PRINCE WILLIAM COUNTY

Prince William County, Virginia
Internal Audit Report: Medicaid Renewal Process

February 27, 2025

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PRINCE WILLIAM COUNTY

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TRANSMITTAL LETTER

February 27, 2025

The Board Audit Committee of
Prince William County, Virginia
1 County Complex Court
Prince William, Virginia 22192

Pursuant to the internal audit plan for calendar year ("CY") 2024 for Prince William County, Virginia ("County" / "PWC"), approved by the Board of County Supervisors ("BOCS"), we hereby present the internal audit of the Medicaid renewal process. We will be presenting this report to the Board Audit Committee of Prince William County at the next scheduled meeting on March 18, 2025.

Our report is organized into the following sections:

Executive Summary	This provides a high-level overview and summary of the observations noted in our internal audit over the Medicaid renewal process.
Background	This provides an overview of the function, as well as relevant background information.
Objectives and Approach	The internal audit objectives are expanded upon in this section, as well as a review of the various phases of our approach.
Observations Matrix	This section includes a description of the observations noted during our internal audit, recommended actions, and Management response, including the responsible party and estimated completion date.

We would like to thank the staff and all those involved in assisting our firm with this internal audit.

Respectfully Submitted,

RSM US LLP

Internal Audit

PRINCE WILLIAM COUNTY

EXECUTIVE SUMMARY

Background

The Medicaid eligibility and enrollment renewal process provides continued healthcare coverage for eligible beneficiaries while maintaining compliance with federal and state regulations. Medicaid is federally funded and state-administered, with counties responsible for processing renewals, assisting beneficiaries, and verifying eligibility. The County's Public Assistance Division facilitates this process by supporting applicants, conducting manual case reviews when automated verification is not possible, and validating compliance with Virginia Medicaid policies. Renewal determinations are documented in the Virginia Case Management System ("VaCMS") and reflected in the Virginia Department of Medical Assistance Services ("DMAS") Medicaid Enterprise System ("MES"), which serves as the Medicaid Management Information System ("MMIS").

Strong internal controls over the renewal process help mitigate risks related to processing errors, delays, and improper determinations while ensuring compliance with regulatory requirements. Weaknesses in these controls may result in financial risks, including improper payments, loss of state or federal funding, and increased administrative costs due to rework or appeals. The County's Public Assistance Division ("PA Division") has developed standard operating procedures ("SOPs") that align with state and federal requirements. These SOPs define manual review procedures, required documentation, and deadlines to facilitate consistency and accuracy.

The County begins the annual Medicaid renewal process two months before the renewal deadline. VaCMS attempts to automatically renew or close coverage if required verifications are available. If automated renewal is not possible, cases undergo manual review, during which County staff verify eligibility, document case actions, and confirm system accuracy. Case transactions in VaCMS are interfaced with MMIS to maintain up-to-date records.

Overall Summary / Highlights

The observations identified during our assessment are detailed in the pages that follow. We have assigned relative risk or value factors to each observation identified. Risk ratings are the evaluation of the severity of the concern and the potential impact on the operations of each item. There are many areas of risk to consider in determining the relative risk rating of an observation, including financial, operational, and/or compliance, as well as public perception or 'brand' risk.

Objectives and Scope

The objective of this internal audit was to assess whether the system of internal controls over the annual Modified Adjusted Gross Income ("MAGI") eligibility and enrollment renewal process for existing Medicaid beneficiaries is adequate and appropriate for facilitating compliance with state and federal requirements without creating unnecessary burdens on employees and VA Medicaid beneficiaries. Procedures performed included the following:

- Compared the County's Public Assistance Division's Medicaid renewal procedures to those of similar jurisdictions and state and federal regulations to confirm alignment with common practices and identify any excessive requirements.
- Assessed the process and controls relevant to identifying and mitigating risks in the Medicaid renewal process.
- Gathered and analyzed feedback from staff and applicable individuals to evaluate whether the current SOPs impose unnecessary burdens or inefficiencies.
- Tested a sample of five (5) MAGI Medicaid renewals due during July, August, and September 2024 to validate adequacy and compliance with select terms of the SOP, such as verification deadlines, notification procedures and alignment with state and federal guidelines.
- Evaluated timeliness within the renewal process related to applicable renewal deadlines, including the timeliness and accuracy of communicating renewal decisions to the beneficiaries.

Our audit period was July 1st – September 30th 2024.

Fieldwork was performed from October through December 2024.

Summary of Observation Ratings
(See page 3 for definitions)

	High	Moderate	Low
Medicaid Renewal Process	-	2	-

We would like to thank all County team members who assisted us throughout this internal audit.

EXECUTIVE SUMMARY (CONTINUED)

Observations Summary

Below is a summary listing of the observations that were identified during this internal audit. Detailed observations are included in the observations matrix section of the report.

Summary of Observations	
Observations	**Rating**
1. State-Owned System Functionality	**Moderate**
2. Adherence to Established Policies & Procedures	**Moderate**

Provided below are the observation risk rating definitions for the detailed observations.

Observation Risk Rating Definitions	
Rating	**Definition**
Low	Observation presents a low risk (i.e., impact on financial statements, internal control environment, or business operations) to the organization for the topic reviewed and/or is of low importance to business success/achievement of goals. Action should be taken within 12 months (if related to external financial reporting, must mitigate financial risk within two months unless otherwise agreed upon).
Moderate	Observation presents a moderate risk (i.e., impact on financial statements, internal control environment, or business operations) to the organization for the topic reviewed and/or is of moderate importance to business success/achievement of goals. Action should be taken within nine months (if related to external financial reporting, must mitigate financial risk within two months).
High	Observation presents a high risk (i.e., impact on financial statements, internal control environment, or business operations) to the organization for the topic reviewed and/or is of high importance to business success/achievement of goals. Action should be taken immediately, but in no case should implementation exceed six months (if related to external financial reporting, must mitigate financial risk within two months).

BACKGROUND

Roles, Responsibilities, & Systems

The County's Public Assistance Division ("PA Division") within the Department of Social Services administers timely and accurate income support benefits to income-eligible individuals and families living in PWC. These programs assist County residents as they transition from dependency on public assistance to self-sufficiency. This internal audit is focused on the Medical Assistance program, specifically for Modified Adjusted Gross Income ("MAGI") beneficiaries due for renewal. The Medicaid and Family Access to Medical Insurance Security Plan ("FAMIS") are medical assistance programs that make direct payments to health care service providers for eligible individuals and families who are unable to pay for needed medical services. Other programs offered by the PA Division include the following: Supplemental Nutrition Assistance Program ("SNAP") and Temporary Assistance for Needy Families ("TANF").

The PA Division is led by the Assistant Director and Program Manager. Administrative Specialists are responsible for managing and assigning casework, receiving and uploading incoming renewal documentation, and facilitating outgoing mail when necessary. There are approximately 15 to 20 Intake Managers who oversee about 200 Intake Specialists broken out into teams. At the time of the audit, the PA Division consisted of 4 Intake Units, 9 Outgoing Units and a Training Unit. Specialists are responsible for determining whether a program renewal they are processing can be authorized based on the information received from the customer.

The Virginia Case Management System ("VaCMS") is an integrated eligibility determination and case management tool used for assigning Medicaid renewal cases to Specialists for review, verifying customer information, and serves as a repository for all case documentation that supports an eligibility determination or other case actions. Renewal decisions and case information from VaCMS are electronically transmitted via daily automatic batch processing to the Medicaid Management Information System ("MMIS"), a system that gathers each state's Medicaid program information and is managed by the US Department of Health and Human Services through the Center for Medicare and Medicaid Services ("CMS").

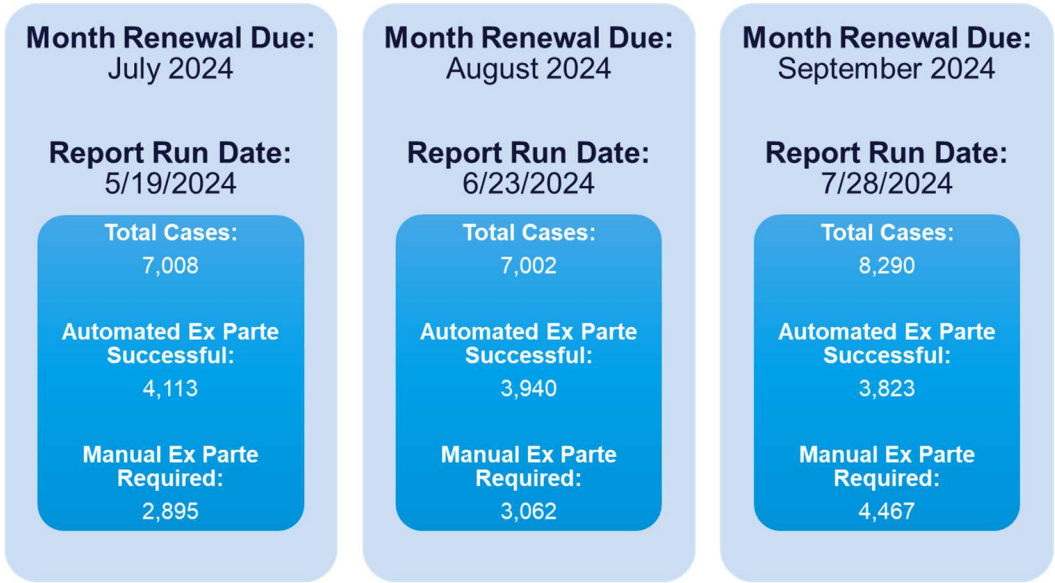
Process Overview

The MAGI Medicaid renewal process begins when the Ex Parte renewal report is generated by the PA Division in the 10th month preceding the renewal due date. The Ex Parte process attempts to automatically renew Medicaid eligibility based on available system data. Cases that do not meet the automated renewal criteria require manual review by a Public Assistance Specialist (manual Ex Parte). In these instances, a renewal packet is automatically issued to both the beneficiary and the assigned Specialist immediately after the report is generated.

Upon receiving the renewal packet, the Specialist determines whether additional documentation is needed to verify eligibility. If required, a Verification Checklist is issued to the beneficiary, requesting supporting documentation (e.g., proof of income). The beneficiary must return the requested documentation within 10 days. Failure to do so results in case closure and termination of coverage.

Once all necessary documentation is received, the Specialist verifies key eligibility criteria, including household composition, non-financial factors, income, and resources. The Specialist then makes an eligibility determination and updates the system accordingly. If the renewal is approved, the case is finalized by the 15th day of the renewal month. If denied due to ineligibility or failure to submit required documentation, the case is closed, and coverage is terminated.

Case data must be transmitted from VaCMS to MMIS by the 16th of the month for successful coverage enrollment effective the 1st of the following month. Internal Audit reviewed Ex Parte renewal reports for cases with renewal due dates in July, August, and September 2024.

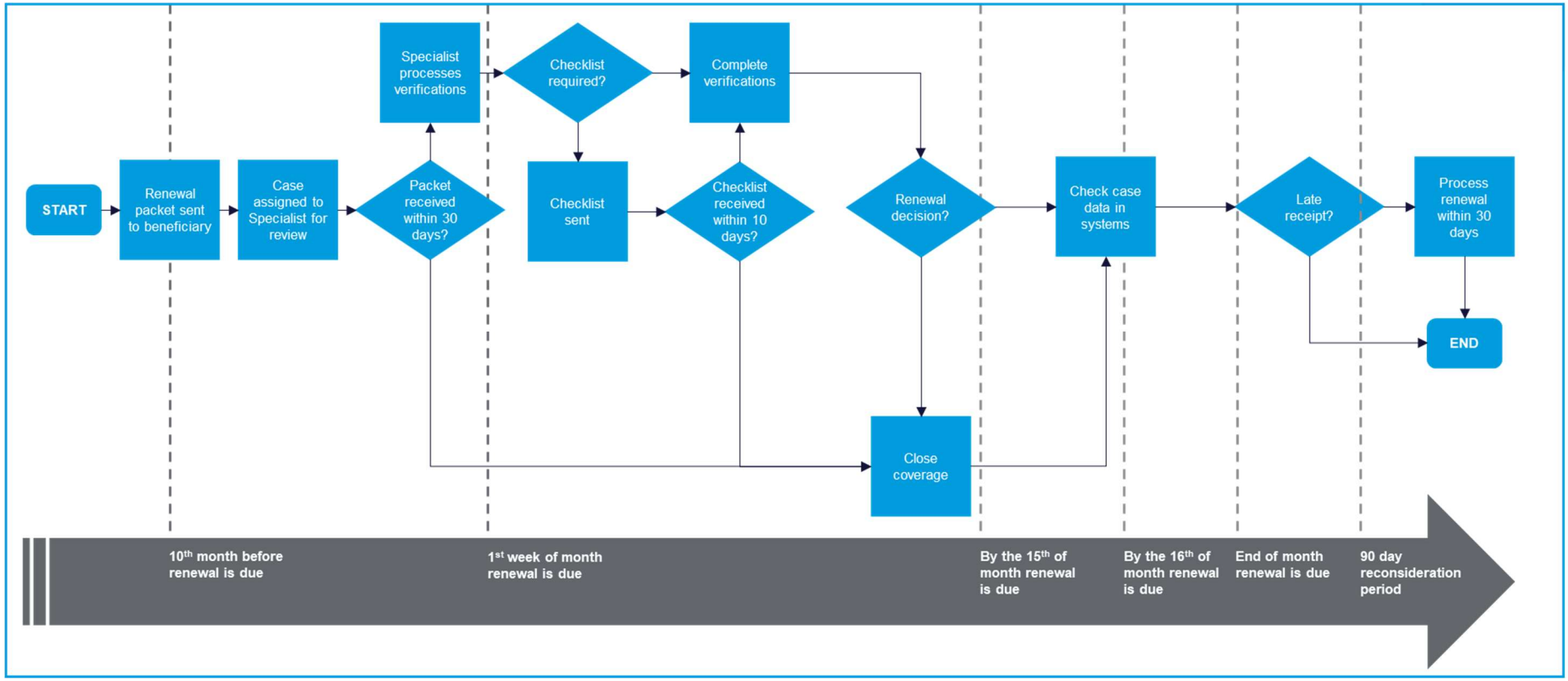


BACKGROUND (CONTINUED)

Process Overview (Continued)

In instances where renewal information is submitted after the due date but within the 90-day reconsideration period, the renewal is processed within 30 days of receipt. During the reconsideration period, the Specialist will check for receipt of renewal packets and/or checklist documentation on closed cases.

The renewal process can be summarized through the below graphic:



BACKGROUND (CONTINUED)

Standard Operating Procedures

The County's PA Division developed an internal Medicaid standard operating procedure ("SOP"). The SOP includes several requirements that align with state and federal policy, as well as procedures aimed at improving efficiency within their own process. Prior to the standardized SOP, the PA Division relied heavily on email communications to track evolving processes, which changed frequently in response to both emerging operational challenges and state and/or federal directives. The PA Division provided Internal Audit with contacts for similar jurisdictions, however there is uncertainty as to whether these localities have also developed a unique and comprehensive SOP. The table below represents a comparison of the County's SOP requirements versus state and federal policy to highlight key differences and reasoning.

SOP Topic	Applicable Standards			Key Differences
	Prince William County Public Assistance Division (PWC)	Virginia Department of Medical Assistance Services (DMAS)	United States Department of Health & Human Services (DHHS)	
Renewal frequency	At least every 12 months	At least every 12 months	At least every 12 months	N/A
Time at which renewal packet is sent to the beneficiary	10th month before renewal is due	Can be 10th month before renewal is due	With sufficient time to ensure the renewal completion prior to the end of the eligibility period	N/A
Time allowed for beneficiary to return renewal packet	30 days from send date	30 days from send date	Minimum 30 days from send date	N/A
Time allowed for beneficiary to return additional documentation	10 days from request date	At least 10 days from request date	Review period must account for the time needed for beneficiaries to return their signed renewal form and submit required documentation	N/A
Pursuit of beneficiaries with outstanding documentation due	During the first week of the month if packet isn't returned within 30 days	Not specified	Encouraged to conduct more intensive outreach to remind individuals to respond to the renewal form and requests for information	PWC SOP requirement reflects encouraged DHHS best practice
Cutoff for completing renewal	15th of the month renewal is due	16th of the month renewal is due	Not specified	PWC SOP requirement to allow an extra day for system interface error identification and correction
Reconsideration period	90 days	90 days	90 days	N/A
Deadline for completing renewal during reconsideration period	Within 30 days of renewal packet receipt	Within 30 days of renewal packet receipt	Within 30 days of renewal packet receipt	N/A
Documentation of case actions	Required	Must include facts to support the decision on the case within case record	Not specified	N/A
Completeness and accuracy check of system interface data	After every transaction, before month cutoff at minimum	Not specified	Not specified	PWC SOP requirement added for system interface error identification and correction

OBJECTIVES AND APPROACH

Objectives

The objective of this internal audit was to assess whether the system of internal controls over the annual Modified Adjusted Gross Income ("MAGI") eligibility and enrollment renewal process for existing Virginia ("VA") Medicaid beneficiaries is adequate and appropriate for validating compliance with state and federal requirements without creating unnecessary burdens on employees and VA Medicaid beneficiaries.

The scope of our Review of the Virginia Department of Medical Assistance Services' ("DMAS") MAGI eligibility and enrollment renewal process included the following:

- Review of the renewal process to determine if it meets applicable state and federal requirements.
- Review of the renewal process to determine if it is more stringent than applicable state and federal requirements, causing unnecessary burdens on VA Medicaid beneficiaries and employees responsible for the renewal process.
- Evaluation of the renewal process' timeliness and ability to meet applicable deadlines for completing Medicaid renewals, including the timeliness and accuracy of communicating renewal decisions to the beneficiaries.
- Analysis of the SOP (e.g., the mid-month Medicaid cutoff date for completing renewals) to confirm alignment with applicable state and federal requirements.
- Analysis of the impact of the current mid-month renewal cutoff SOP on employees responsible for the process, including potential impacts on other program renewal duties (e.g., Temporary Assistance for Needy Families ("TANF") and Supplemental Nutrition Assistance Program ("SNAP")).
- Analysis of the mid-month Medicaid cutoff date configurations / controls, as applicable, within the DMAS instance of the Medicaid Enterprise System ("MES") and Medicaid Management Information System ("MMIS") and its impact on the renewal process.
- Comparison of the County's Medicaid renewal procedures to those of other similar jurisdictions to determine if the County's practices align with common practices or are excessively stringent.
- Risk-based operational effectiveness testing of the renewal process' identified key controls specific to the timeliness of the renewal determination and communication with the applicable beneficiaries.

Out-Scope for Review

This internal audit did **NOT** include the following:

- Review of the eligibility and enrollment processes (MAGI, Non-MAGI, and Long-Term Care (LTC)) for new VA Medicaid beneficiaries.
- Review of the processes and controls related to the annual Non-MAGI and LTC eligibility and enrollment renewal process for existing beneficiaries.
- Impact analysis of the mid-month cutoff date SOP and any other county SOPs for the Non-MAGI and LTC annual renewal processes.

OBJECTIVES AND APPROACH (CONTINUED)

Approach

Our audit approach consisted of the following phases:

Understanding and Documentation of the Process
The first phase of this audit consisted primarily of inquiry and walkthroughs to obtain an understanding of the current operating policies and procedures, monitoring functions, and the overall Medicaid renewal process. The following were performed as part of this phase:

- Obtained and reviewed applicable state and federal policies, procedures, and agreements related to Medicaid renewals.
- Identified key stakeholders and process and control owners.
- Facilitated interviews and process walkthroughs with identified key personnel to understand the in-scope processes, control environments, and systems/applications used.
- Developed a risk-based work plan to evaluate the design effectiveness of processes and controls based on the information obtained through our review, inquiry, and walkthrough procedures.

Evaluation of the Process and Controls Design and Testing of Operating Effectiveness
The purpose of this phase was to evaluate and assess the design of the current operating processes and test the effectiveness of key internal controls based on our understanding of the processes obtained during the first phase. We utilized sampling and other auditing techniques to meet our audit objectives outlined above. Our testing procedures included, but were not limited to:

- Compared the County's Medicaid renewal procedures to those of similar jurisdictions to confirm alignment with common practices and identify any excessive requirements.
- Assessed the process and controls relevant to identifying and mitigating risks in the Medicaid renewal process.
- Assessed adequacy and compliance with select terms of the SOP, such as verification deadlines, notification procedures, and alignment with state and federal requirements.
- Gathered and analyzed feedback from staff and applicable individuals to evaluate whether the current SOPs impose unnecessary burdens or inefficiencies.

Reporting
At the conclusion of this internal audit, we summarized our findings into this report. We have reviewed the results with the appropriate Management personnel and have incorporated Management responses into this report.

OBSERVATIONS MATRIX

Observation	1. State-Owned System Functionality
Moderate	System functionality and interface accuracy should support efficient Medicaid renewal processing by ensuring timely case updates, minimizing manual intervention, and providing reliable reporting. Best practices recommend clearly defined troubleshooting procedures, automated system interfaces that accurately transfer data, and reporting capabilities that support case tracking and oversight. We identified the following deficiencies caused by the state-owned system impacting Medicaid renewal processing: 1. State-Owned System Interface Deficiencies ○ Frequent data transfer failures between the state-owned systems, VaCMS and MMIS, leave renewal transactions unprocessed, requiring manual corrections to renewal determinations, coverage statuses, and renewal dates. ○ The PA Division's SOP requires Specialists to review interface errors, but: ▪ There is no requirement to document these reviews for accountability and tracking. ▪ There is no formalized method to proactively detect errors; issues are primarily identified through customer inquiries or discrepancies in case reports. ○ The PA Division's SOP sets a renewal cutoff date of the 15th, one day earlier than the state-mandated MMIS cutoff on the 16th, to allow time for verification and corrections. However, this workaround does not fully address the impact of interface failures. 2. Functionality Limitations ○ The state-owned system frequently fails to automatically close cases when beneficiaries do not return renewal documentation, increasing manual processing workload. ○ Specialists must enter data one screen at a time in sequential order before the system runs a final verification check, delaying early identification of missing documentation. ○ The PA Division has not fully formalized the troubleshooting strategies used to mitigate state-owned system limitations. ○ Specialists do not consistently document workarounds, leading to duplicated efforts and inefficiencies. 3. Reporting Deficiencies ○ Some state system reports contain errors, requiring duplicate reviews and manual corrections (e.g., a renewal packet was incorrectly flagged as unsent despite being issued). ○ VaCMS cannot generate a consolidated population report of all renewal determinations for a given period, requiring Specialists to manually track case progress. ○ Reliance on manual tracking increases inconsistencies and potential errors (see **Observation 2**). These state-owned system inefficiencies increase manual workload, delay renewal processing, and introduce a higher risk of processing errors. The absence of formalized troubleshooting documentation limits accountability and leads to duplicated efforts. Inadequate reporting reduces oversight effectiveness and hinders the ability to track Medicaid renewals accurately.

OBSERVATIONS MATRIX (CONTINUED)

Observation	1. System Functionality (Continued)

Recommendation	We recommend the following:
	• Conduct a targeted system assessment to advocate for state-owned system enhacements:
	  ○ Evaluate the state-owned systems, VaCMS and MMIS, and their interface to identify configuration improvements and assess factors contributing to inefficiencies or errors. Utilize the assessment results to collaborate with the State to advocate for necessary system enhancements.
	  ○ Confirm that adequate controls are in place to support Medicaid renewal processing.
	• Enhance PA Division's SOPs and Documentation:
	  ○ Revise and develop documented procedures, job aids, and training materials for Medicaid renewal case processing.
	  ○ Clearly define required steps for each role and outline documentation expectations, including system workarounds needed due to system limitations.
	  ○ SOP enhancements should include:
	  ▪ Documentation requirements for Specialist review steps related to identifying and correcting system interface errors before the cutoff date.
	  ▪ Periodic report monitoring procedures to track and correct system interface errors, including documentation, prioritization, and resolution steps.
	  ▪ Guidelines for system workarounds and troubleshooting efforts used by Specialists, including documentation expectations for applied methods.
	• Assess and Improve Reporting Capabilities:
	  ○ Evaluate current VaCMS reporting functions to determine which reports cannot be generated and identify areas where reporting capabilities could be enhanced by the State.

Management Action Plan	**Response:** The PA Division, in collaboration with other jurisdictions, remains committed to advocating for replacement and/or enhancements to the Virginia Case Management System (VaCMS). The Division will continue to advocate for the development and implementation of a more robust and agile platform that better serves our operational needs and reporting requirements. Through ongoing partnerships with the Virginia League of Social Services Executives and VaCMS workgroup, the Division will aim to secure improvements that will streamline workflows, increase efficiency, and provide more comprehensive reporting capabilities to betters support data driven decision making. The PA Division SOP will be updated to reference the existence and location of supplemental job aids/workarounds, directing staff to consult the current versions as needed. The PA SOP will focus on documenting standardized, stable processes that remain relatively consistent over time and will keep frequently changing workarounds separate on the Division's SharePoint site. This will allow quicker updates without going through lengthy SOP revision processes, more agile responses to system issues and changes, easier maintenance and version control, and reduced need to constantly revise the core SOP document. **Responsible Party:** Assistant Director - Public Assistance Division **Estimated Completion Date:** 05/31/2025

PRINCE WILLIAM COUNTY

OBSERVATIONS MATRIX (CONTINUED)

Observation	2. Adherence to Established Policies & Procedures
Moderate	The County's Medicaid renewal process should align with state and federal requirements, including the Virginia Medical Assistance Eligibility Manual and the State Medicaid Manual published by the U.S. Department of Health & Human Services. The County's Standard Operating Procedure ("SOP") further defines key tasks, responsibilities, and documentation expectations to promote consistency, efficiency, and compliance in processing Medicaid renewals. See page 7 for additional detail on local, state, and federal requirements. During our review and detailed testing, we noted several instances of non-compliance with established renewal procedures: 1. Two (2) of five (5) renewal cases tested were not closed on time, resulting in continued Medicaid coverage beyond the renewal due date despite missing renewal packets. Renewal packets were later received during what should have been the 90-day reconsideration period, but processing exceeded the 30-day requirement, taking nearly two months. 2. Case tracking and monitoring procedures are not operating effectively: o Manual tracking methods are inconsistently applied. Specialists rely on personal tracking tools rather than a centralized system, leading to gaps when cases are reassigned or require follow-up. o VaCMS lacks the capability to generate a comprehensive case tracking report (see **Observation 1**), requiring manual workarounds that increase the risk of oversight and errors. o Weekly reports identifying pending and overdue cases are generated, but there is no formalized process for review and resolution, limiting oversight effectiveness. 3. One (1) of five (5) cases tested lacked proper documentation of income verification, despite additional information being provided by the customer. The VaCMS case narrative was not updated, incorrectly showing the case as pending verification, even though: [1] A Notice of Action was issued and [2] MMIS was updated to reflect an approved renewal of coverage. 4. Three (3) of five (5) cases tested did not include documentation of a customer contact attempt after a renewal packet was not returned. While not required by state or federal policy, the County's SOP states that Specialists must attempt to contact customers before closing a case. Non-compliance with Medicaid renewal policies increases the risk of improper payments, delays in case processing, and gaps in beneficiary coverage. The absence of a standardized tracking and review process limits oversight and creates inefficiencies, while inconsistent documentation reduces transparency and increases the risk of eligibility decision errors.

OBSERVATIONS MATRIX (CONTINUED)

Observation	2. Adherence to Established Policies & Procedures

Recommendation	We recommend the following:
	• In addition to the recommendations made in **Observation 1**, we recommend that the County's PA Division continue to enhance the SOP by revising and developing documented procedures, job aides, and training materials related to Medicaid renewal cases, specifically related to the development of standardized monitoring tools and review responsibilities. These procedures should formally define all required steps assigned to a given role and outline the expectation for how the steps should be documented. Recommended SOP enhancements include procedural and/or documentation requirements for the following:
	  ○ Defined procedures for Specialist review steps performed, and whether these steps are required or encouraged;
	  ○ Standardized procedures for case management and tracking case details and status; and
	  ○ Periodic report monitoring by the PA Division to detect and resolve pending and overdue cases, including the process for documenting, prioritizing, and correcting untimely cases identified.
	• We understand that QA procedures have been deprioritized due to resource constraints. We recommend a formal QA process is reintroduced and should include systematic case reviews and periodic peer reviews for case file completeness. Should resource constraints persist, we recommend periodic training be administered to encourage self-reviews and conformity with existing SOPs.

Management Action Plan	**Response:** The Division's SOP will be enhanced to clearly distinguish between required and encouraged processes within the Medicaid Renewal workflow. This delineation will provide specialists with clear guidance on mandatory steps that must be completed versus recommended practices that support optimal outcomes. The enhanced SOP will also detail the specific reports specialists should utilize and compare during their self-review process to verify work completeness. The PA Division will share this audit report with the Customer Support and Services Division to inform their future Medicaid Renewal quality assurance review consideration. **Responsible Party:** Assistant Director - Public Assistance Division **Estimated Completion Date:** 05/31/2025

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