

DEPARTMENT OF SOCIAL SERVICES

PRIOR AUDIT FINDINGS

Federal Compliance Audit Findings:

Finding No. 08000200701:

Payment rates were not updated in accordance with the State Plans for the Medical Assistance Program (Medicaid) and State Children's Health Insurance Program (CHIP). This is the third consecutive audit to contain this finding.

CFDA Title: Medical Assistance Program and State Children's Health Insurance Program

CFDA Number: 93.778 and 93.767

Federal Award Number: 05-0705SD5028 and 05-0705SD5021

Federal Award Year: 2007

Federal Agency: Department of Health and Human Services

Auditee's Corrective Action Plan:

Recommendation was implemented.

Finding No. 08000200702:

The Administrative Rules of South Dakota (ARSD) which contain payment rates for Medicaid and CHIP do not agree with payment rates approved in the Medicaid and CHIP State Plans. This is the third consecutive audit to contain this finding.

CFDA Title: Medical Assistance Program and State Children's Health Insurance Program

CFDA Number: 93.778 and 93.767

Federal Award Number: 05-0705SD5028 and 05-0705SD5021

Federal Award Year: 2007

Federal Agency: Department of Health and Human Services

Auditee's Corrective Action Plan:

Recommendation was implemented.

Finding No. 08000200703:

Internal controls were not adequate over the school administrative claims processing services provided by an outside service organization for the Medicaid and CHIP programs.

CFDA Title: Medical Assistance Program and State Children's Health Insurance Program

CFDA Number: 93.778 and 93.767

Federal Award Number: 05-0705SD5048 and 05-0705SD5021

Federal Award Year: 2007

Federal Agency: Department of Health and Human Services

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Auditee's Corrective Action Plan:

Recommendation was implemented.

Finding No. 08000200704:

Procedures used in writing off third party liability claims were not consistent with those approved in the Medicaid and CHIP State Plans. Proper authorization to write off these claims was not obtained from the federal government or the South Dakota Board of Finance.

CFDA Title: Medical Assistance Program and State Children's Health Insurance Program

CFDA Number: 93.778 and 93.767

Federal Award Number: 05-0705SD5048 and 05-0705SD5021

Federal Award Year: 2007

Federal Agency: Department of Health and Human Services

Auditee's Corrective Action Plan:

No instances were noted in the current audit.

CURRENT AUDIT FINDING AND RECOMMENDATIONS

Federal Compliance Audit Finding:

Finding No. 08000200801:

Internal controls were not adequate over the post-payment review of claims.

CFDA Title: Medical Assistance Program

CFDA Number: 93.778

Federal Award Number: 05-0805SD5028

Federal Award Year: 2008

Federal Agency: Department of Health and Human Services

Type of Finding: Significant Deficiency

Category of Finding: Special Tests and Provisions

Analysis:

42 CFR 456.3 states:

"The Medicaid agency must implement a statewide surveillance and utilization control program that –

- (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;

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- (b) Assesses the quality of those services;
- (c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part;
- (d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part.”

The Department of Social Services, Survey and Utilization Review Subsystem (SURS) unit is responsible for performing the above procedures. The SURS unit conducts post-payment reviews over various paid claims or groups of paid claims to detect possible improper payments. The SURS unit may initiate a review for a variety of reasons, including but not limited to, referral from another DSS staff member, referral from a recipient or provider, or identification during another review.

The SURS unit maintains quarterly Integrity Review Logs to identify and track claims or cases selected for post-payment review. We selected one quarter during our audit period for testing and selected one review from each of the three categories of review logs: the provider log, recipient log, and other log. One of the reviews selected for testing involved a review opened by the SURS unit for claims being paid to an Indian Health Service (IHS) facility for a recipient who informed DSS that he had not received services at that facility since 2003. According to DSS’ records, the recipient’s home address is in Mitchell, which is 275 miles from the IHS facility in Rapid City that issued the claim. Also according to DSS’ records, the recipient has historically utilized facilities in the Mitchell area for medical services. The IHS facility failed to respond to multiple requests for documentation to support these claims. The post-payment review team concluded that the recipient’s card had been lost and that someone other than the eligible recipient had received services on three different occasions at this facility using the eligible recipient’s lost card. The SURS unit properly voided the claims and, according to SURS personnel, monitored activity for this recipient number for six months following the identification of the error. However, our audit procedures discovered that following the six month period two more claims were improperly paid to this facility and were not discovered by SURS staff or any other DSS staff. Prior to identification of these errors during our audit, no further action was taken with regard to this recipient number or facility.

42 CFR 455.15 states:

“If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must take the following action as appropriate:

- (a) If a provider is suspected of fraud or abuse, the agency must –
 - (1) In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit under the terms of its agreement with the unit entered into under Section 1002.309 of this title;
- (b) If there is reason to believe that a recipient has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.”

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Despite the evidence indicating the potential presence of fraud or abuse of the program, the SURS unit failed to refer the case to either the State Medicaid Fraud Control Unit or any law enforcement agency.

Furthermore, no additional procedures were undertaken by the SURS unit or DSS to prevent improper payments to this facility for this recipient number in the future. Some procedures that might have been undertaken to mitigate future losses include special monitoring of claims for this recipient number at this IHS facility into the foreseeable future, informing the IHS facility of the need to check the validity of Medicaid cards at presentation for services, or canceling this recipient number and lost card number and issuing the recipient a new number. None of these actions were taken by DSS.

Because of the deficiencies noted above, testing was expanded to include a judgmental sample of six out of the remaining eight recipient category reviews conducted during our audit period. Of the six additional reviews selected for testing, one was found to have a similar type of internal control error as noted above. This review was opened by the SURS unit regarding improper claims paid under the pregnancy-related claims only aid category. On the date of service, several facilities billed for services related to an injury. The SURS unit investigated and voided all claims for this date of service because they were not pregnancy-related services. After the review was closed, however, two more claims were submitted to DSS and paid without being discovered by DSS.

As a result, the Department faced an increased risk of fraud, abuse, and overpayments occurring within the Medicaid program and not being detected through the post-payment review process.

RECOMMENDATIONS:

1. We recommend that internal controls be strengthened over the post-payment review of claims.
2. We recommend internal controls be implemented to ensure that cases that involve potential fraud or abuse are reported to the Medicaid Fraud Control Unit or appropriate law enforcement agency, as necessary.

Auditee's Corrective Action Plan:

The Department concurs with this finding.

We have enhanced our card issuance procedures to address situations where a recipient's card has been lost or stolen and is being used inappropriately. In these situations the card will be closed with a new recipient identification number assigned and a new card issued. This will prevent any further misuse of the card. We have also implemented some additional edits within the Medicaid Management Information System (MMIS) for pregnancy-related services when specific sets of criteria are met, resulting in the claim being pended for further review prior to payment.

Cases involving potential provider or recipient fraud or abuse will be referred to the appropriate entity.

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This concludes the Departments' corrective action plan. We appreciate the opportunity to share our plans related to the findings and recommendations, and intend to enhance our internal controls so these findings will not occur in the future.