Fairfax County Internal Audit Office

Fairfax-Falls Church Community Services Board
Medicaid Revenue Collection & Compliance Audit
Final Report

March 2012

"promoting efficient & effective local government"

Introduction

The Fairfax-Falls Church Community Services Board (CSB) was established in 1969 under a state mandate and a joint resolution of Fairfax County and the cities of Fairfax and Falls Church to provide mental health, intellectual disabilities and alcohol and drug services as well as specialized services in prevention and early intervention. When the CSB was first established, revenue was received by billing for clinical services only; then in 1990 the Commonwealth of Virginia's Department of Medical Assistance Services (DMAS) expanded its State Plan Option (SPO) to cover certain mental health, rehabilitative services and case management services. The 1990 SPO plan was revised in 1998. The CSB billed DMAS for SPO covered services complying with the periodically updated DMAS provider manual "Community Mental Health and Rehabilitative Services." In 2010, DMAS updated the manual adding mandated service authorization for SPO Services Manual. The CSB continues to bill DMAS for covered services complying with SPO Manual requirements.

Currently, the CSB receives revenue from many sources including private insurance companies, Medicare and clients' self pay; however, Medicaid remains the highest single source of revenue for all services rendered. In FY 2010 the CSB treated 19,572 clients and the total revenue collected was $138,875,521. In FY 2011 the total revenue collected was $151,247,983, an increase of 8.2%.

The system in place during our audit did not have a capable accounts receivable module; therefore, we could not reconcile the twelve month period. However, during the course of our audit, CSB was in the midst of implementing a new system from Credible Wireless, Inc. It is our understanding that the implementation of this system will assist the CSB with better management, compilation of information about billing and receipts, programs, and ability to comply with federal regulations 5010 for 2012.

Executive Summary

Internal Audit found that controls were in place and appeared to be operating effectively to ensure the revenue collection process was complete and accurate. Many of the potential findings were already identified in the Beeman Commission Report dated 2006, and at the time of our audit CSB management had begun the necessary steps to resolve these issues. Internal Audit noted that of the twenty recommendations in the Beeman Commission Report, eighteen of these items had been resolved by the end of FY 2011 and CSB had created a timeline for ensuring that the remaining two *items (1. Ensuring all effective processes developed are consistent and applied effectively and 2. Adjust the business plans based on changes in demand, payers and the provider system.)* would be resolved by the end of FY 2014. Based on audit findings and observations it appears this scheduled timeline is reasonable for completing the remaining works in a timely manner. We found the systems efficiently and effectively support the Medicaid reimbursement process. Billing services were accurately and timely recorded and there was adequate billing, monitoring and prior authorization provided for Medicaid services. Management oversight included effective processes to

ensure staff members complied with established procedures for internal controls in securing the county revenue and adequate segregation of duties was in place and operating effectively. However, as noted below, we did identify a concern regarding the monthly reconciliation and amounts collected. Internal Audit learned that with the implementation of the new EHR system called Credible; CSB will be able to perform monthly reconciliations on current and past receivables. Performing systematic reconciliations on past receivables will validate that (all) revenue is accounted for. Controls were in effect to strengthen the process and management reviews provided compensating controls. We also identified effective compliance with state and federal regulations. However, we did find the following areas for improvement:

- Monthly reconciliations for billing and receipts were not formally documented or performed. Therefore, accounts receivable match with revenue could not be performed, resulting in a difference of approximately $1.4 million for a twelve month period. This could be due to a timing difference.
- CSB did not refund overpayments received from third-party health insurance companies resulting in a $4,900 overstatement of revenue for the twelve month period January through December 2009.
- Preauthorization was not performed for private health insurance companies.
- Clients were not charged the delinquent account fees.
- Not all levels of staff were being informed of regulatory changes.

Scope and Objectives

This audit was performed as part of our fiscal year 2011 Annual Audit Plan and was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. The audit covered the period from July 1, 2009, through September 30, 2010, and included more recent data from January 1, 2011, through June 30, 2011. Our audit objectives were to determine:

- Implementation status of recommendations in the Beeman Commission Report
- The efficiency and adequacy of the systems used to support the Medicaid reimbursement process
- Accurate and timely recording and reconciling of billable services
- Adequate billing, monitoring and prior authorization for services
- Adequate segregation of duties was in place and operating effectively
- Effective compliance with state and federal requirements
- Supervisory review was effectively conducted

Methodology

Our audit approach included on-site visits with the CSB management and staff involved in the six program areas as well as the revenue collection process for Medicaid and other revenue services. We conducted individual interviews and received a system walk-through of the process from initial setup of a client, billing and recording of all client transactions including confidential information to the final remittance of payment from the varied number of third party pay sources. We reviewed the controls over the billing and collection process. This included the controls for accessing the billed charges, operational controls implemented as well as employee job functions. Using automated software, we tested the entire population of billed and received amounts for our audit period to verify the integrity and accuracy. Using numerical data we compared the billed amounts with the payment amounts received and reviewed user documentation including financial reports, job descriptions for segregation of duties, client billings and revenue remittances as well as Financial Accounting Management Information System (FAMIS) postings and transaction detail.

We reviewed the controls over Medicaid and all other revenues collected using the electronic system. This included controls for billings and payments received, accessing and performing transactions on the electronic health record (EHR) system as well as employee job functions performed. We tested the data using automated software to verify the integrity and accuracy. This included comparing the individual amounts billed per client with the amounts received from the third party insurance companies and/or clients. This was necessary to validate the amounts received against the amounts billed. We did not examine the system controls over the SYNAPS application system or the county's financial application system, FAMIS. Our transaction testing did rely on these controls; therefore, this was a scope limitation. The potential impact of this limitation on our findings was that some portion of the transaction data may have been erroneous.

Due to the complexity of the services billing documentation, it was with assistance from CSB staff that Internal Audit was able to identify the billed amounts; however, we could not confirm or deny the accuracy of the remittances because there was no identification in the payments to track back to the billed amounts.

Findings, Recommendations, and Management Response

1. Monthly Reconciliation and Accounts Receivable Tracking

CSB did not perform monthly reconciliations to ensure that the amounts billed to the customers (clients) were reconciled with the revenue amounts received from the health insurance companies or associated clients. Differences between amounts shown on reports for services rendered, amounts billed and payments received were not reconcilable. For example, in calendar year 2009, $70,394,310.11 was billed; however, client adjustments amounted to $49,438,743.07 and the amount collected was $19,561,925.34. This resulted in

an outstanding unaccounted for amount of $1,393,661.70 (6.65%), based on potential differences for a twelve month period. Though some may be attributed to timing differences, there was no supporting documentation for identifying the amounts shown on the reports to determine the billing period to which they pertain.

As stipulated in ATB10020 – Reconciliation of Financial Transactions, all county revenue should be reconciled according to an established systematic schedule. At a minimum, county departments are responsible for performing monthly reconciliations on a timely basis at the transaction level to ensure the integrity of the county's financial records. By not performing an appropriately documented, systematic and accurate reconciliation, the revenue collected could be understated and there could be potential for significant amounts of uncollected revenue.

Recommendation: We recommend that CSB develop and issue appropriate procedures and implement a reconciliation process to identify all steps from beginning to end and appropriate levels of responsibility. These procedures should include the need for accounting entries in order to recognize the earned revenue as receivables until payment is received and should be approved by the Department of Finance. In addition, receivables should be aged and an appropriate follow-up supervisory review process should be established to ensure prompt collection of all amounts due to the county. CSB should ensure they have a reliable accounting system in place that will be able to provide a trail to allow the reconciliation of accounts receivables to receipts, an aging report, etc. to enhance their collection efforts with the new system.

Management Response: Utilizing the Credible EHR system, CSB is initiating new business practices for month-end, accounts receivable, and aging reports. A detailed task list has been prepared to implement these business processes. The anticipated date of completion is March 31, 2012.

2. Overpayments

CSB did not ensure that the third-party health insurance companies accept the refund for extra monies received by the county from services performed. When more than one health insurance company is billed for client services performed, the first company will pay a specific amount and CSB will send a bill for the balance to the second and subsequent health insurance companies to be paid. Internal Audit was informed by CSB staff and management, that though the form sent by CSB stipulates that the first health insurance company has already made a partial payment for the service(s) and only the balance is due, on occasion, the second and/or subsequent health insurance company also pays the full amount. The subsequent companies have been claiming they are not due a refund from CSB because they believe they are the primary insurance company and should pay the greater amount.

The Patient Protection and Affordable Care Act of 2010 (PPACA) also known as "the health care reform law", stipulates that *"… a person who has received an overpayment is required to report and return any such overpayment to the Secretary of Health and Human Services, the State an intermediary, a carrier or a contractor, as appropriate, at the correct address and to notify the Secretary, State, intermediary, carrier or contractor in writing of the reason for the overpayment." It defines "person" as including a provider of services, supplier, Medicaid managed care organization or PDP sponsor. It defines "overpayment" as any funds that a person receives or retains under Medicaid or Medicare to which the person, after applicable reconciliation, is not entitled."*

CSB is potentially in violation of the PPACA if they keep overpayments. CSB could be charged penalties by the secretary of the Department of Health and Human Services. In addition, non-compliance with the PPACA could result in suspension from participating in the Medicare and Medicaid programs.

Recommendation: We recommend that CSB make all necessary attempts to investigate the apparent refunds due to the third-parties and return the extra funds to the affected parties as stipulated in PPACA.

Management Response: With the implementation of the Credible EHR, the CSB is reorganizing the central Revenue Management Team by function. Payments will be audited daily. A detailed task list has been prepared to implement this business process. The anticipated date of completion is March 31, 2012.

3. Private Insurance Revenue

Internal Audit learned from interviews and observed through data reviewed, that approximately $669,000 of private insurance client/patient fees was not being collected. There was no CSB authorization process for private health insurance companies prior to delivering the treatment. Some private health insurance companies require prior authorization before providing services to a client; however, Internal Audit noted that some clients received the service(s) then the charges were sent to the health insurance company. There were many cases where the private insurance company declined the claim but the services had already been provided without authorization and CSB was not able to recoup any revenue. Written insurance procedures or regulations require that CSB obtain authorization prior to providing services. CSB has been losing revenue as a result of not obtaining authorization prior to providing services for members of private health insurance companies. IAO identified from the data reviewed for the period January through June 2011, approximately 78% of the billed amounts may not be collected as a result of not obtaining prior authorization. CSB obtained prior authorization for Medicaid clients, which was the majority of their clients and revenue received through the years. However, in recent years the demand for services from clients with private health insurance has significantly increased. Consequently, the need for authorization prior to providing services

to those clients/patients is a critical step since the risk of loss of revenue for unapproved claims is potentially significant. Obtaining prior authorization from all clients would ensure that all revenue due to CSB is collected whenever services are rendered.

Recommendation: We recommend that CSB implement a process for ensuring that preauthorization is performed on private health insurance companies with developed, implemented and tested procedures to evaluate the effectiveness of the process.

Management Response: With the implementation of the Credible EHR, the CSB is reorganizing the central Revenue Management Team by function. Prior Authorizations for Medicaid and commercial insurance plans will be fielded. A detailed task list has been prepared to implement these business processes. The anticipated date of completion is March 31, 2012.

4. Delinquent Charges

Clients were not charged a penalty for delinquent accounts of 180 days or greater. CSB was forgiving the 20% delinquent collection fee and the one time administrative fee and did not charge the client these charges. ATB036, Billing and Collection Procedures for Billable Revenue, and guidance from the County Attorney interpreting board action requires CSB to charge all delinquent clients for all amounts that are uncollected after a period of 180 days. By not charging the client the stipulated 20% delinquent fee, some clients do not have an incentive to pay early or on-time. The county potentially loses some revenue.

Through the years, ATB036 was not consistently enforced throughout the county; therefore, it was left to the individual agency to decide on an ad hoc basis whether to implement fully or not.

Recommendation: We recommend that CSB management review and comply with ATB036, and collection policies approved by the Board of Supervisors to ensure clients are charged the established applicable stipulated delinquent fees.

Management Response: The CSB intends to schedule a Fee Policy meeting of its Board to update its policy, regulation and fee schedule. It will include compliance with ATB036. The anticipated date of completion is July 31, 2012.

5. Communicated Regulations

Through interviews with CSB program staff, Internal Audit .learned that changes in regulatory information were not being fully disseminated down through all levels of staff. When new state and/or federal regulations were updated, these changes were not communicated to all program managers within CSB. We observed that the agency was at times cited on external reviews and this

appeared to be due to a lack of current knowledge. This absence of an established procedural process for communicating updates to staff members adversely affects the ability of CSB in achieving the agency's objective and results in loss of revenue to the county and/or lack of compliance with regulations.

Recommendation: We recommend that CSB implement procedures to improve communication so that when regulatory updates are made, the information is forwarded to the program managers and other responsible staff. New requirements should be disseminated through to all levels involved in the client services process.

Management Response: The CSB plans to monitor Medicaid regulatory communications, e.g., DMAS website, provider memos, and changes to DMAS manuals. They will assemble and assess regulatory information, coordinate updates for agency policy, regulations and procedures. Additionally, they will communicate Medicaid revisions, changes to policy, regulations and procedures through established CSB communication channels, e.g., emails, training, staff meetings, and the infoweb. The anticipated date of completion is March 31, 2012.