

Audit Report: 6534 M

Finding Number: 001

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not have procedures to identify treatments and services that may not be allowable for reimbursement under the State Medicaid Plan.

Resolution: By policy, the Department intends to pay only for medically necessary services. The Department is not aware of any exception or specific unallowable claims for which corrective action is necessary. Research activities have begun (noted below) and, upon receipt of medical documentation and/or detailed working papers from the auditor, the Department will investigate and initiate appropriate corrective action.

- The Health and Recovery Services Administration (HRSA) researched and verified the medical necessity of the clients who were identified as "exceptions" for having received breast reduction and breast enlargement surgery. Medical records were requested and reviewed for all exceptions. The surgeon in charge indicated in the patient's medical records that the surgery was necessary due to the need for pain management, a qualifying condition for the surgery. This process was completed November 10, 2006.
- Breast enlargement and reduction surgery is paid according to expedited prior authorization criteria included on a claim. HRSA hired a registered nurse July 16, 2006, to perform the responsibilities of managing the Expedited Prior Authorization program.
- The Department implemented a new medical necessity Washington Administrative Code (WAC) 388-501-0165 in December 2005. All cases with a diagnosis of transsexualism will be reviewed according to the amended medical necessity WAC. The Department will continue to participate in Fair Hearings and submit decisions to the Board of Appeals as appropriate and necessary to sustain coverage decisions.
- By December 2006, HRSA will be adding trans-gender surgery as a non-covered service in the new Certificate of Coverage WAC because evidence-based criteria deems hormone therapy and psychotherapy as effective, lower risk and lower cost treatment for the condition of gender dysphoria. The new Certificate of Coverage WAC is designed to clarify which service categories are covered, covered with limitations and non-covered.
- Clients may enter into Medicaid with chronic diseases and/or medical equipment (including penile implants) paid for by the client or another health plan. HRSA will authorize payment for devices or previous procedures that fail or require repair when medically necessary. HRSA will continue to review requests and authorize payment for those procedures that are considered medically necessary.

Status of Audit Resolution

December 2006

- Because office visits are not prior authorized and not reviewed by diagnosis, HRSA will continue to assume that office visits carrying the diagnosis of trans-sexual are medically necessary and backed up with documentation by the provider as required by law and regulation.
- HRSA will continue to make decisions based on medical necessity and will pay for hormone replacement and psychotherapy as equally effective, less risky and less costly alternatives for both pre and post surgery candidates as determined appropriate.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 002

Finding: The Department of Social and Health Services, Aging and Disability Services Administration, does not have adequate controls to ensure that all alleged violations and complaints of abuse and neglect are investigated in accordance with federal law.

Resolution: The Department disagrees with this finding. The Department requires facilities to follow the Code of Federal Regulations (CFR), 42 CFR 483 Subpart I, in order to protect individuals from abuse, neglect, and mistreatment. Residential Care Services, a division in the Aging and Disability Services Administration, conducts complaint investigations according to procedures established in the federal State Operations Manual by the Centers for Medicare and Medicaid Services.

All identified examples have been reviewed and were triaged and investigated according to the established procedures.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 003

Finding: The Department of Social and Health Services, Aging and Disability Services Administration, does not perform certification surveys of Intermediate Care Facilities for the developmentally disabled according to federal law.

Resolution: The Department follows the survey process identified in the Centers for Medicare and Medicaid Services (CMS) State Operations Manual, Appendix J. This is where the directions for survey of intermediate care facilities for the mentally retarded are found.

As authorized by 42 USC § 1302, the Secretary of the Department of Health and Human Services (HHS) has adopted regulations consistent with the requirements of the Social Security Act. Under these rules: Providers of intermediate care facilities for the mentally retarded must meet all of the certification requirements of 42 CFR 483 Subpart I; and state agencies must conduct certification surveys in accordance with 42 CFR 488.26(c), including subsection (5) (d), which states, "the state survey agency must use the survey methods, procedures and forms that are prescribed by CMS."

During an initial certification survey, the Department reviews all of the eight Medicaid conditions of participation, including the associated 489 standards. For a recertification survey, CMS has adopted specific procedures which require state agencies to review four conditions of participation and the associated 57 standards. The procedures also give the Department the authority to expand the scope of the survey at any time, based upon survey findings or upon information from other sources.

The Department sought additional clarification from the federal Department of Health and Human Services (HHS) to resolve the conflicting direction received by the Office of Inspector General and CMS. DSHS Secretary Robin Arnold-Williams initially raised this question with HHS during a conference call in July 2006 and discussions are continuing with HHS. The Department expects to receive an official decision from HHS shortly.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 004

Finding: The Department of Social and Health Services, Aging and Disability Services Administration does not have a process to impose sanctions, recover funds, schedule or hold hearings for Intermediate Care Facilities for the Developmentally Disabled that are not in substantial compliance with federal health and safety standards.

Resolution: The Department continues to follow the Code of Federal Regulations (CFR) regarding scheduling and holding hearings and will establish internal procedures consistent with the CFR.

As of June 2006, the Department established:

- Procedures to schedule and hold appeals hearings.
- Processes for instituting denial of payment sanctions.
- Procedures to recoup funds paid to a facility in denial of payment status.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 006

Finding: The Department of Health and the Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), are not ensuring compliance with federal law regarding hospital surveys.

Resolution: For the Department of Health (DOH) resolution, refer to page 85.

The Department of Health (DOH) and the Department of Social and Health Services (DSHS) have a signed agreement, effective December 2, 2005, that complies with the Medicaid State Plan and federal requirements for hospital surveys as approved by the Centers for Medicare and Medicaid Services (CMS).

The agreement reflects those items that are required by CMS. All reports now indicate that all federal Medicare hospital certification regulations (Conditions of Participation) are reviewed for compliance during the on-site visits. All deficient findings are documented according to CMS principles of documentation. The Department's review of the information made available by DOH indicates that source documents and other information obtained during surveys is retained in accordance with federal requirements and the agreement between the Department and DOH. DOH and DSHS believe that the terms of the agreement are in compliance with CMS rules.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 007

Finding: The Department of Health and the Department of Social and Health Services, Health and Recovery Services Administration, agreement covering hospitals' survey activities does not comply with federal requirements.

Resolution: For the Department of Health (DOH) resolution, refer to page 86.

The Department of Social and Health Services and Department of Health (DOH) have a finalized and signed agreement, dated December 2, 2005, that complies with the Medicaid State Plan and federal requirements for hospital surveys as approved by the Centers for Medicare and Medicaid Services (CMS).

The agreement reflects those items that are required by CMS. The information that is shared by DOH is compliant with those requirements.

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Audit Report: 6534 M

Finding Number: 008

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), received federal Medicaid funds for unallowable services provided to undocumented aliens.

Resolution: The Department will wait for the finalization of the current Alien Emergency Medical (AEM) audit by the federal Office of Inspector General and make appropriate corrections so as to avoid any conflicts on the interpretation of the AEM policy. This is estimated to be completed by December 2006.

As a result of the Fiscal Year 2005 audit, the following corrective steps are currently in progress to improve internal controls of Social Security Number (SSN) verification:

- A review of the automated SSN verification at the time of the Automated Client Eligibility System (ACES) entry was completed on February 4, 2005. In addition, the Department has enhanced procedures including modification of the interface with the federal database to update nightly, with income and Medicare eligibility updated daily.
- The most significant solution for ensuring correct SSNs is the modification to the State Online Query (SOLO). This change was made in ACES April 16, 2006. The SOLO user interface was modified to accommodate users' ability to perform multiple queries without exiting the system. With the upgrade, staffs were trained to verify the SSN upfront to maximize efficiency and accuracy.
- Staff is currently required to act on SSN discrepancy alerts sent by the Social Security Administration. The Department will continue to provide instruction and written guidance to staff regarding the manner in which alerts are handled.
- The Department has initiated a cross-administration SSN quality improvement workgroup and will continue to focus attention on increasing the accuracy of SSNs in ACES and the Medicaid Management Information System.

The auditor also recommended that the Department fund a state program that would pay for the additional care that the state wishes to provide for the undocumented alien population. Such funding decisions are the prerogative of the Legislature and not the Department.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 009

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), is not complying with federal requirements to defer Medicaid expenditures related to undocumented aliens.

Resolution: The Department established account coding in the Agency Financial Reporting System which facilitated the alien emergency medical (AEM) reporting on the CMS64, effective with the quarter ending June 30, 2004.

Effective October 1, 2004, the Department has not drawn federal matching funds for AEM expenditures, except for labor and delivery. The cost for labor and delivery was specifically exempted upon confirmation with the Centers for Medicare and Medicaid Services via an email dated November 17, 2005.

The Department will wait for the finalization of the current AEM audit by the federal Office of Inspector General to draw from the Medicaid award. This is estimated to be complete by December 2006.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 010

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), has not established sufficient internal controls to support its decisions on eligibility of clients enrolled in Medicaid's Basic Health Plus Program.

Resolution: The Department disagrees with this finding.

The Department's Automated Client Eligibility System (ACES) receives data interfaces from several sources including the Employment Security Department; SEMS (Child Support); Social Security/Bendex; and a private income verification system known as TALX. It uses this information to determine employment of all adults in the household using their Social Security Numbers (SSN). Because these are Basic Health (BH) Plus households and the adults are BH members, the Department receives all adult SSNs which are added to ACES. Once in ACES, the SSN is cross matched with the interfaces. "Alerts" are generated if there are unreported earnings or income discrepancies for all adults (spouse included). These interfaces are considered independent sources.

The Department does not accept client declaration of income as stated by the auditor. Staff follow established Department policies for corroborating client income as outlined in the EA-Z Manual. The Department follows the income methodology set forth in Washington Administrative Code, the EA-Z Manual, and federal regulations.

The auditor has not shared with the Department the eligibility time frames they reviewed or the methods they employed to calculate household income. Due to this, the Department is not able to speak to the statements in the auditor's report regarding cases in which income found is thought to be in excess of federal standards.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 011

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not have procedures to determine whether expenditures for anabolic steroids are allowable under the Medicaid program.

Resolution: The Department disagrees with this finding. The Department has hard stops and clinical review of all Point of Sale (POS) expenditures for anabolic steroids. Procedures to assure that anabolic steroid expenditures are allowable have been in place and operating effectively since the products came on the market. The Department received the auditors' working papers and examined each claim number or other specific identifier to determine if there was a weakness in the system that needs to be corrected or if a provider needed to be investigated. This process showed no weaknesses in the system; all questioned claims were paid appropriately.

Prior to the audit, the Department implemented its plan for managing the utilization of these medications and assuring that prescriptions written for medications classified as "anabolic steroids" are medically necessary through prior authorization. Procedures to direct all requests for these prescriptions to the Drug Utilization Review Team (DURT) for review and determination are implemented. Standards for required clinical information from the prescriber are in place, as well as criteria for making medical necessity determinations. In 2005, DURT reviewed 171 requests of which 12 (7 percent) were denied for lack of medical necessity.

The Department continues to assess the strength and consistency of its edits and prior authorization program. A review of data obtained from the Department's contracted POS vendor was completed on May 10, 2006, to test the effectiveness of edits and to determine if any of these medications has "slipped" through without prior authorization. Some problems were found on pharmacy claims and changes to procedures were made in June 2006.

The auditor found that payments for anabolic steroids appear to be at inconsistent rates. The Department acknowledges the complexity of drug programs. Product strengths, dosages, package sizes, and units are among the variables that impact reimbursement costs. The Department has closely examined each claim and payment listed as a questionable cost. It was determined that all payments were made correctly.

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Audit Report: 6534 M

Finding Number: 012

Finding: The Department of Social and Health Services is not adequately reviewing pharmaceutical claims to identify patterns of fraud and abuse.

Resolution: On June 5, 2006, the Pharmacy Point of Sale (POS) vendor loaded Drug Enforcement Authority (DEA) numbers from the national DEA database, and the Department has completed a change request to the Medicaid Management Information System (MMIS) that will utilize this data to validate against the full DEA national database at the time claims are processed for payment. This validation will eliminate the need to rely on a manual process for blocking invalid DEA numbers.

New Health Insurance Portability and Accountability Act rules require the use of a National Provider Identifier (NPI) for medical providers starting in May 2007. The Department has expressed to the Centers for Medicaid and Medicare that upon implementation of the ProviderOne system, projected for February 2008, this number will be used to identify prescribing providers in the POS and the DEA number. It will be used solely for validation that a provider is registered to prescribe controlled substances.

The Department is in the process of development and implementation of a new MMIS and Pharmacy POS. The new MMIS/POS, targeted for implementation in July 2007, is designed to support the NPI as described above.

The Department has a rigorous and extensive Drug Use Review Program and is in full compliance with Sec. 456.709. Post payment review of invalid DEA numbers has been added to the regular Department Payment Review Program (PRP) algorithm process. The PRP ran an algorithm that uses the federal DEA database to identify invalid DEA numbers and issued overpayment notices totaling \$769,000 to 219 pharmacies statewide in January 2006. Upon investigation of overpayment notices and responses from pharmacies, it was determined that virtually all invalid DEA numbers are the result of administrative errors. Given this development, the Department will not perform further post payment review on pharmacy claims through June 2006 (when the automatic check was implemented).

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Department of Social and Health Services

Agency: 300

Audit Report: 6534 M

Finding Number: 013

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), is not in compliance with the federal Medicaid requirements for reporting adult victims of residential abuse to the Medicaid Fraud Control Unit.

Resolution: The Department's Division of Alcohol and Substance Abuse (DASA), Mental Health Division (MHD) Headquarters and Eastern and Western State Hospitals now include procedures and policies to report allegations of abuse and neglect to the Medicaid Fraud Control Unit (MFCU) in accordance with federal law. MHD's policy went into effect March 2005, and DASA's policy went into effect June 30, 2005.

The MHD compliance officer currently reviews 100 percent of incident and daily reports submitted to the Division from the hospitals.

The DASA certification supervisor currently reviews 100 percent of incident reports of fraud or abuse. The DASA internal auditor is monitoring and reviewing incident reports on a monthly basis and ensuring the Division is in compliance with all policies related to reporting requirements of Medicaid fraud and abuse of Medicaid patients.

The Department also examined the adequacy of policies and procedures related to follow-up on contacts made to the Department by the MFCU related to potential abuse. This was completed in September 2006. Policies and procedures were found to be adequate.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 014

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not perform adequate reviews of providers of durable medical equipment to ensure the providers exist, are properly licensed and have submitted accurate information.

Resolution: In February 2006, the Department's Provider Enrollment Unit put new policies in place requiring verification of a provider's address using the reverse directory.

The current Medicaid Management Information System (MMIS) only allows a field for one license. Consequently, both business and professional licenses cannot be stored. The new ProviderOne system will allow both.

The current MMIS system is being replaced with the new ProviderOne/MMIS. The Administration is actively participating in design sessions for the new system. This includes requiring the system to identify expired business licenses. Implementation is targeted for June 2007.

Provider Enrollment is reviewing all providers to assure requirements are met. In January 2006, Provider Enrollment sent out the "24 Month" letters asking providers who have not done any business with the Department for 24 months to respond by Feb 15, 2006, if they wanted to remain on the Department's active list. As of Feb 18, 2006, the Department terminated 820 providers.

The Department initiated a policy where the Provider Relations Field Unit and the Office of Payment Review and Audit (OPRA) visit durable medical equipment (DME) providers ("drive-bys") to verify the address of the DME dealers in that area. This is currently being done and logged.

The Division of Fraud and Investigations also verify DME vendors when their investigators are in the field. This information is provided to OPRA, which is responsible for this activity. As of November 17, 2006, two hundred seventy-one reviews have been conducted. There are twelve vendors that remain to be reviewed by OPRA.

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Department of Social and Health Services (DSHS)

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Audit Report: 6534 M

Finding Number: 015

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), has not established sufficient internal controls to prevent Medicaid payments for services provided after a client's death or to prevent payments for services provided to individuals using the Social Security number of a deceased person.

Resolution: On February 4, 2005, the Department completed a review of the automated Social Security Number (SSN) verification at the time of the Automated Client Eligibility System (ACES) entry. As a result, newly established automated verification of SSN for each ACES entry was implemented. The ACES federal interface was modified to use State Data Exchange/Wire Third Party Query for SSN verification on a nightly basis. In addition, the Department has enhanced procedures including modification of the interface with the federal Social Security Administration (SSA) database to update nightly, with income and Medicare eligibility updated daily.

The SSA's State Online Query (SOLO) user interface was modified April 16, 2006, to accommodate users' ability to do multiple SSN validations without exiting the system. The Department will continue to provide instruction and written guidance to staff regarding the manner in which alerts are handled.

The Department has initiated a cross-administration SSN quality improvement workgroup and will continue to focus attention on increasing the accuracy of SSNs in ACES and the Medicaid Management Information System (MMIS).

The Department is not aware of any known computer interface issues that require specific action at this time. The Department continues to assess, prioritize, and resolve interface issues as they are identified.

The Design Phase of the new MMIS is underway and includes a complete assessment of the ACES/MMIS interface. Implementation of the new ProviderOne interface with ACES will be thoroughly tested prior to implementation to assure that data is being transferred accurately. This is targeted for June 2007.

The Department receives quarterly death data from the Department of Health (DOH). The Department is a stakeholder in a DOH initiative that will provide the Department with real-time online access to DOH death data. Although currently being piloted in two counties, statewide implementation is not anticipated for several years. Until then, DOH will remain dependent upon counties for receipt of death data, resulting in a lag in receipt of the information. Due to this lag, the Department will continue its successful post-pay review activities and the identification and recoupment of claims paid for deceased clients.

Status of Audit Resolution

December 2006

The Department's Payment Review Program follows up with quarterly post-payment review activities related to date of death with the identification of any potential provider fraud and appropriate referral to the Medicaid Fraud Control Unit.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 016

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), did not ensure that home health agencies providing services under the Medicaid program complied with federal surety bond requirements.

Resolution: The Department recognizes the concerns of this finding. Because of that, the Department asked for and received a memorandum from the Department's Assistant Attorney General (AAG) regarding the surety bond issue. The final conclusion of the AAG is: "CMS (the Centers for Medicare and Medicaid Services) suspended the surety bond requirement in July 1998 and has not reinstated this requirement; therefore, Home Health Agencies are not required to show compliance with the surety bond requirement at this time."

DSHS Secretary Robin Arnold-Williams asked the federal Department of Health and Human Services (HHS) to resolve the conflicting direction received by the Office of the Inspector General and CMS on this issue and to provide clarification and direction to the state so both the State Auditor's Office and DSHS are clear about federal expectations and requirements. The Department expects to receive an official decision from HHS shortly.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 017

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not have adequate reviews of home health agencies to ensure providers are licensed, Medicare certified and have signed a Core Provider Agreement as required by law.

Resolution: The Department's Provider Enrollment unit updated the provider enrollment manual in July 2005 to reflect all the required documents. The lead worker in Provider Enrollment personally trained each worker in the unit to ensure that new manual requirements are met.

Provider Enrollment started a project in November 2005 to bring all home health providers up to date and obtain all the needed documents. The project was completed in March 2006.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 019

Finding: The Department of Social and Health Services, Aging and Disability Services Administration, does not ensure providers of home health care services are Medicare-certified as required by the Medicaid State Plan.

Resolution: On March 27, 2006, the Department's Aging and Disability Services Administration submitted recommended State Plan amendment language to the Health and Recovery Services Administration to clarify that Medicare certification is not required when home health agencies provide services that do not require licensed registered nurses or licensed professional nurses. The clarified language is as follows:

State plan skilled nursing services, other than Private Duty, require a home health agency to be Medicare-certified. All other, non-skilled services do not require Medicare certification.

The amended language was approved by the Centers for Medicare and Medicaid Services (CMS) on June 30, 2006. It corrects the identified issues related to private duty nursing services provided by home health agencies under the State Plan.

CMS requested that the exemption of Medicare certification for home health agencies that provide personal care services be addressed in the personal care sections of the State Plan. This necessitated an additional amendment request which was submitted to CMS on June 28, 2006. The Department responded to a CMS request for additional information on August 31, 2006. It is anticipated that a decision regarding this amendment will be made in January 2007.

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Audit Report: 6534 M

Finding Number: 020

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), is not complying with federal regulations that require people receiving Medicaid benefits to have valid Social Security numbers.

Resolution: The Department's current Washington Administrative Code and procedures require that each client applying for Medicaid benefits furnish their Social Security Number (SSN). However, the Department cannot delay or deny a client Medicaid benefits pending the issuance or verification of a SSN from the Social Security Administration (SSA). This requirement is in federal rule.

A review of the automated SSN verification at the time of Automated Client Eligibility System (ACES) entry was completed on February 4, 2005. In addition, the Department enhanced procedures including modification of the interface with the federal SSA database to update nightly, with income and Medicare eligibility updated daily.

The SSA's State Online Query (SOLO) user interface was modified on April 16, 2006, to accommodate users' ability to perform multiple SSN validations without exiting the system. The Department continues to provide instruction and written guidance to staff regarding the manner in which "alerts" are handled.

The Department initiated a cross-administration SSN Quality Improvement Workgroup and will continue to focus attention on increasing the accuracy of SSNs in ACES and the Medicaid Management Information System (MMIS).

Beginning May 2006, the Health and Recovery Services Administration runs a monthly report of all clients who received two months of Medicaid benefits without furnishing a SSN. This facilitates follow-up for clients who are approved for Medicaid while pending a SSN or verification of an SSN. Follow-up includes sending letters and other contacts to clients in order to obtain valid SSNs.

Eligibility for the Take Charge Program clients (about 90,000 statewide) is not currently done in ACES but in a web-based program outside of ACES. The Take Charge Program is scheduled to be moved to the ACES mainframe in January 2007.

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Audit Report: 6534 M

Finding Number: 021

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), has not established internal controls sufficient to ensure payment rates to its Healthy Options managed care providers are based on accurate data.

Resolution: Although the Centers for Medicare and Medicaid Services (CMS) has not found fault with the rate setting process, the Department transferred the encounter data (from the Health Insurance Portability and Accountability Act like format) into the state decision support system (a subset of MMIS data warehouse) in August 2006. This change allows more rigorous analysis of encounter data in the rate setting process.

Central Office CMS has not interpreted the Balanced Budget Act rules as saying that states must collect the cost reimbursement information. Region X, Central Office CMS and the Department have all participated in telephone conversations discussing this issue. Currently, the consensus is that it is a non-issue. If the requirements change, this would need to be addressed by the Department.

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Department of Social and Health Services (DSHS)

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Finding Number: 022

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), made supplemental Medicaid payments to public hospital districts totaling \$41,154,000 without a federally approved payment methodology.

Resolution: The Department submitted a State Plan amendment to the Centers for Medicare and Medicaid Services (CMS), the federal Medicaid funding authority, to clarify the methodology for making supplemental payments (known as Proshare) to public hospital districts with nursing home facilities. The amendment was approved October 25, 2006 by CMS.

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Department of Social and Health Services (DSHS)

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Audit Report: 6534 M

Finding Number: 023

Finding: The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not ensure that providers of motorized wheelchairs have the documentation required to substantiate claims for payment.

Resolution: The Washington Administrative Code was updated on November 18, 2005 to require providers to comply with documentation requirements for Medicare and Medicaid.

A draft "Standardized Prescription and Proof of Medical Necessity Form" is going through internal review and is expected to be implemented by providers by December 2006.

The auditor questioned the Department's policy not to require prior authorization of wheelchair purchases for clients who are dually eligible for Medicare and Medicaid. The Department believes that prior authorizations for dual eligible clients would be an unnecessary burden on the Department, providers and clients. This requirement would not be cost effective given that medical necessity requirements fall to Medicare and the state relies on Medicare for this purpose. Medicare has improved its own guidelines including a prior authorization process which appears to be quite stringent.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 024

Finding: The Department of Social and Health Services, Office of Financial Recovery and Health and Recovery Services Administration (formerly Medical Assistance Administration), does not have adequate internal controls to ensure that final settlement amounts are refunded to the federal government and in a timely manner.

Resolution: In October 2006, the Department's Division of Audit and Information Services (DAIS) finalized new policies and procedures that direct proper reporting of provider overpayments identified during audits conducted by the Office of Payment Review and Audit (OPRA). These policies prescribe guidance for determining the date of discovery for hospital and medical audits.

The Office of Financial Recovery (OFR) also established policy and procedures to ensure the Department refunds the federal share of overpayments within 60 days of the date of discovery (per DAIS policy) rather than within 60 days of being established as a receivable within the Collections and Accounts Receivable System.

OFR and OPRA staffs meet monthly to monitor the overpayment process for all overpayments submitted by OPRA to OFR. This process must operate smoothly if the federal recovery process is to be accurate.

OFR and the Office of Accounting Services reviewed the specific accounts audited to determine how much federal portion has been refunded. All outstanding federal portions were refunded by June 30, 2006.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 025

Finding: The Department of Social and Health Services' Office of Accounting Services does not have adequate internal controls to ensure the federal portion of uncashed and cancelled warrants is refunded at the appropriate rate to the federal Medicaid Program.

Resolution: The Department's Office of Accounting Services (OAS) implemented a process that ensures the correct federal/state allocation for Medicaid warrants is utilized, thus ensuring the warrant is cancelled at the correct federal percentage. The implementation of the process occurred in February 2006.

The Financial Services Administration evaluated the effort required to review the 640 warrants with incorrect federal participation rates. These warrants were identified by the auditor as resulting in overpayments to the federal government in the amount of \$7,568.53. The Department determined that it is not cost effective for staff to review, identify and adjust these 640 items in order to claim the \$7,568.53 in federal overpayments. Therefore, no additional work will be performed to claim the funds from Centers for Medicare and Medicaid Services.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 026

Finding: The Department of Social and Health Services' Office of Accounting Services does not have sufficient controls to ensure that the federal portion of uncashed warrants is refunded to the Medicaid Program in a timely manner.

Resolution: As of April 2005, the Department's Office of Accounting Services (OAS) has appropriate staff to address the warrant cancellation and refunding function and has cross-trained a sufficient number of individuals to ensure adequate coverage for processing the Statute of Limitation (SOL) warrants.

The refunding process has been corrected. It was current for the last three quarters of federal Fiscal Year 2005 and remains current to date.

OAS has increased management oversight and, since April 2005, has ensured staff is processing the transactions in a timely and accurate manner. OAS will continue to develop effective monitoring procedures to identify and ensure SOL warrants are properly addressed so that refunds to federal programs will occur in a timely manner.

The SOL warrants in question have been processed and the resultant Medicaid funds have been refunded to the federal government. This correction occurred on the Medicaid claims (CMS-64) for the quarters ending December 31, 2004 and March 31, 2005.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 027

Finding: The Department of Social and Health Services, Aging and Disability Services Administration and Health and Recovery Services Administration (formerly Medical Assistance Administration), has not set up an effective system to ensure Medicaid payments are not being made to nursing homes that are not in compliance with federally mandated health and safety standards.

Resolution: The Department has re-contacted the Centers for Medicare and Medicaid Services (CMS) regarding access to their Adaptive Spatial Peer-to-Peer Network (ASPEN) for view only security to be able to access information, a follow-up of the Department's November 2005 request. CMS has provided additional names for contact but does not feel that access to this system is beneficial to the Department. CMS agrees with Claims Processing that in Fiscal Year 2005 things improved significantly and that the majority of the time the Department receives appropriate notices in a timely manner. The Department has also eliminated confusion related to notices where action was taken prematurely (due to lack of understanding what the notices meant), which has helped with the overall improvement.

The Department does not have the authority to control the accuracy or timeliness of letters sent by the federal government. The Department will continue to work with the regional CMS office to ensure that business processes are seamless and accurate information is shared in a timely manner.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6534 M

Finding Number: 028

Finding: The Department of Social and Health Services paid providers with Medicaid funds through the Social Services Payment System for services to clients using Social Security numbers belonging to deceased persons.

Resolution: The auditor recommended that the Department require staff to verify accuracy of Social Security Numbers (SSN) for all clients. Washington Administrative Code (WAC) 388-476-0005 defines the Department's current SSN requirements for medical eligibility and can be found in the Department's A-Z Manual. Section 3 states "Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration (SSA). However, a person who does not comply with these requirements is not eligible for assistance." If a current and valid SSN is not available, the Department is responsible to assist a client in making an application for an SSN.

Verification procedures are described under the section titled "Clarifying Information." SSNs are automatically verified through a cross match with the SSA Numident file once the data is entered into the Automated Client Eligibility System (ACES). SSN discrepancies in Numident generate "alerts" to the workers, as do discrepancies in State Data Exchange (SDX) or Beneficiary Data Exchange (BENDEX).

In many cases, the SSN is correct in ACES but may be incorrect in the Social Services Payment System (SSPS). This may be because the claim number was used in SSPS, or it may be due to data entry errors. When the Home and Community Services Quality Assurance Unit reviews client files to confirm financial eligibility, they check to see that the SSN recorded in SSPS is the same as the SSN recorded in ACES. They report discrepancies, using ACES as the correct record of the SSN.

The limitations with SSPS will be corrected in the new ProviderOne system when all payments made in SSPS will become part of the new Medicaid Management Information System (MMIS). This is scheduled to occur in 2008 or later. At that time, all medical and social services payments will be made from the same system and will use the same ACES SSN verification processes described above.

On April 5, 2006, the Department issued a Management Bulletin (MB) reminding staff of the importance of using the client's correct SSN from ACES with instructions on how to obtain the ACES SSN. When the new MMIS (ProviderOne) is implemented, using an incorrect SSN in ProviderOne will cause payments to suspend.

The auditor also recommended that the Department ensure staff understand state law regarding identify theft. Revised Code of Washington (RCW) 9.35.020 defines first-degree identity theft as the use of false identification to obtain anything of value. Staff

Status of Audit Resolution

December 2006

members were informed of this RCW via MB in 2005, and the MB previously referenced reiterated the provisions of this state law.

Finally, the auditor recommended that instances of apparent identity theft be referred to the appropriate authorities. The Department's Payment Review Program reruns algorithms quarterly and findings are referred to the Office of Financial Recovery or the Medicaid Fraud Control Unit for recovery. No instances of identity theft were found as a result of the Fiscal Year 2005 audit.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6539

Finding Number: 001

Finding: The Department of Social and Health Services does not have adequate internal controls over the processing of expenditures through the Agency Financial Reporting System.

Resolution: The Department's Accounting Policy Management Board (APMB) developed and adopted Policy 20.01 – the Agency Financial Reporting System (AFRS) Input Security Options. The policy became effective February 1, 2006. In addition, the AFRS/DRS security request form and instructions were updated to correspond with the policy.

APMB Policy 20.01 allows Department offices to select from two options that must be implemented to ensure there are adequate controls in place regarding AFRS Security. Option 1 requires a separation of input and release capability. Option 2 allows that a single individual may input and release, but an independent individual receives and reviews all warrants and turnaround documents. A Listserv message was sent out on January 30, 2006 notifying Department fiscal staff of the new policy, the need to adopt one of the two options and that AFRS security needed to be updated for all users.

In addition, the use of V0D1 (payments to vendors that do not require tax information to be obtained) is monitored closely. On a quarterly basis, the Office of Accounting Services (OAS) sends out a V0D1 report that lists all V0D1 payments made that quarter to each fiscal program manager for review. The program is responsible to ensure the payments are accurate and only for prescribed V0D1 purposes. Additional analysis with the Office of Financial Management is necessary to determine if AFRS can limit V0D1 users and create exception reports. This initial analysis work is scheduled to begin in June 2007.

The Financial Services Administration/Information Technology Office (FSA/ITO) consulted with the Information Systems Services Division (ISSD) to better coordinate and streamline the process of notifications on requests for security access, changes and deletions. Currently FSA/ITO coordinates the AFRS access while the ISSD coordinates the mainframe (RACF) access. AFRS access cannot be used without mainframe (RACF) access. FSA/ITO has obtained an electronic file of all AFRS user IDs as well as all mainframe (RACF) user IDs and matched the two files for comparison and research. These files were also matched against current employees in an effort to identify and resolve discrepancies. This process is performed semiannually in April and October and ensures access between the two systems is consistent. By June 2006, all AFRS users were required to submit a new AFRS Security form. If a new form was not submitted, access to AFRS was terminated. This update required supervisors and managers to ensure the level of access was appropriate for the duties and batch types.

State of Washington

Status of Audit Resolution

December 2006

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6539

Finding Number: 002

Finding: The Department of Social and Health Services, Division of Child Care and Early Learning, does not have adequate internal controls over support for payments to child care providers.

Resolution: The Department's Division of Child Care and Early Learning (DCCEL) was merged into a new agency, the Department of Early Learning (DEL), effective July 1, 2006.

Prior to the transfer to DEL, DCCEL coordinated with the Quality Assurance Office in the Division of Management Resources and Services to conduct an audit of family child care homes by June 30, 2006. The audit included a review of provider attendance records.

DEL mailed the non-mandatory attendance keeping form to all licensed child care providers in August 2006. A cover memo reminded providers that they may use this form or a form of their own design as long as it contains the required elements. DEL is currently reviewing the option of requiring providers to use a specific attendance form.

DEL reviewed the detailed case review information from the auditors and completed the following by August 31, 2006:

- Ensured visits were documented correctly.
- Followed-up with an onsite visit when necessary.
- Followed-up as needed to resolve issues.
- Documented outcomes in the case records.

DEL is pursuing the development of a new technology system which would automatically track attendance at each child care facility and interface with the payment system for billing purposes. This is expected to greatly decrease errors in attendance-keeping and payment for child care services. DEL is updating the feasibility study for the new system and has requested funding for this project. The funding request has been incorporated in the Governor's 2007-2009 budget proposal.

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State of Washington

Status of Audit Resolution

December 2006

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6539

Finding Number: 003

Finding: The Department of Social and Health Services, Division of Child Care and Early Learning and Children's Administration, did not perform adequate background checks.

Resolution: The Department does not concur with this finding. The Department trains licensors in all aspects of conducting and monitoring background checks and cites providers and applicants when they are out of compliance. Agency regulatory actions include civil penalties, license suspension and license revocation.

The Department reviewed the auditor's files for accuracy. When deficiencies were identified, providers were contacted and trained on Washington Administrative Code requirements for background checks.

The Department conducts approximately 35,000 background checks for childcare and about 16,500 for foster care. Requiring licensors to perform a visual confirmation of the person and photo identification is not possible for such a large number of background checks. Currently the Department's licensors visually confirm the identification of all licensees and require the providers visually confirm the identity of all of their employees.

There is no requirement that the Department document Washington state residency, and there is no uniform widely accepted documentation for proving residency. Photo identification and residency documents can also be falsified.

State law RCW 74.15.030(2) (b) only requires that nationwide fingerprint-based background checks be performed on persons who have not lived in the state for the prior three years or cannot verify their residency. Performing checks on a broader population would require a statutory change because the Federal Bureau of Investigations (FBI) will not accept fingerprint checks unless there is clear and specific state authority to perform them. Current Washington statute does not provide the clear and specific authority that the FBI requires.

The Department understands that there are two legislators who are strongly considering introducing legislation during the 2007 legislative session to expand the Department of Early Learning's authority to do these checks. Additionally, the Joint Legislative Task Force on Background Checks intends to review the legislative, fiscal, stakeholder and information technology infrastructure changes needed to implement such fingerprint checks as a priority agenda item in 2007.

The most recent data available (March 6, 2006 Government Management Accountability and Performance presentation) shows the Department's Children's Administration is at 99 percent timeliness for monitor visits. The Department has a goal of 95 percent or greater, and has met that goal in each month since October 2005.

Status of Audit Resolution

December 2006

The Department's Division of Child Care and Early Learning was merged into a new agency, the Department of Early Learning (DEL), effective July 1, 2006. DEL continues to meet the goal and the monitoring visits are used to help ensure required background checks are completed.

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Audit Report: 6539

Finding Number: 004

Finding: The Department of Social and Health Services, Economic Services Administration, reimbursed contractors for services that were not adequately supported.

Resolution: The Department's Basic Food Education and Outreach Program requires contractors to input the date Basic Food Education and Outreach was delivered into the online reporting system. Payments to contractors are only made for client intake and application assistance contacts and assistance that include the date of service or contact. The Basic Food Education and Outreach contracts were amended to add this requirement in May 2006.

Contractors are required to maintain backup documentation of client intake and application assistance contacts and group presentations that contain at a minimum:

- Client name
- Date of birth
- Signature
- Phone number or contact information
- Date of service

For all application and intake contacts, prior to authorizing payment, the Department:

- Compares invoiced billing information to information in the online reporting system. No payment is made for duplicate contacts and the contractor is informed in writing.
- Pulls a monthly random sample (100 intake clients and 25 application assistance clients) and makes contact by phone to verify services were provided prior to payment.
- Authorizes payment only for sampled claims when delivery of services is verified. If unable to verify services, the Department asks the contractor to provide documentation/verification, within 30 days, that services were indeed provided.
- Requires contractors to develop a corrective action plan if contact discrepancies exceed 5% of verified contacts for any given billing period.

The Department also conducts the following monitoring practices, after payment has been authorized, to verify services were received as described in the monitoring plan:

- Desk review of monthly billings, compare billings against the online reporting system.
- Desk review of quarterly billings, a randomly selected 5% sample.
- On-site monitoring visits, confirming client information is stored securely.

Status of Audit Resolution

December 2006

As of March 2006, the Department only pays for Basic Food Education and Outreach services on a reimbursement basis for services made available to potential food stamp recipients. Invoices are checked for duplicate names within the entire list of contractors and subcontractors to verify a contact is not seen by different contractors or subcontractors within the same month of service. No payment is made for duplicate contacts by the same contractor or subcontractor.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6539

Finding Number: 005

Finding: The Department of Social and Health Services made unallowable duplicate payments through the Social Services Payment System.

Resolution: The Department continues to work closely with the Payment Review Program to run algorithms to detect duplicate payments. The costs determined by the auditors to be duplicate payments for Aging and Disability Services Administration (ADSA) (\$76,455) represent approximately .008 percent of the \$933,899,668 in Social Services Payment System (SSPS) payments made by ADSA in Fiscal Year 2005. Most of the payments initially identified as potential duplicate payments in the auditor's testing were found to be valid and justified. The Department didn't find it cost effective to make programming changes to SSPS that would prevent this small amount of duplicate payments from being made. It is anticipated that edits in the new ProviderOne system will help prevent duplicate payments in the future.

In subsequent review, only one of the five clients identified for duplicate payments in the Children's Administration was actually a duplicate payment. An overpayment for this exception was established in October 2004.

The ADSA established overpayments on the eight duplicate payments identified in the audit process in October 2005.

Once overpayments are established, they are sent to the Office of Financial Recovery for collection. If fraud is not involved, funds are returned to the appropriate funding source within 60 days. All nine overpayments have been recovered and returned.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6539

Finding Number: 006

Finding: The Department of Social and Health Services does not ensure that all recovered overpayments are credited to the appropriate funding source.

Resolution: The Department's Financial Services Administration developed a new Social Services Payment System (SSPS) account code history table that cross matches SSPS program codes (service, source, reason) to Agency Financial Reporting System account codes for the period of time in which they were used for warrant processing. This new process modified the Client Receivable System accounting module to distribute payment recoveries according to the distribution of the SSPS program code lines ensuring overpayments are credited to the appropriate funding sources.

These changes were implemented on October 1, 2005.

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Audit Report: 6539

Finding Number: 007

Finding: The Department of Social and Health Services does not have adequate internal controls over the Social Service Payment System.

Resolution: Of the issues itemized in the finding, most have been resolved, primarily by the replacement of the system front-end program with WebConnect Plus. Resolution is noted for issues identified by the auditor as follows:

- UNISYS was not capable of generating a list of operator identification and the associated user names. WebConnect now has a database that can generate a list of operator identifications and the associated user names and exact locations.
- The Department used "generic" (shared) operator IDs and passwords to facilitate inquiry. These generic IDs have been eliminated. In order to do inquiry, users must use unique identifications and have a specific password. All access is recorded.
- Four individuals had more than one operator ID. With WebConnect Plus security, each user has only one set of security access data and the additional operator IDs were totally eliminated.
- The Department did not require the use of hardened passwords. All access to the Social Service Payment System (SSPS) and Fortress now require the use of a hardened password.
- The Department did not use a lock-out mechanism to deter access. As of April 2006, the system has a lock-out mechanism in place that conforms to the Department of Information Services' standard of allowing no more than five attempts.
- UNISYS does not allow for the tracking of transactions within the system. The new front end WebConnect rewrite, rolled out in April 2006, allows for the tracking of transactions within the system and stores data for each transaction that is linked to the user profile.
- There was no read-only access to the Worker-ID screen. This function was added with the implementation of WebConnect Plus and has security-limited access.

Other issues were mitigated as much as possible given the age and functioning limitations of the system and operations requirements. These include the following:

- SSPS expenditures were not reconciled to the state's Agency Financial Reporting System (AFRS). Payments are now reconciled daily to AFRS. A Sequel database has been created which stores transactions that were completed outside the system for errors, adjustments, and returned payments. This information is compiled for processing with internal system information. The database allows the Office of Accounting Services (OAS) to reconcile the expenditures to AFRS monthly.
- There were inadequate controls to limit users establishing providers and ten operators had provider file input and authorization rights. The Department has reduced the 32 individuals that had access to provider file input to 12 and those who

had both input and authorization access to seven. These individuals work in high level positions in OAS or SSPS headquarters and require access to these program areas to complete integral functions on the SSPS. As a compensating control, WebConnect Plus records a string of data relating directly to the user profile on the individual's system account when any change is made in the provider file. A monthly report that shows all activity by these individuals is reviewed by an SSPS employee separate from these work functions.

- The software that controls the system and changes did not have adequate controls and did not maintain an adequate record of changes. Specifically, the auditors found that personnel could re-point Executive Control Language (ECL). While the SSPS Unit continues to make a concerted effort to locate appropriate software, no software for the UNYSIS mainframe is currently available to resolve the defined issues. As of July 2006, SSPS has used Visual Studio and Source Safe to record changes to the system and who is responsible for enacting these changes. As compensating controls for the ECL re-pointing issue, the Department has required approval from the Information Systems Services Division to use ECL, a paper trail with checks and balances, and a review of a monthly report tracking activity. Within the software limitations the risk has been limited as much as feasible until software becomes available.
- Payments could be made to providers designated as closed, deceased or restricted. Blocking payments to restricted providers (status codes 1, 2, and 4) would remove the ability to pay for services due providers or their estates. The Department uses the following as compensating controls:
 - Several of the divisional front-end systems to SSPS block field staff from opening or extending authorizations that attempt to pay providers that have a 1, 2 or 4 status code in the SSPS provider file.
 - Within WebConnect, a pop-up warning has been added in the authorization screen for providers that are status 1, 2 or 4 to prevent inappropriate new authorizations to these providers.
 - SSPS sends each office the Change of Service Authorization Error Report to alert them to the use of these providers.
 - A monthly report that lists all providers in status 1, 2 or 4, who have had services authorized, is monitored for problem areas.
 - Most status 4 coded files do not contain addresses, thereby ensuring SSPS is contacted for approval before any payment would be made.
- The System used screens not appropriate to meet Health Insurance Portability and Accountability Act (HIPAA) requirements. SSPS is able to accept and make electronic payments for HIPAA purposes. A new Medicaid Management Information System is in the implementation phase and will provide full HIPAA compliance in 2008.

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Audit Report: 6539

Finding Number: 008

Finding: The Department of Social and Health Services, Economic Services Administration, should improve compliance with eligibility requirements for the Temporary Assistance for Needy Families Program.

Resolution: The Department compared Social Security Numbers (SSN) provided by applicants to those contained in records maintained by other state or federal agencies for the 68 adult cases and the 34 child cases noted by the auditor in the finding. When the cases were sent to the field for review and completion, the Department found:

- 38 cases were closed.
- 12 cases were worked and require no further action.
- 52 cases were referred to the Community Service Offices for review and correction. All corrections were made by March 31, 2006.

The Automated Client Eligibility System upgrade to the State Online Query (SOLQ) system was implemented on April 16, 2006. The upgrade helps ensure correct SSNs. Notification was sent to field staff on SOLQ changes. The Department continues to verify SSNs by following state regulations.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6539

Finding Number: 009

Finding: The Department of Social and Health Services, Division of Developmental Disabilities, should establish adequate internal controls to ensure that vehicles used to transport clients of supported living services are properly insured.

Resolution: Washington Administrative Code (WAC) 388-101-2300 was amended in March 2006 to define "properly insured" to mean the vehicle must be insured to meet minimum personal vehicle insurance requirements per state law.

As of April 2006, all service provider contracts were amended to require providers to verify that privately-owned vehicles used to transport clients are insured to meet minimum personal vehicle insurance requirements per state law. Contracts also require service providers to verify the presence of a valid driver's license for all staff and volunteers who transport clients.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6539

Finding Number: 010

Finding: The Department of Social and Health Services, Economic Services Administration, does not adequately monitor other state agencies to which it provides funds from the federal Temporary Assistance to Needy Families Program.

Resolution: The Department partially concurs with the finding. The initial monitoring plan contained weaknesses that have been corrected and the following action steps have been taken:

The Department amended the Employment Security Department (ESD) contract with language that clearly specifies quarterly reporting of:

- Client names served by the partner agency.
- The size of the monitoring sample and the percentage of the sample that will require eligibility and service verification.
- Billing methodology.
- Verification that the methodology is being applied correctly.

The Department monitored a random selection of clients for eligibility and continues this practice quarterly. In addition, the Department has become involved in ESD's internal monitoring process by partnering with ESD staff on site visits to ensure that eligibility, services and billing methodology are being accurately and consistently applied. This was implemented in June 2006.

The Department amended the contracts with the Department of Community, Trade and Economic Development and the State Board for Community and Technical Colleges (SBCTC) to include language that clearly specifies quarterly reporting of:

- Client names served by the partner agency.
- The size of the monitoring sample and the percentage of the sample that requires eligibility and cost verification.

The Department also monitored a random selection of clients from these organizations for eligibility and continues this practice quarterly.

The Department's Division of Employment and Assistance Programs (DEAP) requested and received verification from SBCTC of the screening process used to identify low income students that are eligible for Temporary Assistance to Needy Families Program (TANF) funded services. Three colleges are selected for random sampling on a quarterly basis. DEAP requires SBCTC to provide further eligibility and billing verification for 5% of the students selected in the random sample. The Department conducted the first round of visits to Clark College, Renton Technical College and Spokane Valley Community College. These steps were completed May 14, 2006. DEAP continues to conduct monitoring visits to randomly selected colleges in conjunction with SBCTC. DEAP continues to ensure that the method used by the colleges to screen low income non-TANF recipients is accurate for TANF-funded services.

Status of Audit Resolution

December 2006

Beginning in April 2006, DEAP required that SBCTC provide a count of the numbers of students being served at every billing. The students were also separated between the number of TANF recipients and low income recipients eligible for the TANF-funded employment and training program.

DEAP also required the SBCTC to provide eligibility verification with billing information for 5% of the random sample of students each quarter beginning in April 2006. The amount billed from the 5% sample plus that of the remainder of the students should equal the total amount of the quarterly invoice.

The Department disagreed with the auditor on the questioned \$7,516,082 cost. DEAP requested and received verification from the SBCTC on randomly selected colleges that provided proof of income and eligibility for the low income recipients eligible for the TANF-funded employment and training program in question. All clients meet the definition of low income and are eligible to be served by the colleges. Therefore, the SBCTC is entitled to bill and receive payment for services rendered under the TANF contract.

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Agency: 300

Audit Report: 6539

Finding Number: 011

Finding: The Department of Social and Health Services, Economic Services Administration, did not comply with state and federal regulations requiring a monthly inventory of electronic benefit transfer cards used by the Food Stamp Program.

Resolution: The Department's Economic Services Administration implemented the following changes by April 1, 2006:

- The reconciliation and reporting process was detailed in a letter from the Community Service Division director and sent to all regional administrators and the Community Service Offices (CSO).
- All CSOs are required to send an electronic benefit transfer card inventory reconciliation report each month to their region office. Region office staffs are required to send a monthly report to Headquarters reporting all offices in the region have reconciled.
- Headquarters monitors and follows up on any region not reporting as required.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6539

Finding Number: 012

Finding: The Department of Social and Health Services, Division of Disability Determination Services, received reimbursement for unallowable costs for the Social Security Disability Insurance Program.

Resolution: The auditor found that the memorandum of understanding (MOU) between the Washington State Patrol (WSP) and Division of Disability Determination Services (DDDS) did not include a provision for indirect costs and did not require backup documentation prior to payment. The MOU between WSP, DDDS and Social Security Administration (SSA) was valid until September 2006. The subsequent MOU was revised in October 2006 to reflect allowable indirect costs that WSP can charge to SSA.

The Division's administrative Fiscal Unit reviewed all WSP billings since inception of the program and determined that all costs were allowable (with the exception of indirect costs). However, the Division now requires WSP to send payroll backup documentation that matches their billings so that there is no confusion on what is being billed in the future.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6539

Finding Number: 013

Finding: The Department of Social and Health Services, Division of Disability Determination Services, reported incorrect expenditures for the Social Security Disability Insurance Program on several reports, including the Schedule of Expenditures of Federal Awards.

Resolution: The Department's Division of Disability Determination Services had a temporary breakdown of internal controls when two of four of the administrative accounting staff were out on maternity leave. Since then, the Division has reviewed internal controls to ensure that this type of error will not occur in the future.

The Division reports disbursements from the state accounting system and reports obligations from an in-house legacy system. The Division is highly motivated to ensure that the amounts from both systems agree to the official report to the federal grantor.

The Division implemented a reconciliation method and other procedures to ensure that the disbursement amounts reported on the official report to the federal grantor agree to the state accounting system. This reconciliation was completed by June 30, 2006 and included reconciliation during the time period of the audit.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6539

Finding Number: 014

Finding: The Department of Social and Health Services, Health and Recovery Services Administration, claimed costs for unallowable activities under the State Children's Health Insurance Program.

Resolution: The Department's Health and Recovery Services Administration has policies and procedures in place to identify allowable costs for transfer from Medicaid to the State Children's Health Program (SCHIP). The current process involves a quarterly matching of Department of Health (DOH) live births to claims data for the period of one day prior to birth and back 270 days. From this data, inpatient hospital claims for labor & delivery, abortion and sterilization are excluded.

Additionally, the Administration has been advised by the Centers for Medicare and Medicaid Services (CMS), in an email from Elizabeth Trias dated December 12, 2005, that they "allow costs for such services as dental, vision care and physical therapy since Washington covers all services for women under the SCHIP unborn as they do under the pregnant women's program."

The Administration received guidance from CMS on the allowability of costs, as noted above. As a result, the use of SCHIP funds for these costs is based on CMS guidance and is allowable.

The Administration obtained additional detail information of the questioned costs of \$1,573,409. Review of this information indicates that the questioned costs are allowed since the expenditures are for services that CMS allowed in their audit of the SCHIP program.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6539

Finding Number: 015

Finding: The Department of Social and Health Services, Mental Health Division, is not complying with subrecipient monitoring requirements for the Community Mental Health Services Block Grant.

Resolution: The Department's Mental Health Division (MHD) completed its review of open issues identified through its various monitoring activities in July 2006 and ensured that corrective action plans were implemented for each subrecipient receiving block grant funds. In October 2006, the Division revised contract requirements to ensure that reimbursement methods in each contract are in compliance with federal requirements and that appropriate supporting documentation is required before payments are made.

MHD modified current contract language in October 2006 with non-tribal subrecipients requiring contractors to formally report to the MHD who they subcontract with and for what amounts. Additionally, the MHD requires, through contract language, that the contractor and their non-tribal subrecipients submit copies of any federal audits (other than those done by the State Auditor's Office (SAO)) to the MHD within 30 days of the completed audit report.

MHD explored its legal authority to require Tribes to submit audit reports pursuant to their block grant contracts. It was found that these reports can be obtained from a central online repository. If the Division requires an audit report, it can be obtained from this repository.

Federal audits submitted to MHD were reviewed for corrective action issues related to community mental health block grant funds, and MHD provided follow-up as needed to verify action steps have been implemented. This was completed in October 2006. Staff are permanently assigned to monitor block grant funds, including corrective action plans.

MHD developed internal policies for addressing timely corrective action items related to non-SAO conducted federal audits in October 2006.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6539

Finding Number: 016

Finding: The Department of Social and Health Services, Mental Health Division, did not comply with state laws or the Department's policies and procedures for recovering a Community Mental Health Services Block Grant overpayment reported in the previous audit.

Resolution: Based on the state Assistant Attorney General's opinion, the Department's Mental Health Division (MHD) referred the case to the Office of Financial Recovery for collection.

MHD developed and/or modified policies and procedures to define and prevent advance payments. MHD also coordinated with Office of Financial Recovery to develop necessary policies and procedures to identify and resolve questionable bills from, or payments to, contractors. The new procedures were communicated to financial staff. These steps were completed by May 31, 2006.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 6539

Finding Number: 017

Finding: The Department of Social and Health Services, Mental Health Division, did not comply with state and federal regulations when contracting for services paid with federal Community Mental Health Services Block Grant funds.

Resolution: In October 2006, the Department's Mental Health Division (MHD) completed staffing a Contracts Unit that had been lacking for more than a year. The Contracts Unit is responsible for ensuring that there is proper tracking of start dates for Mental Health Block Grant funds in the future. Since February 2006, no federal block grant contracts or amendments have been executed with start dates prior to the signing date.

Training was provided to all program managers on contract management in October 2006 and after-the-fact signing was addressed.

MHD ensures it is following its own Policy 6.03 that requires that block grant contracts not be approved after work has started. Reviews of federal block grant contracts are completed each year to monitor this requirement.

In addition, MHD follows the new draft Administrative Policy 13.10 which directly addresses after-the-fact contracts for the Department.

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Audit Report: 6539

Finding Number: 018

Finding: The Department of Social and Health Services, Mental Health Division, did not comply with federal requirements for independent peer reviews of the Community Mental Health Services Block Grant.

Resolution: As of September 2006, the Department's Mental Health Division (MHD) revised the Mental Health Block Grant (MHBG) Policy (6.03) to include the requirement and execution of peer reviews related to Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.] section 1943. Policy 6.03 now clearly defines and addresses each of the following:

1. For the fiscal year for which the grant involved is provided, the State:
 - Provides for independent peer review to assess the quality, appropriateness and efficacy of treatment services provided in the state to individuals under the program involved.
 - Ensures that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the state and the populations served by these entities are representative of the total population covered.
2. The State permits and cooperates with federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements].
3. The State provides to the Secretary of DSHS any data required pursuant to Section 505 and cooperates with others in the Department to develop uniform criteria for the collection of data pursuant to such section.

The MHBG state planner coordinated with federal and other state planners to implement the policy and completed the independent peer review as of October 15, 2006.

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Agency: 300

Audit Report: 6539

Finding Number: 019

Finding: The Department of Social and Health Services, Juvenile Rehabilitation Administration, is not complying with federal requirements for time and effort reporting for the Juvenile Accountability Incentive Block Grant Program.

Resolution: The Department's Juvenile Rehabilitation Administration (JRA) implemented the Federal Compliance with Time Allocation/Certification requirement of the Department's Fiscal Policy 50.01 in February 2005. Semiannual certifications were completed for salaried and part-time employees for both the current period and the audit review period.

JRA employees who work on multiple activities keep daily timesheets on their activities. JRA staff who work on single activities with multiple funding sources complete the semiannual certifications.

Due to the lidded federal funds available, JRA believes that staff working on single federal grant activity 100 percent of the time, such as those meeting the purpose areas of the federal Juvenile Accountability Block Grant, should only need to complete the semiannual certifications even though there may be multiple funding sources. Accordingly, beginning in Fiscal Year 2006, JRA began charging such staff fully to the Juvenile Accountability Block grant and these staff complete the semiannual certifications.

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Audit Report: 6539

Finding Number: 020

Finding: The Department of Social and Health Services, Division of Vocational Rehabilitation, is not complying with federal requirements for time and effort reporting for the Rehabilitation Services Vocational Rehabilitation Grants to States.

Resolution: The auditor identified a number of positions charged to the Department's Division of Vocational Rehabilitation (DVR) during Fiscal Year 2005. These positions belonged to other divisions of the agency. By 2006, three of the individuals had left the agency, one was no longer charged to DVR, and the Office of Accounting Services (OAS) received the required semiannual certifications for the five remaining staff for the period October 1 through March 31, 2006. The Department continues to require semiannual certification.

The Department has implemented a policy that addresses multi-coded positions. The policy establishes responsibility and requirements for verifying the allocation of funds to these positions. DVR has established additional steps to monitor positions partially coded to their program. In addition, OAS continually works with the Department's administrations to raise awareness of the policy requirements for split-coded positions. Additional training on this policy will continue to be provided in Fiscal Year 2007.

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Audit Report: 6539

Finding Number: 021

Finding: The Department of Social and Health Services, Division of Disability Determination Services, did not comply with state and federal regulations when contracting for services paid with Social Security Disability Insurance Program funds.

Resolution: The Department's Division of Disability Determination Services consulted with the Office of Financial Management (OFM) regarding the proper classification for consultative evaluation services. OFM determined that services provided to the Division's claimants by physicians, psychologists and psychiatrists are, in fact, personal services.

The Division will develop a plan, to be phased in by October 2007, that will provide for the issuance of a personal service contract to any medical provider who agrees to see claimants at the Department's fee schedule. The Division will utilize the competitive procurement process when additional providers are needed to perform evaluations. Until that time, contracts remain in place as client services contracts.

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