U.S. Department of the Interior
Office of Inspector General

AUDIT REPORT

MEDICAID PROGRAM GRANTS, DEPARTMENT OF HEALTH, GOVERNMENT OF THE VIRGIN ISLANDS

REPORT NO. 99-I-957
SEPTEMBER 1999

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United States Department of the Interior

OFFICE OF INSPECTOR GENERAL
Washington, D.C. 20240

SEP 30 1999

Honorable Charles W. Tumbull
Governor of the Virgin Islands
No. 2 1 Kongens Gade
Charlotte Amalie, Virgin Islands 00802

Subject: Audit Report on Medicaid Program Grants, Department of Health, Government of the Virgin Islands (No. 99-I-957)

Dear Governor Turnbull:

This report presents the results of our audit of the management of Medicaid Program grants by the Bureau of Health Insurance and Medical Assistance of the Virgin Islands Department of Health. The objective of the audit was to determine whether (1) the Department complied with grant terms and applicable laws and regulations; (2) charges made against grant funds were reasonable, allowable, and allocable pursuant to the grant agreement provisions; (3) funds received through electronic transfers were appropriately deposited to and accounted for in the Government's Financial Management System; and (4) drawdowns were made in accordance with the Cash Management Act of 1990. The scope of the audit included Program activities that occurred during fiscal years 1997 and 1998.

Based on our audit, we concluded that the Bureau of Health Insurance and Medical Assistance generally expended grant funds for purposes that were allowable under the grants and accomplished the primary objective of providing low-income individuals with quality health care services. However, the Bureau did not effectively perform some of the administrative functions of the Medicaid Program, did not effectively follow up on the results of quality control reviews, and did not ensure that all payroll costs were correct and adequately supported. Specifically, we found that:

- The Bureau did not (1) ensure that health care providers were properly licensed and had current agreements with the Medicaid Program, (2) purchase equipment and supplies at the most cost-effective prices, (3) maintain complete and accurate property management records and perform physical inventories of equipment at least biennially, and (4) establish a claims processing assessment system that was in compliance with Federal regulations. As a result, Medicaid Program funds of at least $1,169 were expended for purchases that, in our opinion, were not needed to accomplish Program objectives.

- The Bureau did not ensure that (1) individuals whose eligibility for the Medicaid Program was initially questioned as a result of quality control reviews were prevented from continuing to receive Medicaid benefits, (2) individuals who were subsequently found to have been ineligible were required to reimburse the Program for medical services received, and (3) individuals who misrepresented information submitted as part of the

application/certification process were referred for appropriate legal action. As a result, medical bills totaling at least $23,325 were paid on behalf of individuals who did not meet Medicaid Program eligibility requirements.

- The Bureau did not ensure that (1) Medicaid Program employees were paid at the correct salary rates, (2) the salaries of individuals who worked for other branches of the Department of Health were not charged to the Medicaid Program, and (3) consultants adequately documented the number of hours worked on Medicaid Program tasks. As a result, we took exception to salary costs of $60,818 that were incorrectly charged against the Medicaid Program.

We made 14 recommendations to you, as the Governor of the Virgin Islands, to address the deficiencies identified by the audit. On July 14, 1999, we discussed a preliminary draft of this report with representatives of the Department of Health, who generally concurred with the recommendations but provided additional information on the finding areas, which we incorporated into the report as appropriate.

Based on your September 3, 1999, response to the draft report (Appendix 2), we considered Recommendations A.2, A.3, A.4, A.5, C. 1, and C.2 resolved and implemented and requested additional information for Recommendations B.l, B.2, B.3, B.4, B.5, and C.3. Also based on the response, we revised Recommendation A. 1 and request that your office respond to that recommendation and to Recommendation A.6, both of which are unresolved. (The status of all of the recommendations is in Appendix 3.)

Section 5(a) of the Inspector General Act (Public Law 95-452, as amended) requires the Office of Inspector General to list this report in its semiannual report to the Congress. Therefore, please provide a response to this report by November 5, 1999. The response should be addressed to our Caribbean Office, Federal Building - Room 207, Charlotte Amalie, Virgin Islands 00802. The response should provide the information requested in Appendix 3.

We appreciate the assistance provided by the Department of Health staff during the conduct of the audit.

Sincerely,

Earl E. Devaney

Earl E. Devaney
Inspector General

CONTENTS

INTRODUCTION

BACKGROUND

The Medicaid Program (also known as the Medical Assistance Program) was established under Titles XIX and XVIII of the Social Security Act of 1965. In the Virgin Islands, the Program is administered by the Bureau of Health Insurance and Medical Assistance of the Virgin Islands Department of Health. According to the Code of Federal Regulations (42 CFR 430.0), the Program provides Federal grants for "medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children."

The Medicaid Program is jointly funded by the U.S. Department of Health and Human Services and the Government of the Virgin Islands on a 50-50 matching basis. Federal funding included Title XIX grants of $4.3 million and Title XVIII grants of $15,600 in fiscal year 1997 and Title XIX grants of $5.2 million and Title XVIII grants of $15,000 in fiscal year 1998. The Government of the Virgin Islands provided its matching share of Program costs through a combination of cash and in-kind services provided by Government-owned hospitals and health clinics. These contributions included funding of $1.8 million and in-kind services of $1 million in fiscal year 1997 and funding of $3 million and in-kind services of $3.3 million in fiscal year 1998. However, because the combination of Federal and local funding did not cover the complete cost of providing health care services to eligible participants, the Medicaid Program had accumulated unpaid medical bills totaling more than $2 1.5 million for fiscal years 1993 through 1998. According to Medicaid Program records, about $18 million (83 percent) of this amount was owed Government-owned hospitals, $3.3 million (16 percent) was owed Government-owned health clinics, and the remaining $200,000 (1 percent) was owed private health care providers. Because of the limits imposed (42 CFR 433.10) on Federal funding for the Medicaid Program in the Virgin Islands, the Government of the Virgin Islands, in fiscal year 1998, subsidized about 66 percent of the total cost of the Medicaid Program as opposed to the 50 percent matching share defined in the Social Security Act. The Virgin Islands Delegate to Congress has been actively pursuing legislative action to remove or increase the legal limit on Federal funding for the Medicaid Program in the Virgin Islands. At the exit conference, the Department of Health provided additional information on this issue, which we have included in the "Other Matters" section of this report.

To be eligible for participation in the Medicaid Program, applicants are required by the Code of Federal Regulations (42 CFR436) to meet specific income and financial resources criteria and to be certified as eligible by the Bureau of Health Insurance and Medical Assistance. There were 17,154 certified participants during fiscal year 1997 and 19,764 certified participants during fiscal year 1998. The Bureau of Health Insurance and Medical Assistance had 33 employees and offices at three locations on St. Croix and two locations on St. Thomas.

OBJECTIVE AND SCOPE

The objective of the audit was to determine whether (1) the Department of Health complied with grant terms and applicable laws and regulations; (2) charges made against grant funds were reasonable, allowable, and allocable pursuant to the grant agreement provisions; (3) funds received through electronic transfers were appropriately deposited to and accounted for in the Financial Management System; and (4) drawdowns were made in accordance with the Cash Management Improvement Act of 1990. The third and fourth parts of the objective relating to electronic transfers and drawdowns will be addressed in separate audit reports to be issued after completion of ongoing grant audits.

The scope of the current audit included Program activities that occurred during fiscal years 1997 and 1998. To accomplish the audit objective, we reviewed grant documents, supporting documentation for expenditures claimed against the grants and for electronic transfers of Federal funds, and the operating procedures of the Bureau of Health Insurance and Medical Assistance of the Virgin Islands Department of Health. The audit was conducted at the offices of the Bureau of Health Insurance and Medical Assistance, the Department of Health, and the Department of Finance.

Our review was made, as applicable, in accordance with the "Government Auditing Standards," issued by the Comptroller General of the United States. Accordingly, we included such tests of records and other auditing procedures that were considered necessary under the circumstances.

As part of our audit, we evaluated the internal controls over Program operations to the extent we considered necessary to accomplish **the** audit objective. Internal control weaknesses were identified in the areas of Program administration, participant eligibility, and personnel costs. These weaknesses are discussed in the Findings and Recommendations section of this report. The recommendations, if implemented, should improve the internal controls in these areas.

PRIOR AUDIT COVERAGE

The Office of Inspector General has not conducted any prior audits of the Medicaid Program in the Virgin Islands. However, the single audit report of the Government of the Virgin Islands for the fiscal year ended September 30, 1994, included 11 findings related to the Medicaid Program. Those findings were in the areas of quality assurance, property management, procurement, expenditure control, indirect costs, financial reporting, participant eligibility, and staffing. Our current audit revealed that deficiencies related to 5 of the 11 findings had not been corrected. The unresolved recommendations related to (1) establishing a claims processing assessment system, (2) establishing and maintaining property control records, (3) establishing and enforcing reimbursement rates in health care provider agreements, (4) reconciling internal accounting records to the Government's Financial Management System, and (5) establishing controls to ensure that debarred providers were excluded from Medicaid Program participation. At the July 14, 1999, exit conference on the preliminary draft of this report, the Executive Director of the Medicaid Program stated that these findings had been resolved as part of the fiscal year 1995 single audit. However, as of

July 15, 1999, the fiscal year 1995 single audit report of the Government of the Virgin Islands had not been finalized and issued by the independent accounting firm and the Government.

FINDINGS AND RECOMMENDATIONS

A. ADMINISTRATIVE FUNCTIONS

The Bureau of Health Insurance and Medical Assistance did not effectively perform some of the administrative functions of the Medicaid Program. Specifically, the Bureau did not (1) ensure that health care providers were properly licensed and had current agreements with the Medicaid Program, (2) purchase equipment and supplies at the most cost-effective prices, (3) maintain complete and accurate property management records and perform physical inventories of equipment at least biennially, and (4) establish a claims processing assessment system that was in accordance with Federal regulations. The Code of Federal Regulations contains the administrative requirements (45 CFR 74) for Medicaid Program grants and the quality assurance requirements (42 CFR 43 1) for the Medicaid Program, and U.S. Office of Management and Budget Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments," contains the standards for allowability of grant costs. However, Medicaid Program personnel did not comply with or were not familiar with all of the Federal guidelines, did not comply with related local guidelines, and did not coordinate the equipment and supply needs of the St. Thomas and St. Croix offices. As a result, (1) there was little assurance that health care providers were properly licensed and charged appropriate fees for services provided to Medicaid Program participants; (2) purchases of $1, 169 were, in our opinion, not necessary for Program operations (the monetary impact of these purchases is in Appendix 1); (3) equipment was not adequately accounted for; and (4) there was little assurance that payments made to health care providers were accurate.

Health Care Providers

The Medicaid Program designates the health care providers to which Program participants are required to go for medical treatment. The Program's first-choice health care providers are Government-owned hospitals and health clinics. Program participants may go to approved private health care providers only when the required services are not available at one of the Government-owned institutions and the institution refers the individual to a private provider. However, we found that the Medicaid Program's files pertaining to health care providers did not accurately reflect the current status of health care providers who were active participants in the Program.

Government-Owned Providers. We found that the most recent agreements between the Medicaid Program and the Government-owned facilities (two hospitals and five clinics), which specify the services that the facilities will provide to Medicaid Program participants and the rates that will be charged by the facilities for such services, had not been renegotiated since the period of 1991 through 1995. Although a September 1997 internal memorandum from the Medicaid Program's Executive Director to the Program staff listed the daily room rates that were to be charged by the two hospitals and a March 1994 letter listed the rates for emergency medical services, the Medicaid Program files did not have current health care agreements for fiscal years 1997 or 1998.

In addition, we found that although the Government-owned facilities provided health care services totaling $6.6 million during fiscal year 1998, the facilities were paid only $3.3 million, or one-half of the amount billed. The unpaid balance of $3.3 million was treated by the Government of the Virgin Islands as in-kind contributions towards its matching share of Medicaid Program costs. The Chief Executive Officers of the two hospitals told us that the hospitals (as of May 14, 1999) were semiautonomous entities that had to generate their own operating revenues and that it was therefore imperative that they receive payment for all services provided to Medicaid Program participants.

Private Providers. We were unable to determine the number of private health care providers who were certified by the Medicaid Program because the files were numbered sequentially with no identifying information as to the applicable fiscal years or as to which files were active. Further, based on our detailed review of the files for 25 providers who were identified to us by Medicaid Program employees as active, we found that only 6 of the providers had executed health care provider agreements for the current year and that only 5 of the providers had submitted documentation evidencing the current status of their health care licenses or certifications. The Medicaid Program's internal regulations require that Medicaid Program staff obtain copies of health care providers' licenses or certifications prior to accepting the providers as Program participants. In addition, we noted a January 1998 letter sent to a specific provider which stated that hospitals had to submit a current copy of their accreditation status or certification letter and that physicians and other ancillary service providers had to submit a current copy of their health care licenses. However, Medicaid Program staff did not ensure that these requirements were met.

Medicaid Program officials told us that although letters were sent to health care providers reminding them of the documentation requirements, many providers did not submit the copies of licenses or certification letters.

We also found that providers were allowed to participate in the Program on the basis of agreements that had been negotiated as many as 10 years ago (1989) and for which cost reimbursement rates and other negotiated conditions may have changed. Additionally, current agreements were not always complied with. For example, a pharmacy negotiated a provider agreement in July 1998 and agreed to bill the Medicaid Program at approved Medicare rates. However, the pharmacy subsequently billed the Program and was paid at its standard rates for medications. The single audit report on the Government of the Virgin Islands for fiscal year 1994 (see Prior Audit Coverage) recommended that the Bureau of Health Insurance and Medical Assistance implement procedures to ensure that health care provider agreements and established billing rates are recertified annually. Based on our current review, we found that this recommendation had not been implemented.

In an effort to contain costs, the Program's Executive Director had initiated efforts, as of September 1998, to contract with a pharmacy card system provider in Atlanta, Georgia. Additionally, Program employees were instructed to mark down bills received at standard rates to the approved Medicare rates. However, because of the reduced rates and the delays that have occurred in the payment of provider bills, some private health care providers have refused to participate in or have discontinued participation in the Medicaid Program.

At the July 14, 1999, exit conference on the preliminary draft of this report, the Executive Director of the Medicaid Program stated that, in her opinion, it was not necessary to prepare new provider agreements unless the rates to be charged by the providers changed or new agreements were required by other Federally funded programs which provided reimbursements for Medicaid services provided to participants of those other programs. The Executive Director did agree, however, that many of the more than 1,000 provider agreements on file at the Medicaid offices needed to be removed from the files because they were inactive.

Procurement Practices

During fiscal year 1998, the Medicaid Program purchased equipment totaling $105,200 ($100,700 from Federal funds) and supplies totaling $26,200 ($17,000 from Federal funds). In general, these purchases were made in accordance with competitive procurement requirements. For purchases of $5,000 or less, the Medicaid Program obtained two price quotations, and for purchases of more than $5,000, the Program processed the procurement actions through the Commissioner of Property and Procurement with letters ofjustification. However, we did note two areas where improvements could be made by the Medicaid Program as follows:

- Medicaid Program officials on St. Thomas and St. Croix did not coordinate purchases to obtain better prices by consolidating their orders for common supplies. For example, while the St. Croix office was able to purchase certain Medicaid forms at a unit price of $77.60 per case of 1,000 forms, the St. Thomas office paid another vendor $88.3 1 per case of 1,000 of the same forms. If the purchases had been consolidated and made from the St. Croix vendor, the St. Thomas office could have saved $10.71 per case, or a total of $535.50 for 50 cases.

- In April 1999, the Medicaid Program purchased a refrigerator and two microwave ovens, at a total cost of $1,169. These items were purchased with Federal funds and, in our opinion, were not essential to the functioning of the Medicaid Program. Also, Medicaid Program employees had access to a refrigerator and a microwave oven at the administrative offices on St. Thomas. Because of the limited Federal and local funding available to the Medicaid Program, we believe that the purchase of new items in April 1999 was not a reasonable expenditure of Program funds, as defined in U.S. Office of Management and Budget Circular A-87.'

At the July 14, 1999, exit conference on the preliminary draft of this report, the Executive Director of the Medicaid Program stated that, in her opinion, the refrigerator and the two microwave ovens were legitimate purchases from grant funds. However, we disagreed with the Executive Director and noted that our report recommended (see Recommendation 4) that

'Circular A-87 states, "A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs." The Circular further states that "the cost is of a type generally recognized as ordinary and necessary for the operation of the governmental unit or the performance of the Federal award."

the supporting documents for those expenditures be provided to the Federal grantor agency for its final determination as to the allowability of the questioned costs.

Property Management

The Medicaid Program did not maintain current and accurate property management records or perform biennial physical inventories of equipment, as required by the administrative requirements (commonly referred to as the "Common Rules") for Federal grant programs. The single audit report on, the Government of the Virgin Islands for fiscal year 1994 (see Prior Audit Coverage) recommended that the Bureau of Health Insurance and Medical Assistance establish property management records in compliance with the Code of Federal Regulations (45 CFR 74.34). However, our current review disclosed that existing property management records were not complete and that, although a physical inventory was performed at the St. Thomas Medicaid Program offices during December 1998 through February 1999, the records documenting that inventory were not complete. Specifically, the property records did not include 29 items that were located at the Program's Certification Unit office; did not identify the source of funds used to purchase equipment items; and did not include the cost of 29 items, the serial numbers for 5 items, and the Government property numbers for 2 items. We also found that, although the "Common Rules" requires that adequate maintenance procedures be developed to keep Federally funded equipment in good condition, seven items of equipment were not operative and a maintenance contract could not be negotiated with the vendor for a $15,000 photocopier because the Government of the Virgin Islands had not paid the vendor for services provided to other agencies.

Although the Medicaid Program's St. Croix branch provided us with property management records for 58 equipment items, there was no documentation indicating that complete physical inventories were performed biennially. The Assistant Director told us that the property records were updated each year as new items were purchased, which we believe indicates that the records were not reconciled and updated based on periodic physical inventories of equipment.

Claims Processing

The Code of Federal Regulations (42 CFR 43 1.806) requires that states participating in the Medicaid Program establish a claims processing assessment system as part of their quality control procedures. The purpose of a claims processing assessment system is to ensure that bills submitted by health care providers for services to Medicaid participants are accurate and are prepared in accordance with Medicaid Program requirements. However, the Health Care Financing Administration's Director of State Systems told us that the Virgin Islands was exempt from the requirement to establish a formal claims processing assessment system that met the Federal requirements. Despite the exemption, the Bureau of Health Insurance and Medical Assistance had internal procedures for limited quality assurance reviews of claims received for payment at the time of our audit. Our review of these internal procedures disclosed that the Medicaid Program's quality assurance review process included the review and approval by a designated physician of procedural codes on bills submitted by private health care providers and the reduction of bills that were based on rates which were above

the established reimbursement rates. However, we also found that such reviews were not performed for bills submitted by the Government-owned hospitals and clinics and by privately owned pharmacies. Although we did not find any errors as a result of our review of 32 reimbursement vouchers, totaling $874,000, the sample represented only 3 percent of the total value of Medicaid Program reimbursements made to health care providers during fiscal years 1997 and 1998. Without a quality assurance review process that includes all claims that were processed for payment, there was little assurance that erroneous reimbursement claims were not made.

Recommendations

We recommend that the Governor of the Virgin Islands direct the Commissioner of Health to ensure that the Bureau of Health Insurance and Medical Assistance:

1. Establishes and implements procedures to require that health care providers submit to the Bureau and periodically update their medical licenses, certifications, and/or accreditation status reports (as appropriate) and periodically execute (preferably annually) provider agreements with the Bureau that specify the rates at which they will bill for services provided to Medicaid Program participants.

2. Requires that its branch offices coordinate their supply and equipment needs to ensure that the most economical prices are obtained through consolidated purchases of such items.

3. Ensures that its staff becomes familiar with and complies with the cost principles contained in U.S. Office of Management and Budget Circular A-87.

4. Submits to the Federal grantor agency supporting documents for the questioned costs of $1,169 so that the grantor agency can make a final determination as to whether the costs are allowable.

5. Establishes and implements procedures to require that property management records are maintained and updated in accordance with the "Common Rules" (45 CFR 74) and that physical inventories of equipment are conducted at least biennially.

6. Revises its internal quality assurance review process for claims received for payment to include a sample of claims submitted by the Government-owned hospitals and clinics and by privately owned pharmacies.

Governor of the Virgin Islands Response and Office of Inspector General Reply

The September 3, 1999, response to the draft report (Appendix 2) from the Governor of the Virgin Islands concurred with Recommendations 2, 3, and 5; partially concurred with Recommendation 1; and nonconcurred with Recommendations 4 and 6. Based on the response, we consider Recommendations 2, 3, 4, and 5 resolved and implemented. Also

based on the response, we revised Recommendations 1 and 6 and request that the Governor provide a response to both recommendations, which are unresolved (see Appendix 3).

Recommendation 1. Partial concurrence.

Governor of the Virgin Islands Response. The response concurred with the part of the recommendation requiring that health care providers periodically update their medical licenses, certifications, and/or accreditation reports. In that regard, the response stated that "[a] form will be developed by the Assistant Director in charge of Special Services by October 31, 1999 which will incorporate" the recommendation. However, the response did not concur with the part of the recommendation requiring the Medicaid Program office to execute annual provider agreements which specify the rates at which medical services will be reimbursed. The response stated that this part of the recommendation "is not practical and there is no regulation requiring this. In addition, the recommendation to specify the rates at which [health care providers] will bill for services is redundant in that providers have already been advised that they will be reimbursed by the Medicaid Program at Medicare rates. There is no reason for an annual update. Providers will be updated when and if necessary as reimbursement policies changes."

Office of Inspector General Reply. The response sufficiently addressed the part of the recommendation regarding medical licenses, certifications, and accreditations. However, our recommendation requiring that health care service provider agreements be renewed periodically (preferably annually) was based on our findings that (1) provider agreements had not been renewed or renegotiated for periods of up to 10 years, (2) it was not possible to identify active providers by reviewing the Bureau's files because the files included agreements that had expired and had not been removed from the files, and (3) some providers did not bill in accordance with their existing agreements. Additionally, although there was no specific legal requirement for provider agreements to be renewed annually, periodic annual renewals or extensions of contracts are common business practices, which, in our opinion, should be applied to the health care provider agreements. We revised the recommendation from the draft report to specify the frequency of execution of provider agreements.

Recommendation 4. Nonconcurrence.

Governor of the Virgin Islands Response. The response stated, "While we philosophically do not agree with this recommendation in terms of the interpretation of Circular A-87 in that federal dollars cannot be used to purchase these items [a refrigerator, a microwave oven, and a television/video recorder unit for use by the staff], we have prepared a Voucher for Adjustment of Expenditures ... which will return the $1,169 to the federal account and charge the local account for the same amount."

Office of Inspector General Reply. We continue to believe that Federal funds should not have been used to purchase a refrigerator and a microwave oven for use by Medicaid Program staff because these purchases were not considered to be reasonable or allowable costs in accordance with Circular A-87 in that those items were not "generally recognized as ordinary and necessary for the operation" of the Medicaid Program. However,

we believe that the corrective actions taken by the Medicaid Program are sufficient to meet the intent of the recommendation.

Recommendation 6. Nonconcurrence.

Governor of the Virgin Islands Response. The response stated that the requirement for a claims processing assessment system does not apply to the United States territories (including **the** Virgin Islands) and that the Government's independent public accountants had verified this exemption with U.S. Health Care Financing Administration officials as part of the fiscal year 1995 single audit of the Government.

Office of Inspector General Reply. Upon receipt of the Governor's response, we confirmed from the Health Care Financing Administration that the Virgin Islands is exempt from the Federal requirement for establishment of a formal claims processing assessment system as defined in the Code of Federal Regulations (42 CFR 431.806 and 431.830-43 1.836). However, even with such an exemption, we believe that the Medicaid Program in the Virgin Islands should have an internal quality assurance process that requires a review (a limited statistical sample) of all claims received for processing so as to provide full assurance that Medicaid payments are legitimate and accurate. Such assurance would be especially beneficial because of the legal limit on Federal funding provided for the Medicaid Program in the Virgin Islands, which places a greater financial burden on the Government of the Virgin Islands (see the Other Matters section of this report). To the extent that the Medicaid Program can eliminate claims that are erroneous, the Program can more effectively use the limited Federal and local funds that are available to provide quality health care services to needy individuals in the Virgin Islands. Based on the response and the additional information obtained from the Health Care Financing Administration, we have revised the recommendation to ensure that the internal quality assurance review process for claims received for payment is revised to include a sample of claims submitted by the Government-owned hospitals and clinics and by privately owned pharmacies.

B. PARTICIPANT ELIGIBILITY

The Bureau of Health Insurance and Medical Assistance did not effectively follow up on the results of quality control reviews performed to ensure the eligibility of Medicaid Program participants. The requirements for eligibility under the Medicaid Program are contained in the Social Security Act and summarized in the Medicaid Program Certification Manual and the State Plan. Additionally, the Code of Federal Regulations (42 CFR 455) contains guidelines for investigating and penalizing persons who defraud or abuse the Medicaid Program. However, the Bureau did not develop internal guidelines for preventing, detecting, and taking action on ineligible participants, including the collection of amounts owed for services inappropriately received through Program participation. As a result, during fiscal years 1997 and 1998, at least 18 ineligible participants in the St. Thomas and St. Croix districts improperly received free medical services under the Medicaid Program, at a total cost to the Program of $23,325 (see Appendix 1).

Quality Control Process

The Bureau's Quality Control Unit performed monthly quality control reviews of a sample of 12 Medicaid Program cases (7 cases that were closed during the month and 5 cases that were certified or recertified during the previous month). The purpose of the quality control reviews was to identify "technical" and "eligibility" errors in the Medicaid Program application/certification process. "Technical" errors involved mistakes made by Medicaid Program staff during the process, and "eligibility" errors involved mistakes or misrepresentations of information by applicants. Eligibility errors were identified through confirmations obtained by quality control staff from such sources as local banks, the Social Security Administration office, the Tax Assessor's Office, and the applicants' employers. The results of the quality control reviews were presented to the Certification Unit through memoranda that summarized the quality control findings and requested a response within a specific time period, usually 2 weeks. Based on our review of the quality control process, we concluded that the Quality Control Unit had been effective in detecting and reporting errors in the application/certification process that resulted in losses of Medicaid Program funds. However, we found that prompt follow-up actions were not taken by other Medicaid Program units to (1) prevent ineligible individuals from continuing to receive Medicaid benefits, (2) recoup amounts improperly paid for medical services provided to such individuals, and (3) refer cases that potentially involved intentional fraud or abuse for legal actions.

Suspension of Ineligible Participants. If Medicaid Program participants were found by the Quality Control Unit to have resources (cash in bank accounts, real property, or other assets) in excess of the established Program guidelines, their eligibility was questioned. However, the individuals were not considered ineligible and their participant certifications were not suspended or revoked until they came to the Certification Unit office to have their financial situation reevaluated. We found instances in which the individuals with questioned eligibility refused to return to the Certification Unit to have their cases reevaluated, and Medicaid Program officials did not suspend the individuals' participation in the Program

after giving them a reasonable opportunity to have their cases reviewed. Section 401 of the Medical Program Certification Manual states:

> If the information provided by the applicant or recipient is inconclusive, and the Bureau is unable to obtain necessary data from other records, and the individual is unwilling to have the Bureau seek verification of information, there is no other recourse but to deny or terminate assistance. The individual will be provided with official notification of the Bureau's decision and of the right to appeal that decision if the person so desires.

To determine whether individuals were required to provide supplemental documentation to the Certification Unit or had their eligibility suspended if they refused to come into the Certification Unit for review after their eligibility was questioned by a quality control review, we examined the records related to all eligibility errors reported by the Quality Control Unit during fiscal years 1997 and 1998 We found that there were 50 such eligibility errors and that medical service bills totaling $35,842 were paid on behalf of 26 of the 50 participants (22 on St. Thomas/St. John and 4 on St. Croix). According to Medicaid Program requirements, individuals who had more than $1,500 in cash were not eligible to participate in the Program; therefore, eligibility was questioned when participants were found to have cash resources in excess of the $1,500 limit. For example, a St. Croix participant's eligibility was questioned by the Quality Control Unit on August 13, 1996 (with a second notice to the Certification Unit on October 3 1, 1996), because the participant had a total of $4,887 in two local bank accounts. Despite these findings, medical bills totaling $1,162 were paid for services provided to the individual during the period of December 1996 through March 1998, which was after the August 13, 1996, finding of questioned eligibility.

The Medicaid Program did not have detailed written guidelines for handling cases in which participants were found, as a result of quality control reviews, to have had their eligibility questioned. For at least 5 of the 50 eligibility errors reported by the Quality Control Unit, Certification Unit personnel stated that the participants had refused to return to the Medicaid Program for formal reevaluation of their eligibility status and/or to give up their Medicaid Program participant cards. Although Section 401 of the Medicaid Program Certification Manual states that in such cases participation in the Medicaid Program will be terminated, these individuals were allowed to continue obtaining medical services through the Medicaid Program for which health care providers billed the Medicaid Program.

In our opinion, the Medicaid Program should establish procedures, supplemental to the basic guidelines contained in the Certification Manual, to suspend the Medicaid Program cards of participants who are found to be ineligible or who refuse to come to the Certification Unit to have their eligibility reassessed after a finding of questioned eligibility by the Quality Control Unit. In addition, we believe that the Medicaid Program should establish procedures by which the Fiscal Services Unit would review bills from health care providers to identify and delete charges for individuals who had been suspended or terminated from the Program. The Executive Director of the Medicaid Program told us that it was not practical to require the Fiscal Services Unit to perform the recommended review of bills because of the large numbers of such bills and the labor-intensive manual nature of the bill processing system.

However, the Executive Director stated that the Medicaid Program was planning to implement an automated bill processing system in fiscal year 2000 and that, at that time, reviewing bills for the names of suspended and terminated individuals would be possible.

Recovery of Ineligible Medical Costs. The Medicaid Program did not have formal policies and procedures for collecting, from participants who were found to be ineligible, amounts paid to health care providers on their behalf. We found that, during fiscal years 1997 and 1998, at least 18 ineligible participants in the St. Thomas and St. Croix districts improperly received free medical services under the Medicaid Program, at a total cost to the Program of $23,325. The Medicaid Program was able to recover only $658 of that amount. For example, as a result of a quality control review conducted during the period of November 1997 to January 1998, the Medicaid Program determined that a participant who had received medical services costing the Program $11,173 was ineligible because he had more than $16,000 in a local bank account. On January 14, 1998, the individual was notified in writing that he had improperly received $607 in medical services (since determination of his ineligibility). Although the individual reimbursed the Medicaid Program for this $607, the remaining $10,566 that was improperly paid on his behalf was not recovered.

In our opinion, the Medicaid Program should develop and implement procedures for billing and collecting from ineligible participants amounts improperly paid to health care providers on their behalf. Such procedures should include referring uncollected amounts for legal action after reasonable administrative efforts, such as written notifications, telephone contacts, and personal contacts, to collect the bills have been unsuccessful.

Referral of Fraud and Abuse Cases. The Code of Federal Regulations (42 CFR 455.15) states, "If there is reason to believe that a recipient has defrauded the Medicaid program, the [Medicaid] agency must refer the case to an appropriate law enforcement agency." The Code (42 CFR455.2) defines "fraud" as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person."

Of the **50** eligibility errors reported by the Medicaid Program's Quality Control Unit, individuals in 8 instances had more than $11,000 in cash at the time they applied to participate in the Medicaid Program, Additionally, in each instance, the individuals stated, at the time of their certification reviews, that they did not have bank accounts. In one instance, the individual had $56,400 in a bank account and also owned rental property valued at $10,400. In our opinion, these eight cases were appropriate for referral to a law enforcement agency in accordance with the Code of Federal Regulations. However, because the Medicaid Program did not have formal procedures for such referrals, they were not made.

The Medicaid Program's Executive Director told us that she had suggested to the former Commissioner of Health that an interagency fraud task force be established to investigate potential fraud cases originating in the Department of Health and the Department of Human Services. We agree that an interagency fraud task force should be established. However, we also believe that the Medicaid Program needs to establish internal procedures to refer potential Medicaid fraud cases to an appropriate law enforcement agency.

Recommendations

We recommend that the Governor of the Virgin Islands:

1. Direct the Commissioner of Health to ensure that the Bureau of Health Insurance and Medical Assistance establishes and implements procedures to prevent ineligible participants from continuing to obtain free medical services at the expense of the Medicaid Program. Such procedures should include deactivating the ineligible individuals' Medicaid Program cards, notifying health care providers of the individuals' ineligible status, and reviewing health care providers' bills (either manually or mechanically) for charges related to individuals who have been determined to be ineligible for participation.

2. Direct the Commissioner of Health to ensure that the Bureau of Health Insurance and Medical Assistance establishes and implements procedures to enforce the collection of amounts improperly paid to health care providers on behalf of individuals who are determined to be ineligible for participation in the Medicaid Program. These procedures should include referring the individuals for legal action after reasonable administrative efforts, such as written notification, telephone contacts, and personal contacts, have been made but have not been successful.

3. Direct the Commissioner of Health to ensure that the Bureau of Health Insurance and Medical Assistance submits to the Federal grantor agency supporting documents for the questioned costs of $23,325 so that the grantor agency can make a final determination as to whether the costs are allowable.

4. Direct the Commissioner of Health to ensure that the Bureau of Health Insurance and Medical Assistance establishes and implements procedures to identify and refer to appropriate law enforcement authorities (such as the Virgin Islands Attorney General or the U.S. Attorney's Office) cases of suspected fraudulent intent in misrepresenting personal information as part of the Medicaid application and certification process.

5. Establish an interagency fraud task force to identify, coordinate, and investigate cases where individuals use fraudulent practices to improperly obtain certification for participation in Government-financed programs intended to service needy segments of the community.

Governor of the Virgin Islands Response and Office of Inspector General Reply

The September 3, 1999, response to the draft report (Appendix 2) from the Governor of the Virgin Islands concurred with Recommendations 4 and 5, partially concurred with Recommendations 1 and 2, and nonconcurred with Recommendation 3. Based on the response, we request additional information for Recommendations 1, 2, 3, 4, and 5 (see Appendix 3).

Recommendation 1. Partial concurrence.

Governor of the Virgin Islands Response. The response included a schedule with additional information based on the Medicaid Program's followup analysis of the specific cases of questioned eligibility cited in the draft of this report. Based on this analysis, the response concurred with our initial determination in 12 cases, did not concur in 10 cases, and could not make a determination in 4 cases. With regard to the recommendation, the Bureau stated that it was "negotiating for a new computer system for certification and billing which will allow for interfacing between all of these departments." The response further stated:

> At the point that a client is found ineligible, we will have the capability to enter the system and remove the client's name from the master list. ... We expect to have this system in place and running by the middle of FY [fiscal year] 2000. In the interim, attached instructional memos have been issued to Certification Supervisors regarding this subject. The major problem in the past has been the severe lack of staffing in the Certification Units on both St. Thomas and St. Croix. We continue to have staff shortages in this area.

Office of Inspector General Reply. Based on the information included with the response, we have revised the number of ineligible participants in the finding from 27 to 18 and the associated questioned costs from $37,672 to $23,325.

Recommendation 2. Partial concurrence.

Governor of the Virgin Islands Response. The response stated:

> Establishment and implementation of procedures to enforce the collection of amounts improperly paid to health care providers on behalf of individuals who are determined to be ineligible for participation in the Medicaid Program was done about one year ago. Many of the cases reviewed by the auditors were for service dates prior to that time. ... The QC [Quality Control] Supervisor is meeting with the newly appointed attorney in the office of the Commissioner of Health in an effort to get legal guidance on how to proceed once all administrative efforts have been exhausted.

Office of Inspector General Reply. As stated in our reply to Recommendation 1, we have revised the finding and the reported questioned costs based on the additional information provided.

Recommendation 3. Nonconcurrence.

Governor of the Virgin Islands Response. The response stated:

> An indepth review of cases reveal that there is some difference of opinion in the disposition of the cases. We therefore request that before the amount of $35,672 is submitted to the grantor agency, auditors should re-review the

cases in conjunction with the Certification Supervisors and the Assistant Directors. We also request that, once final disposition is made, our office be given the opportunity to attempt recovery of the specified monies. Any remaining amounts would then be submitted to the grantor agency for final determination.

Office of Inspector General Reply. We have revised the recommendation and Appendix 1 by reducing the amount of questioned costs from the $35,672 stated in the draft report to the $23,325 verified by the Medicaid Program's followup analysis.

C. PERSONNEL COSTS

The Bureau of Health Insurance and Medical Assistance did not ensure that payroll charges made against Medicaid Program funds were reasonable, allowable, and allocable pursuant to the grant agreement provisions. Specifically, the Bureau did not ensure that (1) Medicaid Program employees were paid correct salary rates, (2) the salaries of individuals who worked for other branches of the Department of Health were not charged to the Medicaid Program, and (3) consultants adequately documented the hours they worked on Medicaid Program tasks. The requirements for the allowability of grant costs are contained in U.S. Office of Management and Budget Circular A-87. However, the Medicaid Program did not have internal procedures to require that payroll records be routinely reviewed to ensure their accuracy. As a result, we took exception to salary costs of $60,818 that were incorrectly charged to the Medicaid Program (see Appendix 1).

Personal Services Costs

U.S. Office of Management and Budget Circular A-87 contains detailed guidance on the types of personal services costs that may be charged against Federally funded programs and the type of documentation required to support such charges. Among other provisions, Circular A-87 requires that the related personal services costs for employees who are expected to work for only one activity be supported by semiannual certifications which state that the employees' work activities are for the specific program. When employees are expected to work for more than one activity, detailed personnel activity reports or other time distribution records are required to be maintained to record the number of hours worked by the employees on each activity, and those records are required to be used to distribute the related personal services costs among the various activities. To determine the extent of compliance with Circular A-87, we reviewed the payroll documents for a statistical sample of 10 pay periods (5 from each fiscal year reviewed), which had gross salary costs totaling $144,732.

Incorrect Salary Rate. We found that an employee of the Medicaid Program was paid at the incorrect salary rate for 34.5 biweekly pay periods (July 21, 1997, to November 13, 1998) with the Program. The employee's salary as shown on the Notice of Personnel Action was $16,019 per year. However, the employee was paid $19,019 per year, which resulted in an overpayment of $3,981 for the 34.5 biweekly pay periods. Because the employee's salary was funded 50 percent from Federal funds, $1,990 of the $3,981 overpayment was charged against Federal funds. Medicaid Program officials stated that the incorrect salary rate may have occurred because of a data entry error.

Medicaid Program officials said that under established procedures, Notices o&Personnel Action are prepared and the pertinent information entered into the centralized payroll system by the Virgin Islands Division of Personnel. Once the employees' records have been established on the payroll system, the Payroll Section of the Department of Health enters the number of hours worked and hours of leave taken by each employee each pay period. After the biweekly payrolls are processed, a copy of the payroll register is provided to the Department of Health for its records. Medicaid Program officials said that although they had

been consistently receiving copies of the biweekly payroll registers for Program employees since fiscal year 1998, they did not review the registers thoroughly to ensure that the salary rates paid to employees were accurate and that they therefore did not detect the $3,981 overpayment to the employee we identified.

We believe that the Medicaid Program should establish written procedures to require the initial salaries and subsequent salary changes for ail employees to be verified between the Notices of Personnel Action and the first payroll register on which the new or revised salary appears. For subsequent pay periods, the current payroll totals should be compared with the totals on the prior payroll register for followup review.

Non-Employee Salary Costs. We also found that when a former employee of the Medicaid Program was transferred to another job, the employee's biweekly payroll costs continued to be charged against Medicaid Program funds. On May 9, 1996, the employee transferred from a $21,539 per year position with the Medicaid Program to a $23,090 per year position in another unit of the Department of Health. However, the employee's biweekly payroll costs at the new $23,090 salary rate continued to be charged against Medicaid Program funds until November 22, 1997 (a total of 64 biweekly pay periods). Therefore, salary costs of $56,837 ($888.08 per pay period times 64 pay periods), plus an undetermined amount of fringe benefit costs, were improperly charged against the Medicaid Program. Program officials told us that they became aware of the incorrect payroll charges in November 1997, when payroll registers were first provided to them on a consistent basis, and that they requested Department of Health, Department of Finance, and Division of Personnel officials to correct the error. However, during our audit, the Administrator of Fiscal Services told us that the incorrect charges had not been corrected.

Unsupported Contractor Hours. We found that two medical consultants who were responsible for reviewing bills submitted by health care providers to ensure the accuracy of the amounts billed did not provide the Medicaid Program with detailed records to document the number of hours they worked and for which they charged the Program. One consultant was paid $45 per hour for 10 hours per week, and we observed him at the Medicaid Program for about 4.5 hours on Thursdays. The second consultant was paid $26.08 per hour for 12 hours per week, and we observed him at the Medicaid Program for about 4.5 hours each on Tuesdays and Fridays. When we asked Program officials how the first consultant justified charges for 10 hours per week when he worked only about 4.5 hours on Thursdays, they stated that the consultant also performed some of his review work via telephone from home. However, we were not provided with any documentation to support the number of hours worked by either consultant. We believe that consultants who are paid on an hourly basis should be required to provide documentation of the hours worked in accordance with the requirements of Circular A-87.

At the July 14, 1999, exit conference on the preliminary draft of this report, the Executive Director of the Medicaid Program stated that the medical consultants were now required to till out time sheets to document the actual hours they worked on Medicaid Program tasks.

Recommendations

We recommend that the Governor of the Virgin Islands direct the Commissioner of Health to ensure that the Bureau of Health Insurance and Medical Assistance:

1. Establishes and implements procedures to require the initial salaries and subsequent salary changes for all Medicaid Program employees to be verified between the Notices of Personnel Action and the first payroll register on which the new or revised salary appears and that the current payroll totals be compared with the totals of the prior payroll register for subsequent pay periods to identify any errors that might require followup inquiry.

2. Establishes and implements procedures to require documentation, as required by Circular A-87, to be maintained for all Medicaid Program employees and for consultants who are paid on an hourly basis. Such documentation should include, for individuals who work for only one activity, semiannual certification that they work for the Medicaid Program and, for individuals who work for more than one activity, personnel activity reports or other time distribution records that record the hours worked for each activity

3. Submits to the Federal grantor agency supporting documents for the cost exception of $60,818 for salaries so that the grantor agency can make a final determination as to whether the costs are allowable.

Governor of the Virgin Islands Response and Office of Inspector General Reply

The September 3, 1999, response to the draft report (Appendix 2) from the Governor of the Virgin Islands concurred with Recommendations 1, 2, and 3. Based on the response, we consider Recommendations 1 and 2 resolved and implemented and request additional information for Recommendation 3 (see Appendix 3).

Regarding Recommendation 3, the response addressed the salary costs of $56,837 for employees of another Department of Health unit that were erroneously charged to Medicaid Program accounts but did not address the $3,981 that was overpaid to a Medicaid Program employee.

OTHER MATTERS

During our July 1999 exit conference, the Executive Director of the Medicaid Program requested that we include in our report information from her February 1999 issue paper, which, according to her, presented information to document the "negative effect" that legislated limitations on Medicaid reimbursements to the United States territories has had on the ability of the Government of the Virgin Islands to provide health care services to eligible residents. The issue paper discussed four areas as follows:

- The issue paper stated that amendments to Section 1108c of the Social Security Act passed in 1997 imposed a limit on the amount of Federal reimbursements the territories may receive each year for Medicaid costs; that the limit was $2.6 million until fiscal year 1993, when the Congress passed an additional amendment to establish a formula for annual increases to the limit; and that the formula links increases in the Medicaid reimbursement limit to the percentage increase in the medical component of the consumer price index for all urban consumers. The issue paper further stated that, under this formula, the Medicaid reimbursement ceiling has increased by an average of 5 percent per year and accordingly was set at $5.26 million for fiscal year 1998 and $5.4 million for fiscal year 1999. However, according to the issue paper, Medicaid costs in the Virgin Islands were significantly higher. The issue paper then cited the example of the Medicaid Program providing health care services valued at $14.2 million during fiscal year 1997 and $15.6 million during fiscal year 1998. However, we found, in each instance, that the Government of the Virgin Islands had to fund (either through cash or in-kind contributions) the health care services in excess of the Federal limit.

- The issue paper stated that the Federal matching share for Medicaid Program costs in the 50 states is based on a formula that is connected to the per capita income in each state, with the matching share increasing as per capita income decreases and that for the 50 states, the Federal matching share ranged from 50 to 83 percent, However, according to the issue paper, the Federal matching share for the territories is fixed at 50 percent. The issue paper cited, "for comparison," the examples that 9 of the 50 states had a per capita income of less than $15,000 and Federal matching share rates of more than 70 percent and that the Virgin Islands, with a per capita income of $11,052, was limited to a matching share of 50 percent. Additionally, according to the issue paper, the mandated limit on Federal Medicaid reimbursements to the territories resulted in an actual Federal matching share in the Virgin Islands of only 3 1 percent in fiscal year 1997 and 34 percent in fiscal year 1998.

- The issue paper stated that the treatment of U.S. territories under the Medicaid legislation also prevented the Virgin Islands from participating in programs that are supplemental to the basic Medicaid Program. The issue paper cited as an example the fact that although the 50 states receive additional funding for the establishment and upgrade of computerized management information systems for their Medicaid operations, the Virgin Islands must fund such computerization from the basic Federal Medicaid allocation.

- The issue paper stated that the Medicaid Program in the Virgin Islands was further negatively impacted by the inability of the Government of the Virgin Islands to fully fund the

larger matching burden placed on it by the limitations on the level of Federal cost sharing. As a result, we noted that the Government-owned hospitals and clinics have had to absorb the unfunded costs of providing health care services to Medicaid participants, which has put an additional financial burden on those institutions. According to the issue paper, the government-owned health care facilities had incurred cumulative deficits of about $21 million related to providing services to Medicaid participants.

The issue paper further stated that as a result of these four issues, low-income residents of the Virgin Islands have not been receiving the level and the quality of health care services comparable to those given to Medicaid participants in the 50 states, such as specialized physician services, long-term care, wheelchairs, dentures, or prosthetics. According to the issue paper, the Virgin Islands Medicaid Program spent about $670 per Medicaid participant in 1995 as compared with the national average cost of $3,3 11 per Medicaid participant.

CLASSIFICATION OF MONETARY AMOUNTS

Finding	Questioned Costs* (Cost Exceptions)
A. Administrative Requirements	$1,169
B. Participant Eligibility	23,325
C. Personnel Costs	60.818
Totals	$85,3

* Amounts consist of Federal funds of $42,656 and local funds of $42,656 based on the 50 percent local matching requirement of the Medicaid Program.

THE UNITED STATES VIRGIN ISLANDS
OFFICE OF THE GOVERNOR
GOVERNMENT HOUSE
Charlotte Amalie. V.I. 00802
340-774-0001

September 3, 1999

Mr. Robert J. Williams
Acting Inspector General
United States Department of Interior
Office of Inspector
Washington D. C. 20240

Attention: Mr. Arnold van Beverhoudt

Dear Mr. Williams:

Enclosed is the response of V. I. Government to the audit of the Medicaid Program for 1997and 1999.

I thank you for your efforts in identifying deficiencies in the operations of the program and assure you that steps will be taken to correct them.

Sincerely,

Charles W. Turnbull
Governor

CWT: JTRM:po

GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF HEALTH
Bureau of Health Insurance and Medical Assistance
210-3A Altona, Suite 302 - Frostco Center
St. Thomas, U.S. Virgin Islands 00802

Priscilla Berry Quetel
Executive Director

Telephone: (340) 774-4624
Fax: (340) 774-4918

AUDIT REPONSES
U.S. DEPARTMENT OF INTERIOR AUDIT
BUREAU OF HEALTH INSURANCE AND MEDICAL ASSISTANCE
FISCAL YEARS 1997, 1998, 1999
August 23, 1999

A. ADMINISTRATIVE FUNCTIONS

Recommendation #1: Ensure that BHIMA establishes and implements procedures to require that health care providers submit to the Bureau and periodically update their medical licenses, certifications, and/or accreditation status reports (as appropriate) and execute annual provider agreements with the Bureau that specify the rates at which they will bill for services provided to the Medicaid program participants.

Response to Part 1: Require that health care providers submit to the Bureau and periodically update their medical licenses, certifications, and/or accreditation status reports.

CONCUR – A form will be developed by the Assistant Director in charge of Special Services by October 31,1999 which will incorporate the above.

Response to Part 2: Execute annual provider agreements with the Bureau that specify the rates at which they will bill for services provided to Medicaid program participants.

DO NOT CONCUR – The requirement to execute an *annual* provider agreement is not practical and there is no regulation requiring this. In addition, the recommendation to specify the rates at which they will bill for services is redundant in that providers have already been advised that they will be reimbursed by the Medicaid program at Medicare rates. There is no reason for an annual update. Providers will be updated when and if necessary as reimbursement policies changes.

Recommendation #2: Requires that its branch offices coordinate their supply and equipment needs to ensure that the most economical prices are obtained through consolidated purchases of such items.

CONCUR – See attached memo dated August 18, 1999 (Attachment #1) with new policy regarding consolidated purchases.

[NOTE: ATTACHMENTS NOT INCLUDED BY OFFICE OF INSPECTOR GENERAL.]

Recommendation #3: Ensures that its staff becomes familiar with and complies with the cost principles contained in U.S. Office of Management and Budget Circular A-87,

CONCUR – Copies of OMB Circular A-87 have been distributed to pertinent staff

Recommendation #4: Submits to the Federal grantor agency supporting documents for the questioned costs of $1,169 **so** that the grantor agency can make a final determination as to whether the costs are allowable.

DO NOT CONCUR: While we philosophically do not agree with this recommendation in terms of the interpretation of Circular A-87 in that federal dollars cannot be used to purchase these items, we have prepared a Voucher for Adjustment of Expenditures (Attachment #2) which will return the $1,169 to the federal account and charge the local account for the same amount.

Recommendation #5: Establishes and implements procedures to require that property management records are maintained and updated in accordance with the "Common Rules" (45CFR74) and that physical inventories of equipment are conducted at least biennially.

CONCUR – The Administrator for Financial Services has been instructed to change the current inventory format to incorporate guidelines from Common Rules (45CFR74) and to assure that the Administrative Assistants conduct a physical inventory every other year. See memo dated August 18, 1999 (Attachment #3).

Recommendation #6: Establishes and implements a claims processing assessment system for bills submitted to health care providers that meets the requirements of the Code of Federal Regulations (42CFR43 1).

DO NOT CONCUR – This is a requirement of the states but not the territories. When KPMG performed their 1995 single audit, they placed a call to Bow Eng of HCFA, Region II, to verify HCFA's requirement for this reporting system. KPMG were told that because of the size of our program, this process and reports to HCFA were not required. Subsequently, KPMG removed this recommendation from their 1995 single audit report. As verification, HCFA has never cited us on this requirement. Bo Eng can be reached at 212-264-3839.

B. PARTICIPANT ELIGIBILITY

Recommendation #1: Direct the Commissioner of Health to ensue that the Bureau of Health Insurance and Medical Assistance establishes and implements procedures to prevent ineligible participants from continuing to obtain free medical services at the expense of the Medicaid Program. Such procedures should include deactivating the ineligible individuals' Medicaid Program cards, notifying health care providers of the individuals' ineligible status, and reviewing health care providers' bills (either manually or mechanically) for charges related to individuals who have been determined to be ineligible for participation.

PARTIALLY CONCUR: Please see the attached list of cases (Attachment #4) which were reviewed in depth by the Certification Supervisors and Assistant Directors for both St. Thomas and St. Croix. Of the total of 26 cases reviewed (only those with a dollar amount attached), we concurred with 12 cases, did not concur with 10 cases, and had four cases undetermined. As explained to the auditors, it is nearly impossible to administratively track these type of cases which may or may not be terminated to the point of payment since the entire computer system is not interfaced and one department cannot talk to the other electronically. As was relayed, we are in the process of negotiating for a new computer system for certification and billing which will allow for interfacing between all of these departments. At the point that a client is found ineligible, we will have the capability to enter the system and remove the client's name from the master list. When the provider checks the master list prior to treatment for approval, they will find that this person's name is not on the list; they will not provide service and the client will have to return to our office for investigation, The system will not allow for the processing of a bill of a client who is found ineligible. We expect to have this system in place and running by the middle of FY 2000. In the interim, attached instructional memos have been issued to Certification Supervisors regarding this subject. The major problem in the past has been the severe lack of staffing in the Certification Units on both St. Thomas and St. Croix. We continue to have staff shortages in this area. We request that the auditors again review those cases where we do not concur with their findings.

Recommendation #2: Direct the Commissioner of Health to ensure that the Bureau of Health Insurance and Medical Assistance establishes and implements procedures to enforce the collection of amounts improperly paid to health care providers on behalf of individuals who are determined to be ineligible for participation in the Medicaid Program. These procedures should include referring the individuals for legal action after reasonable administrative efforts, such as written notification, telephone contacts, and personal contacts, have been made but have not been successful.

PARTIALLY CONCUR: Establishment and implementation of procedures to enforce the collection of amounts improperly paid to health care providers on behalf of individuals who are determined to be ineligible for participation in the Medicaid Program was done about one year ago. Many of the oases reviewed by the auditors were for service dates prior to that time. We do send clients certified written notices. The Executive Director has instructed the QC Supervisor to review once again all those collection amounts and make another attempt to contact the clients involved. The QC Supervisor is meeting with the newly appointed attorney in the office of the Commissioner of Health in an effort to get legal guidance on how to proceed once all administrative efforts have been exhausted.

Recommendation #3: Direct the Commissioner of Health to ensure that the Bureau of Health Insurance and Medical Assistance submits to the Federal grantor agency supporting documents for the questioned costs of **$35,672 so** that the grantor agency can make a final determination as to whether the costs are allowable.

DO NOT CONCUR: As stated above, an indepth review of cases reveal that there is some difference of opinion in the disposition of the cases. We therefore request that before the amount of $35,672 is submitted to the grantor agency, auditors should re-review the cases in conjunction with the Certification Supervisors and the Assistant Directors. We also request that, once final disposition is made, our office be given the opportunity to attempt recovery of the specified monies. Any remaining amounts would then be submitted to the grantor agency for final determination.

Recommendation #4: Direct the Commissioner of Health to ensure that the Bureau of Health Insurance and Medical Assistance establishes and implements procedures to identify and refer to appropriate law enforcement authorities (such as the Virgin Islands Attorney General or the U.S. Attorney's Office) cases of suspected fraudulent intent in misrepresenting personal information as part of the Medicaid application and certification process.

CONCUR: As indicated above, the QC Supervisor will be meeting with Department of Health legal counsel to receive guidance on how to establish and implement procedures for handling suspected cases of fraudulent intent. We have found in the past that the Attorney General's office is overwhelmed with work and does not have the resources to devote to this complex program.

Recommendation #5: Establish an interagency fraud task force to identify, coordinate, and investigate cases where individuals use fraudulent practices to improperly obtain certification for participation in Government-financed programs intended to service needy segments of the community.

CONCUR: We wholeheartedly agree with this concept. Since we are talking about additional dollars in staffing, we are not sure how quickly this can be implemented.

C. PERSONNEL COSTS

Recommendation #1: Establishes and implements procedures to require the initial salaries and subsequent salary changes for all Medicaid Program employees be verified between the Notices of Personnel Actions and the first payroll register on which the new or revised salary appears and that the current payroll totals be compared with the totals of the prior payroll register for subsequent pay periods to identify any errors that might require follow up inquiry.

CONCUR: Please see attached memo dated August 18, 1999 (Attachment #5) which instructs the Administrator of Financial Services to verify as prescribed above. For the record, please see memo dated November 3, 1997 (Attachment #6) where the Medicaid Director advised the Deputy Commissioner and the Director of Financial Services that the Industrious salary costs were inappropriately being charged to Medicaid and that adjustments were necessary on their part to correct this error. Also please be aware that the Medicaid Bureau, after a multitude of requests, did not start receiving payroll registers where these type of errors could be checked until November, 1997. As we are now routinely receiving the payroll registers for Medicaid, we do not anticipate this error will occur again.

Recommendation #2: Establishes and implements procedures to require documentation, as required by Circular A-87, to be maintained for all Medicaid Program employees and for consultants who are paid on an hourly basis. Such documentation should include, for individuals who work for only one activity, semiannual certification that they work for the Medicaid Program and, for individuals who work for more than one activity, personnel activity reports or other time distribution records that record the hours worked for each activity.

CONCUR Although the two Medical Consultants work for only one activity under Medicaid, we have nevertheless established a sign in time sheet for each Medical Consultant and time card completion is based on this sign in sheet. Both Medical Consultants are certified annually in that their NOPA's are for only one fiscal year. Each year, the NOPA is renewed.

Recommendation #3: Submits to the federal grantor agency supporting documents for the cost exception of $60,818 for salaries so that the grantor agency can make a final determination as to whether the costs are allowable.

CONCUR: In the interim of submitting the above to the federal grantor, we will be attempting to make internal record adjustments to recoup the costs of the incorrectly charged salary of $56,837 from the Division of Environmental Health.

STATUS OF AUDIT REPORT RECOMMENDATIONS

Finding/Recommendation Reference	Status	Action Reauired
A.1	Unresolved.	Reconsider the part of the recommendation pertaining to the execution of provider agreements and provide a response indicating concurrence or nonconcurrence. If concurrence is indicated, provide an action plan that identifies the target date and the title of the official responsible for updating the health care provider service agreements on a periodic (preferably annual) basis. If nonconcurrence is indicated, provide reasons for the nonconcurrence.
A.2, A.3, A.4, and A.5	Implemented.	No further action is required.
A.6	Unresolved.	Provide a response to the revised recommendation, indicating concurrence or nonconcurrence. If concurrence is indicated, provide an action plan that identifies the target date and the title of the official responsible for implementation. If nonconcurrence is indicated, provide reasons for the nonconcurrence.
B.l	Management concurs; additional information needed.	Provide a target date and the title of the official responsible for implementing the planned certification and billing computer system and for providing the Medicaid Program's Certification Unit with the staff resources needed to effectively carry out its required quality assurance responsibilities.

Finding/Recommendation Reference	Status	Action Required
B.2	Management concurs; additional information needed.	Provide the target date and the title of the official responsible for establishing administrative procedures to recover amounts improperly paid on behalf of ineligible individuals.
B.3	Management concurs; additional information needed.	Provide the target date and the title of the official responsible for completing administrative recovery activity on the $23,325 in questioned costs and reporting any unrecovered amounts to the grantor agency.
B.4	Management concurs; additional information needed.	Provide the target date and the title of the official responsible for implementing procedures for handling suspected cases of fraud against the Medicaid Program.
B.5	Management concurs; additional information needed.	Provide the target date and the title of the official responsible for establishing an interagency task force to identify, coordinate, and investigate cases of fraud against more than one program for needy segments of the community.
C.l and C.2	Implemented.	No further action is required.
C.3	Management concurs; additional information needed.	Provide the target date and the title of the official responsible for processing adjustments to recoup the $56,837 in salary costs that was incorrectly charged to Medicaid Program grants and reporting any unrecovered amounts to the grantor agency. Also provide an action plan for recovering the $3,981 that was overpaid to a Medicaid Program employee. The plan should include the target date and the title of the official responsible for implementaiton.

ILLEGAL OR WASTEFUL ACTIVITIES SHOULD BE REPORTED TO THE OFFICE OF INSPECTOR GENERAL

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TDD for hearing impaired
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