copies of current professional licenses or certifications for 34 active Medicaid service providers. Regarding another 16

providers, three providers had a copy of a current license in their file, three providers were inactive (as of June 30, 2003) and ten providers did not provide the types of services which require professional licensure or certification.

Also, during our audit of provider license status, we noted a physician's Medical Physician and Surgeon's license had been expired since December 31, 2002, even though he was listed as active in the MMIS as of June 1, 2003. This provider, however, had no claims paid during the period his license was invalid.

Additionally, we learned an expired license/certification status for a provider in the MMIS enrollment module was designed to prevent claims from being paid. To override this internal control feature, the BMS Provider Enrollment Unit has established a policy of manipulating the expiration date of the provider's license, as the Medical Service provider's information is entered in the MMIS enrollment module, by entering either 010150 or 999999, rather than the actual expiration date stated on the license/certification. We evidenced this manipulation for all 39 providers that required professional license/certification. As a result, BMS has not made full and complete use of the available internal control features designed to prevent payments to providers that do not have current licenses.

Chapter 5A, Article 8, Section 9, of the West Virginia Code, states in part:

> "(b) Make and maintain records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures and essential transactions of the agency designed to furnish information **to protect the legal and financial rights of the state and of persons directly affected by the agency's activities." (Emphasis added.)**

Item number 4 on the Medicaid Provider Enrollment Application, states in part:

> "Enter your most current **Professional License/Certification Number** information below for state in which you currently practice for which you are making an application. **(ATTACH A COPY OF YOUR LICENSE/CERTIFICATION - THIS IS REQUIRED. CURRENT LICENSE MUST BE ON FILE AT ALL TIMES-YOU MAY FAX YOUR RENEWALS PRIOR TO EXPIRATION)."**

According to a BMS Provider Enrollment Unit employee, it is not possible for them to ensure licenses/certifications remain current since the effective periods and the expiration dates of licenses/certifications vary significantly. Also, we were told that medical services providers are responsible for sending in copies of licenses/certifications. However, we believe the possibility exists for BMS to pay for claims filed by providers who do not have valid professional licenses or certifications if the status of provider licenses or certifications are not verified and the license/certification dates are not correctly entered into the provider subsystem.

We recommend the DHHR comply with Chapter 5A, Article 8, Section 9 and 17, of the West Virginia Code and the Provider Enrollment Application , by ensuring that all providers with licensing requirements have current license(s)/certification(s)/approval(s) on file at all times. We also recommend BMS enter the actual expiration dates in the MMIS provider enrollment subsystem. We also recommend the DHHR maintain an effective system of managing Medicaid beneficiary files as required by the aforementioned sections of the West Virginia Code.

Agency's Response

With regard to these findings, we can only acknowledge that the findings are accurate as stated. The Bureau, as previously stated, is in the process of contracting with a new fiscal

agent who will assume the responsibilities of provider enrollment under the terms of the revised contract, which will be implemented in February 2004. The new fiscal agent will be responsible for all provider enrollment functions, to include assembling and maintaining appropriate credentialing documents, licenses, and certifications. Additionally, it should be pointed out that the issue of maintaining current professional practitioner licenses and provider files was addressed in a single audit finding recently, and the Bureau responded by working with the West Virginia Board of Medicine (physician licensing board) to obtain an annual listing of physician license renewals via electronic media transmission.

INDEPENDENT AUDITORS' OPINION

The Joint Committee on Government and Finance:

We have audited the statement of appropriations/cash receipts, expenditures/disbursements and changes in fund balances of the Medicaid Program of the West Virginia Department of Health and Human Resources for the years ending June 30, 2002 and June 30, 2001. The financial statement is the responsibility of the management of the Medicaid Program of the West Virginia Department of Health and Human Resources. Our responsibility is to express an opinion on the financial statement based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance as to whether the financial statement is free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statement. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As described in Note A, the financial statement was prepared on the cash and modified cash bases of accounting, which are comprehensive bases of accounting other than generally accepted accounting principles.

In our opinion, the financial statement referred to above presents fairly, in all material respects, the appropriations and expenditures and revenues collected and expenses paid of the Medicaid Program of the West Virginia Department of Health and Human Resources for the years ended June 30, 2002 and June 30, 2001 on the bases of accounting described in Note A.

Our audit was conducted for the purpose of forming an opinion on the basic financial statement taken as a whole. The supplemental information is presented for purposes of additional analysis and is not a required part of the basic financial statement. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statement and, in our opinion, is fairly stated in all material respects in relation to the basic financial statement taken as a whole.

Respectively submitted,

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

August 19, 2003

Auditors: Michael E. Sizemore, CPA, Supervisor
Stanley D. Lynch, CPA, Auditor-in-Charge
Peter J. Maruish, Jr., CPA
Trenton W. Morton

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
MEDICAID PROGRAM
STATEMENT OF APPROPRIATIONS/CASH RECEIPTS
AND CHANGES IN FUND BALANCE

	Year Ended June 30, 2002	
	General Revenue	Special Revenue
Appropriation/ Cash Receipts:		
Appropriations	$191,898,803.00	$ 0.00
Transfers from Department of Tax and Revenue for Provider Tax Collections	0.00	148,200,000.00
Transfers from Bureau for Senior Services - Title XIX Waiver for Senior Citizens	0.00	12,600,000.00
Transfers from Bureau for Senior Services - Medicaid Match for Senior Services	0.00	10,300,000.00
Transfers of Federal Funds for Maternal and Child Health Programs	0.00	1,419,493.08
Transfers from Office of Maternal, Child and Family Health for Medical Claims Processed	0.00	193,523.93
Transfers from Office of Behavior Health Services for Health Care Costs for former Colin Anderson Center Patients	0.00	3,437,443.90
Transfers of Federal Funds for HIV/AIDS Special Pharmacy Grant	0.00	0.00
Unclaimed Property/Esheated Checks	0.00	14,987.60
Transfers from William R. Sharpe, Jr. Hospital for Disproportionate Share Income	0.00	13,817,723.00
Transfers from Welch Community Hospital for Disproportionate Share Income	0.00	3,494,505.50
Transfers from Mildred Mitchell - Batemen Hospital for Disproportionate Share Income	0.00	8,231,662.00
Interest Earnings	0.00	216,580.53
Federal Funds	0.00	0.00
	191,898,803.00	201,925,919.54
Expenditures/Disbursements:		
Transfers to Human Services Administrative Expense Account - Account 5362	3,686,789.00	0.00
Current Expenses	0.00	358.58
Payments to Medicaid Providers	0.00	1,609,963,509.53
Federal Subrecipient Payments	0.00	195,819.35
Transfers to Human Services Personal Services Account - Account 5065	0.00	0.00
Transfers to Human Services Employee Benefit Account - Account 5072	0.00	0.00
Miscellaneous Transfers	0.00	0.00
	3,686,789.00	1,610,159,687.46
Appropriations/Cash Receipts Over/(Under) Expenditures Disbursements	188,212,014.00	(1,408,233,767.92)
Expirations and Expenditures After June 30	0.00	0.00
Transfers (Out)/In	(188,212,014.00)	1,394,393,520.62
Beginning Balance	0.00	23,350,366.13
Ending Balance	$ 0.00	$ 9,510,118.83

See Notes to Financial Statement

Federal Funds	Combined Totals	General Revenue	Special Revenue	Federal Funds	Combined Totals
		Year Ended June 30, 2001			
$ 0.00	$ 191,898,803.00	$187,883,000.00	$ 0.00	$ 0.00	$ 187,883,000.00
0.00	148,200,000.00	0.00	145,800,000.00	0.00	145,800,000.00
0.00	12,600,000.00	0.00	12,600,000.00	0.00	12,600,000.00
0.00	10,300,000.00	0.00	6,500,000.00	0.00	6,500,000.00
0.00	1,419,493.08	0.00	1,715,898.43	0.00	1,715,898.43
0.00	193,523.93	0.00	387,136.02	0.00	387,136.02
0.00	3,437,443.90	0.00	1,367,961.88	0.00	1,367,961.88
0.00	0.00	0.00	100,627.42	0.00	100,627.42
0.00	14,987.60	0.00	4,193.98	0.00	4,193.98
0.00	13,817,723.00	0.00	8,439,903.00	0.00	8,439,903.00
0.00	3,494,505.50	0.00	3,857,007.00	0.00	3,857,007.00
0.00	8,231,662.00	0.00	6,096,617.00	0.00	6,096,617.00
0.00	216,580.53	0.00	546,135.23	0.00	546,135.23
1,274,533,969.16	1,274,533,969.16	0.00	0.00	1,154,485,574.86	1,154,485,574.86
1,274,533,969.16	1,668,358,691.70	187,883,000.00	187,415,479.96	1,154,485,574.86	1,529,784,054.82
34,951,575.39	38,638,364.39	0.00	107,946.00	29,207,039.60	29,314,985.60
0.00	358.58	0.00	219,506.53	0.00	219,506.53
0.00	1,609,963,509.53	0.00	1,460,292,289.64	0.00	1,460,292,289.64
0.00	195,819.35	0.00	491,872.12	0.00	491,872.12
25,475,121.03	25,475,121.03	0.00	308,403.00	27,585,410.26	27,893,813.26
7,925,766.12	7,925,766.12	0.00	97,659.00	8,451,435.00	8,549,094.00
0.00	0.00	0.00	42,834.00	0.00	42,834.00
68,352,462.54	1,682,198,939.00	0.00	1,461,560,510.29	65,243,884.86	1,526,804,395.15
1,206,181,506.62	(13,840,247.30)	187,883,000.00	(1,274,145,030.33)	1,089,241,690.00	2,979,659.67
0.00	0.00	(4,118,650.00)	0.00	0.00	(4,118,650.00)
(1,206,181,506.62)	0.00	(183,764,350.00)	1,273,006,040.00	(1,089,241,690.00)	0.00
0.00	23,350,366.13	0.00	24,489,356.46	0.00	24,489,356.46
$ 0.00	$ 9,510,118.83	$ 0.00	$ 23,350,366.13	$ 0.00	$ 23,350,366.13

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID PROGRAM

NOTES TO FINANCIAL STATEMENTS

Note A - Accounting Policies

Accounting Method: The modified cash basis of accounting is followed for the General Revenue Fund. The major modification from the cash basis is that a 31-day carry-over period is provided at the end of each fiscal year for the payment of obligations incurred in that year. All balances of the General Revenue Fund appropriations for each fiscal year expire on the last day of such fiscal year and revert to the unappropriated surplus of the fund from which the appropriations were made, except that expenditures encumbered prior to the end of the fiscal year may be paid up to 31 days after the fiscal year-end; however, appropriations for buildings and land remain in effect until three years after the passage of the act by which such appropriations were made. The cash basis of accounting is followed by all other funds. Therefore, certain revenue and related assets are recognized when received rather than when earned, and certain expenses are recognized when paid rather than when the obligation is incurred. Accordingly, the financial statement is not intended to present financial position and results of operations in conformity with generally accepted accounting principles.

Expenditures paid after June 30 in the carry-over period and expirations were as follows:

	Expenditures Paid After June 30,		Expirations	
	July 31, 2002	July 31, 2001	July 31, 2002	July 31, 2001
Unclassified	$0.00	$0.00	$0.00	$4,118,650.00

Combined Totals: The combined totals contain the totals of similar accounts for the various funds. Since the appropriations and cash receipts are restricted by various laws, rules and regulations, the totaling of the accounts is for memorandum purposes only and does not indicate that the combined totals are available in any manner other than that provided by such laws, rules and regulations.

Note B - Pension Plan

All eligible employees are members of the West Virginia Public Employees' Retirement System. Employees' contributions are 4.5% of their annual compensation and employees have vested rights under certain circumstances. The West Virginia Department of Health and Human Resources matches contributions at 9.5% of the compensation on which the employees made contributions. The West Virginia Department of Health and Human Resources' pension expenditures related to the Medicaid Program were as follows:

	Year Ended June 30,	
	2002	2001
General Revenue	$2,307,134.93	$2,212,715.42

SUPPLEMENTAL INFORMATION

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID PROGRAM

STATEMENT OF APPROPRIATIONS AND EXPENDITURES

GENERAL REVENUE

	Year Ended June 30, 2002	2001
Medical Services - Account 0403-189		
Appropriations	$186,898,803.00	$182,883,000.00
Expenditures:		
Transfers to Medical Services Program Account - Account 5084	183,212,014.00	178,764,350.00
Transfers to Human Services Administrative Expense Account- Account 5362	3,686,789.00	0.00
	186,898,803.00	178,764,350.00
	0.00	4,118,650.00
Transmittals Paid After June 30	0.00	0.00
Balance	$ 0.00	$ 4,118,650.00

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID PROGRAM

STATEMENT OF APPROPRIATIONS AND EXPENDITURES

GENERAL REVENUE

	Year Ended June 30, 2002	2001
Medical Services Trust Fund Transfer - Account 0403-512		
Appropriations	$5,000,000.00	$5,000,000.00
Expenditures:		
Transfers to Medical Services Trust Fund Account - Account 5185-553	5,000,000.00	5,000,000.00
	0.00	0.00
Transmittals Paid After June 30	0.00	0.00
Balance	$ 0.00	$ 0.00

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
MEDICAID PROGRAM
STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
SPECIAL REVENUE

	Year Ended June 30, 2002	2001
Medical Services Program Account - 5084-999		
Beginning Balance:		
State Treasury	$ 17,934,046.83	$ 8,794,442.89
Cash Receipts:		
Transfers from Federal Account for Federal Medicaid Match - Account 8722	1,206,181,506.62	1,089,241,690.00
Transfers from State General Revenue for State Matching - Account 0403-189	183,212,014.00	178,764,350.00
Transfers from Department of Tax and Revenue for Provider Tax Medicaid State Share Account - Account 5090	148,200,000.00	145,800,000.00
Transfers from Medicaid Trust Fund Account - Account 5185	29,366,764.05	33,704,248.50
Transfers from Bureau for Senior Services for Title XIX Waiver for Senior Citizens - Account 5405-539	12,600,000.00	12,600,000.00
Transfers from Bureau for Senior Services for Medicaid Match for Senior Services - Account 5405-871	10,300,000.00	6,500,000.00
Transfers from Federal Funds for Maternal and Child Health Programs - Account 8750	1,419,493.08	1,715,898.43
Transfer from Office of Maternal, Child and Family Health for Medical Claims Processed - Account 0570	193,523.93	387,136.02
Transfer from DHHR Office of Behavior Health Services for State Share of Health Care Costs incurred for former Colin Anderson Center Patients - Account 0525-803	3,437,443.90	1,367,961.88
Transfer from Federal Funds for HIV/AIDS Special Pharmacy Grant - Account 8802	0.00	100,627.42
Unclaimed Property/Esheated Checks	14,987.60	4,193.98
	1,612,859,780.01	1,470,186,106.23
TOTAL CASH TO ACCOUNT FOR	$1,630,793,826.84	$1,478,980,549.12
Disbursements:		
Current Expenses	$ 358.58	$ 219,506.53
Payments to Medicaid Providers	1,627,897,556.36	1,460,292,289.64
Federal Subrecipient Payments	195,819.35	491,872.12
Miscellaneous Disbursement	0.00	42,834.00
	1,628,093,734.29	1,461,046,502.29
Ending Balance		
State Treasury	2,700,092.55	17,934,046.83
TOTAL CASH ACCOUNTED FOR	$1,630,793,826.84	$1,478,980,549.12

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID PROGRAM

STATEMENT OF APPROPRIATIONS AND EXPENDITURES

SPECIAL REVENUE

	Year Ended June 30, 2002	2001
Medical Services Trust Fund Account		
Non-State Institution Disproportionate Share Hospital-		
Account 5185-492/287		
Appropriations	$14,557,600.00	$14,557,600.00
Expenditures:		
Transfers to Medical Services Program Fund for Non-State Institution Disproportinate Share	11,098,065.21	13,996,524.00
	3,459,534.79	561,076.00
Transmittals Paid After June 30	0.00	0.00
Balance	$ 3,459,534.79	$ 561,076.00

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID PROGRAM

STATEMENT OF APPROPRIATIONS AND EXPENDITURES

SPECIAL REVENUE

	Year Ended June 30, 2002	2001
Medical Services Trust Fund Account		
Medicaid Eligibility Expansion - Account 5185-582		
Appropriations	$5,478,398.00	$5,461,714.00
Expenditures:		
Transfers to Medical Services Program Fund - Account 5084	1,026,448.53	4,418,152.50
Transfers to Human Services Personal Services Account - Account 5065	0.00	308,403.00
Transfers to Human Services Administrative Expense Account - Account 5362	0.00	107,946.00
Transfers to Human Services Employee Benefit Account - Account 5072	0.00	97,659.00
	1,026,448.53	4,932,160.50
Transmittals Paid After June 30	0.00	0.00
Balance	$1,026,448.53	$4,932,160.50

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID PROGRAM

STATEMENT OF APPROPRIATIONS AND EXPENDITURES

SPECIAL REVENUE

	Year Ended June 30, 2002	2001
Medical Services Trust Fund Account		
State Institution Disproportionate Share Hospital - Account 5185-583		
Appropriations	$6,566,355.00	$6,566,355.00
Expenditures:		
Transfers to Medical Services Program Fund - 5084	6,566,355.00	4,477,457.00
	0.00	2,088,898.00
Transmittals Paid After June 30	0.00	0.00
Balance	$ 0.00	$2,088,898.00

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID PROGRAM

STATEMENTS OF APPROPRIATIONS AND EXPENDITURES

SPECIAL REVENUE

	Year Ended June 30, 2002	2001
Medical Services Trust Fund Account		
Hospice Services - Account 5185-584		
Appropriations	$ 342,975.00	$ 340,115.00
Expenditures:		
Transfers to Medical Services Program Fund - Account 5084	203,895.31	340,115.00
	139,079.69	0.00
Transmittals Paid After June 30	0.00	0.00
Balance	$ 139,079.69	$ 0.00
Medical Services Trust Fund Account		
Federal Match Rate Drop- Account 5185-585		
Appropriations	$10,472,000.00	$10,472,000.00
Expenditures:		
Transfers to Medical Services Program Fund - Account 5084	10,472,000.00	10,472,000.00
Balance	$ 0.00	$ 0.00

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
MEDICAID PROGRAM
STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
SPECIAL REVENUE

	Year Ended June 30, 2002	2001
Medical Services Trust Fund Account - Account 5185-999		
Beginning Balance:		
State Treasury	$ 1,020,227.60	$ 0.00
Cash Receipts:		
Transfers from General Revenue - Account 0403-512	5,000,000.00	5,000,000.00
Transfers from William R. Sharpe, Jr. Hospital for State Disproportionate Share Income - Account 2926	13,817,723.00	8,439,903.00
Transfers from Welch Community Hospital for State Disproportionate Share Income - Account 2845	3,494,505.50	3,857,007.00
Transfers from Mildred Mitchell - Bateman Hospital for State Disproportionate Share Income - Account 2927	8,231,662.00	6,096,617.00
Interest Earnings	216,580.53	546,135.23
Transfer from Investment Management Board-Account N-310000000-01	28,666,765.05	34,538,484.10
Miscellaneous Receipt	0.00	42,834.00
	59,427,236.08	58,520,980.33
TOTAL CASH TO ACCOUNT FOR	$60,447,463.68	$58,520,980.33
Disbursements:		
Transfers to Medical Services Program Fund Account for Non-State Institutions Disproportionate Share Hospital - Account 5084-492/287	$11,098,065.21	$13,996,524.00
Transfers to Medical Services Program Fund Account for Medicaid Eligibility Expansion - Account 5084	1,026,448.53	4,460,986.50
Transfers to Medical Services Program Fund for State Institution Disproportionate Share Hospital - Account 5084	6,566,355.00	4,477,457.00
Transfers to Medical Services Program Fund for Hospice Services - Account 5084	203,895.31	340,115.00
Transfers to Medical Services Program Fund for Federal Match Rate Drop- Account 5084	10,472,000.00	10,472,000.00
Transfers to Human Services Personal Services Account for Medicaid Eligibility Expansion - Account 5065	0.00	308,403.00
Transfers to Human Services Administrative Expense Account for Medicaid Eligibility Expansion - Account 5362	0.00	107,946.00
Transfers to Human Services Employee Benefit Account for Medicaid Eligibility Expansion - Account 5072	0.00	97,659.00
Transfers to Investment Management Board	31,080,699.63	23,239,662.23
	60,447,463.68	57,500,752.73
Ending Balance		
State Treasury	0.00	1,020,227.60
TOTAL CASH ACCOUNTED FOR	$60,447,463.68	$58,520,980.33

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAID PROGRAM

STATEMENT OF CASH RECEIPTS, DISBURSEMENTS

AND CHANGES IN CASH BALANCE

SPECIAL REVENUE

	Year Ended June 30,	
	2002	2001
Investments - Account (N310000000-01)		
Cash Receipts:		
Transfers from the Medical Services Trust Fund Account - Account 5185	$30,864,119.10	$22,693,527.00
Interest	216,580.53	546,135.23
	31,080,699.63	23,239,662.23
Disbursements:		
Transfers to the Medical Services Trust Fund Account - Account 5185	28,666,765.05	34,538,484.10
Cash Receipts Over Disbursements	2,413,934.58	(11,298,821.87)
Beginning Balance	4,396,091.70	15,694,913.57
Ending Balance	$ 6,810,026.28	$ 4,396,091.70

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
MEDICAID PROGRAM
STATEMENT OF CASH RECEIPTS, DISBURSEMENTS
AND CHANGES IN CASH BALANCE
FEDERAL PROGRAMS

	Year Ended June 30, 2002	2001
Consolidated Federal Funds		
General Administration Account - Account 8722-999		
Cash Receipts:		
Federal Funds	$1,322,318,984.24	$1,196,659,831.86
Returned to U.S. Department of Health and Human Services - Previous Fiscal Year Disallowed Federal Share Administrative Costs for West Virginia Child Support Enforcement Program	0.00	398,851.00
	1,322,318,984.24	1,196,260,980.86
Disbursements:		
Transfers to the Medical Services Program Account - Account 5084	1,206,181,506.62	1,089,241,690.00
Transfers to Human Services Administrative Expense Account - Account 5362	34,951,575.39	29,207,039.60
Transfers to Human Services Personal Services Account - Account 5065	25,475,121.03	27,585,410.26
Transfers to Human Services Employee Benefit Account - Account 5072	7,925,766.12	8,451,435.00
Transfers to Food Stamp Employment Program Account - Account 5077	792,243.66	362,568.00
Transfers to Child Enforcement Fund - Account 5094	18,591,484.42	18,477,983.00
Transfers to Services to Children and Adults Fund Account - Account 5074	28,401,287.00	20,103,597.00
Transfers to West Virginia Title XXI - Medicaid Fund Account - Account 5452	0.00	219,469.00
Transfers to West Virginia Children's Health Fund Account - Account 5451	0.00	2,295,164.00
Transfers to West Virginia Children's Health Fund Account - Account 2154	0.00	316,625.00
	1,322,318,984.24	1,196,260,980.86
Cash Receipts Over Disbursements	0.00	0.00
Beginning Balance	0.00	0.00
Ending Balance	$ 0.00	$ 0.00

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 report 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 a true and correct copy of said report.

Given under my hand this 19th day of October 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 West Virginia Department of Health and Human Resources; Governor; Attorney General; State Auditor; and, Director of Finance Division, Department of Administration.