
Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 1001539

Finding Number: 001

Finding: The Department of Social and Health Services, Children's Administration and Economic Services Administration paid an adoptive parent, foster care providers and childcare providers who had not cleared background checks.

Resolution: The Department is addressing this finding as follows:

During May 2009, Working Connections Child Care (WCCC) coordinators reinforced current policy with staff and reminded them to ensure background checks are completed on every provider prior to authorizing payment until the automated process is in place.

During June 2009, Children's Administration (CA) issued a management directive to staff responsible for reviewing background check results. The directive explained the new procedure on how to deal with rejected background check forms. CA worked with the Background Check Central Unit when preparing the directive.

By February 2010, CA will implement the second release of its FamLink system which will prevent payments to providers that do not have proper documentation of a completed background check. This is in addition to the edits FamLink currently has in place that prevent payments to providers who are not properly licensed.

By December 2009, Economic Services Administration is anticipating the implementation of an automated feature to its Barcode system that will prevent workers from finalizing an authorization for childcare until verifying a current background check is on file for the provider. The anticipated Barcode feature will also assist staff in ensuring background checks include all required data elements before they are processed.

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Status of Audit Resolution

December 2009

Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 1001539

Finding Number: 002

Finding: The Department of Social and Health Services did not have controls in place to prevent misappropriation and ensure payroll accuracy.

Resolution: In March 2009, the Department reviewed all Human Resource Management System (HRMS) users and removed conflicting roles where possible. These changes will help to ensure that individuals responsible for processing payroll do not have the ability to add or delete individuals from the personnel system. Where conflicting roles could not be eliminated, the Department established compensating controls.

In June 2009, written communication was sent to all the Department's HRMS users identifying the necessary compensating controls. Also, procedures were developed and published to provide applicable staff with information on how to run necessary reports and expectations for their use. These corrective actions will help the Department ensure payroll accuracy and prevent misappropriation through HRMS.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 1001539

Finding Number: 003

Finding: The Department of Social and Health Services internal controls over provider payments are not adequate, resulting in misappropriations totaling approximately \$230,000.

Resolution: In response to the issue of inadequate internal controls noted in this finding, Department administrations took the following actions:

Economic Services Administration:

- Developed and completed training for supervisors on the proper use of reports that stresses payment accuracy.
- Implemented a preauthorization process that includes systems controls that prevent staff from submitting authorizations for payments that are over the standard amount and do not have appropriate supervisory approval.
- Began requiring a no authorizing supervisor to review and approve childcare authorizations made by childcare supervisors.

Aging and Disability Services Administration:

- The Developmental Disabilities Division (DDD) program manager for the Social Service Payment System (SSPS) began reviewing Client Authorization Services Input System (CASIS) output reports on a quarterly basis to provide additional monitoring of all authorizations including those made by supervisors.
- Began requiring staff who authorize payments to verify that the provider has a current contract for the service being authorized. This was accomplished in accordance with DDD's internal policy. Supervisors are also required to verify this work during case file reviews.
- Increased percentage of required supervisory review of client case files and CASIS output reports from 41% to 50%. ADSA is working toward 100% compliance by clarifying policy expectations; providing additional training and Quality Control and Compliance support to accomplish file reviews; streamlining the file review and reporting process; and monitoring compliance more closely.

Note: This finding addresses the inadequate internal controls under which misappropriations occurred. The actual misappropriations cited in this finding were written as two separate fraud findings in the statewide single audit report. The resolution for the misappropriations are reported in the fraud section of this publication under audit report 2008 F, finding numbers 014 and 019, on pages 96 and 97, respectively.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 1001539

Finding Number: 004

Finding: The Department of Social and Health Services does not ensure all payments made through its Social Services Payment System are supported and approved.

Resolution: By June 2009, the Economic Services Administration (ESA) and Aging and Disability Services Administration (ADSA) reviewed and took action on their respective overpayment exceptions identified during the course of the audit. ESA developed report training that stresses payment accuracy and conducted the training for supervisors. ESA also implemented a preauthorization process that requires supervisors to approve authorizations over the standard amount prior to payment.

By July 2009, ADSA provided training to staff on identifying possible duplicate authorizations before they are made. ADSA also instituted a monthly program manager review of output reports to identify possible duplicate payments. These are referred to regional staff for follow-up. In addition, ADSA is continuing to participate in the development of the ProviderOne payment system which will include features to prevent duplicate authorizations and payments.

Children's Administration (CA) reviewed all exceptions identified in the audit for possible overpayments and referred all confirmed overpayments to the Office of Financial Recovery by December 2009. By February 2010, CA will implement a second release to its FamLink system that will have edits designed to prevent overpayments.

All three administrations consulted with federal grantors to determine if funds used for inappropriate payments need to be repaid to the federal government and are taking action where necessary.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 1001539

Finding Number: 005

Finding: The Department of Social and Health Services' Economic Services Administration systems are vulnerable to misappropriation and inappropriate data changes.

Resolution: The three systems discussed in this finding are Jobs Automated System (eJAS), Support Enforcement Management Systems (SEMS) and Automated Clearinghouse (ACH) Manager. In May 2009, the Department implemented manual procedures to ensure program changes made in all three systems are properly authorized, reviewed, and accurate.

By the end of March 2010, the Department will:

- Implement a two-step process to prevent changes to program code between the time it is approved and released.
- Develop a new ACH Manager system that allows only authorized staff to log in. Staff who process payments through the ACH Manager will each be assigned a unique logon ID and password.
- Review change control software to determine whether any currently available software packages meet the needs of the Department and provide an automated solution. This will be done in relation to eJAS, SEMS, and ACH Manager to ensure program changes are properly authorized, reviewed, and are accurate.
- Implement a process to review and maintain logged changes to ACH Manager data to ensure changes are appropriate.

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Agency: 300

Audit Report: 1001539

Finding Number: 006

Finding: The Department of Social and Health Services does not adequately monitor access to critical systems.

Resolution: The critical systems discussed in this finding are utilized by the Economic Services Administration (ESA) and the Aging and Disability Services Administration (ADSA).

The finding directed at ESA dealt with access to Job Automated System (eJAS), Automated Client Eligibility System (ACES), and Support Enforcement Management System (SEMS). The policy is to update system access immediately upon a change in employment status, and ESA will continue to stress this requirement.

To ensure compliance with the policy, ESA is implementing an automated reconciliation process that compares employment changes with system access accounts monthly. Changes in state employment status (termination or change of duties) will result in appropriate changes to system access. This process will be implemented for SEMS in December 2009 and is planned for eJAS and ACES in 2010.

To prepare for the implementation of the automated process, ESA is in the process of performing a complete manual review and cleanup of current system access for all three systems (eJAS, ACES, and SEMS). This cleanup includes access by users as well as programmer access to directly modify critical data files and programs. Access is being updated or revoked as appropriate.

The part of the finding directed at ADSA dealt with ADSA contractors having access to the Electronic Agency Contracts Database (EACD).

In April 2009, ADSA completed the following corrective actions:

- All individuals having access to the EACD were reviewed by Contract Management staff, and access was updated or revoked as necessary.
- A report detailing access to the EACD was created and is distributed quarterly to field offices of Area Agencies on Aging, Home and Community Services, and Division of Developmental Disabilities for review. Field office staff mark the report and return it to Headquarters, where contract staff also review the report and are responsible to revoke access as appropriate based on their internal review and field office feedback.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 1001539

Finding Number: 007

Finding: The Department of Social and Health Services does not adequately monitor contracts with Crisis Residential Centers to ensure compliance with state law and contract requirements.

Resolution: In June 2009, Children's Administration (CA) staff met with stakeholders, including CA staff and Crisis Residential Center staff, to revise recommendations on how the compensation structure of the contracts can be changed to comply with new state law. CA developed proposals to change contract language to clearly outline the monitoring obligation and process. In addition, proposals were developed for payment methodologies that prohibit payment for stays beyond the number of days allowed by state law.

The proposed contract improvements and proposed payment methodologies were approved and implemented in 2009. The new payment structure requires staff to review the number of days clients stayed at the facility and to reduce the amount paid if the maximum stay was exceeded.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 001

Finding: The Department of Social and Health Services does not ensure that retroactive Food Assistance payments to clients are calculated correctly as prescribed by state and federal law.

Resolution: In June 2009, the Department's Economic Services Administration (ESA) reviewed all twenty-four cases cited in this audit. Nineteen cases were identified as having a potential error. Community Services Division (CSD) headquarters staff reviewed these cases and determined nine cases were acceptable and did not require additional work; ten were returned to field staff to determine the correct supplement amount the client was eligible for in each case. The remaining five cases were for incorrect payments for which the Department followed established rules and policies to determine the amount of overpayment. Once the overpayment was established, the appropriate paperwork was sent to the Office of Financial Recovery.

To prevent this situation from occurring in the future, ESA developed training and sent a memo to the field alerting staff of the newly released, mandatory online training for Basic Food underpayment/overpayment rules and process titled "The Business of Benefit Errors." All eligibility staff were required to complete the training by September 2009. Completion of the online training was tracked automatically by the Learning Center training system.

In addition to the training, existing reviews are still in effect and completed regularly. Mandatory supervisory audits are completed monthly, and the Operations Support Division conducts management evaluations and audits the Food Assistance Program on an ongoing basis.

Once the statewide single audit is distributed at the federal level, federal agencies will be in a position to work with ESA to determine if the questioned costs identified in the audit need to be adjusted or repaid.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 002

Finding: Food Assistance public funds were misappropriated at the Department of Social and Health Services' Economic Services Administration.

Resolution: Finding of fraud. Refer to page 93.

Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 003

Finding: The Department of Social and Health Services, Economic Services Administration, did not comply with documentation requirements for its Random Moment Time Sample to ensure administrative costs was properly charged to federal and state funds.

Resolution: The Department took or will take the following steps to address the issues noted in this finding:

- In October 2008, instructions for Random Moment Time Sample (RMTS) and RMTS-Barcode, the computer system that generates the RMTS samples and results, were sent electronically to all RMTS coordinators. Communication included contact information for coordinators who have questions or need technical assistance.
- In December 2008, an internal newsletter article was published in an effort to educate field staff on RMTS requirements, processes, and responsibilities. This was followed by the Operations Support Division (OSD)/Fiscal creating and distributing a monthly report for Community Service Office (CSO) administrators that communicates RMTS audit results by location. OSD/Fiscal will continue to conduct monthly audits of RMTS samples. Each CSO will be audited annually.
- In January 2009, the OSD/Fiscal chief attended a Community Services Division regional administrator meeting to discuss RMTS requirements and audit results. This was followed by OSD/Fiscal identifying members of a workgroup to evaluate the current process, update the current RMTS instructions, and develop training materials for CSO administrators and RMTS coordinators. The RMTS workgroup met in May 2009 and established an "Improvement Charter" that was approved by Economic Services Administration (ESA) division directors. In August 2009, the RMTS workgroup recommended automating the sampling process through Barcode to achieve efficiencies and eliminate common errors. Information Technology staff were able to automate the process, and the RMTS workgroup conducted usability testing in October 2009.
- In November 2009, six CSOs piloted the automated RMTS sampling process. Refinements to the automated process are scheduled to occur in December 2009 with implementation and training scheduled to occur by the end of January 2010. This change in the RMTS process must be updated and approved in the Public Assistance Cost Allocation Plan. The changes will be submitted to the Office of Accounting Services to be included with the January 2010 update.
- Once the statewide single audit is distributed at the federal level, federal agencies will be in a position to work with ESA to determine if the questioned costs identified in the finding need to be adjusted or repaid.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 004

Finding: The Department of Social and Health Services is not complying with federal requirements for allocating employee salaries and wages in accordance with its Public Assistance Agency Cost Allocation Plan (PACAP).

Resolution: This finding involves twelve employees at three of the Department's administrations: Financial Services Administration (FSA), Social Service Payment System (SSPS), and Economic Services Administration (ESA).

FSA responded that in light of this audit finding:

- The Information and Technology Office (ITO) and the Office of Accounting Services (OAS) began maintaining documentation on how the ITO staff time is charged to the benefiting funding sources as described in the Public Assistance Cost Allocation Plan (PACAP). Documentation is maintained by the Grants Management section within OAS.
- The Office of Financial Recovery (OFR) began maintaining documentation on how the enforcement manager position is charged to the benefiting funding sources as described in PACAP's base methodology.

SSPS responded to this finding as follows:

- The SSPS office chief worked with the affected administrations and developed a memorandum of understanding (MOU), which established a specific methodology for accurately allocating the costs of the four staff in the Provider File unit to the correct federal funding source. The MOU was reviewed and signed by administrations, and the methodology was implemented in March 2009.
- The PACAP was updated to reflect the exception for the allocation of these four staff using the methodology agreed to in the MOU. The plan was submitted to the Division of Cost Allocation (DCA), but was returned for additional work. It will be amended and resubmitted to DCA in December 2009.

ESA is addressing this finding as follows:

- In October 2008, ESA's Operations Support Division (OSD)/Fiscal placed the discussion of time and effort requirements and how it relates to the written PACAP as a standing item on the quarterly Community Services Division (CSD) regional business manager (RBM) meeting agenda.
- In December 2008, OSD/Fiscal worked with the RBMs to determine why the six ESA staff identified by the auditors were split-coded and if language needs to be added to the written PACAP. The outcome was that there currently is language in the PACAP about four of the employees' positions. The RBM initiated and is maintaining the proper documentation to support the split coding. For the remaining two employees, an update to the PACAP was submitted in April 2009.

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In regards to whether any questioned costs need to be repaid to the federal agencies:

- OAS worked with the Centers for Medicare and Medicaid Services, Region 10, to determine if any repayments are required for FSA and SSPS. CMS is satisfied with the resolution and did not request repayments due to this audit finding.
- After the statewide single audit has been completed and distributed at the federal level, federal agencies will be in a position to work with ESA to determine if the questioned costs identified need to be adjusted or repaid.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 005

Finding: The Department of Social and Health Services did not comply with federal requirements for time and effort documentation for the Medical Assistance and Food Stamps Employment and Training programs.

Resolution: In January 2008, prior to the audit undertaken by the State Auditor's Office, the Economic Services Administration (ESA) regional business managers (RBMs) received time and effort training from the Office of Accounting Services (OAS). The RBMs are responsible for compliance with time and effort requirements in their respective regions. This includes providing technical assistance on these requirements to supervisors and Community Service Office administrators.

In August 2008, OAS updated the Department's administrative policies regarding time and effort to more clearly reflect federal requirements. These updated policies were presented and discussed with the Community Service Division (CSD) RBMs at their quarterly meeting in October 2008. The discussion of time and effort requirements was added as a standing item on the quarterly meeting agenda.

In January 2009, the Operations Support Division's (OSD) Fiscal office chief attended a CSD regional administrator meeting to emphasize the importance of time and effort requirements and to discuss the audit findings and resolution.

In February 2009, OSD reviewed the Region 3 time certification and timesheets and found them to be in compliance. In May 2009, OSD reviewed the Region 6 time certification and timesheets and found them to be in compliance. Due to time constraints, no time and effort documentation was reviewed at the September 2009 meeting. However, OSD has committed to completing a review of the remaining four regions' time and effort documentation by June 30, 2010, and continuing the review cycle as an ongoing task.

After the statewide single audit has been distributed at the federal level, federal agencies will be in a position to work with ESA to determine if the questioned costs identified in the audit need to be adjusted or repaid.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 010

Finding: Federal funds were misappropriated at the Department of Social and Health Services' Division of Children and Family Services.

Resolution: Finding of fraud. Refer to page 95.

Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 011

Finding: The Department of Social and Health Services does not ensure that Temporary Assistance to Needy Families payments are reduced for clients who do not participate in WorkFirst activities as required by state and federal law.

Resolution: During March 2009, the Department reviewed the cases cited in this audit to determine if the teens were in school. For cases where they were not in school, appropriate actions were taken to follow state policy and pursue the sanction process. All cases were acted on and updated.

As a result of this finding, the Department's further review of applicable state statutes has clarified that the state statutes governing teen education requirements apply to teens who are themselves parents and not to teens in general. Neither state nor federal law nor regulation requires dependent teens age 16 or older who are not parents to complete an individual responsibility plan and participate in WorkFirst activities.

The Department amended the Temporary Assistance to Needy Families state plan in August 2009 to eliminate the requirement to sanction dependent children (16 and 17 years of age) who are not in school. In addition, the Department revised the WAC and WorkFirst handbook to eliminate documentation of dependent teen school attendance as a program requirement.

After the statewide single audit has been distributed at the federal level, federal agencies will be in a position to work with Economic Services Administration to determine if the questioned costs identified in the audit need to be adjusted or repaid.

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Status of Audit Resolution

December 2009

Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 012

Finding: The Department of Social and Health Services is not reimbursing the federal government its proper share of child support collections.

Resolution: The finding and questioned costs were the result of a failure to update the accounting system to reflect the correct federal medical assistance percentage (FMAP) rate for state fiscal year 2008. Only the Department's Office of Accounting Services (OAS) can change the FMAP rate in the accounting system, and the Division of Child Support accounting unit did not communicate the correct rates to OAS.

In September 2008, the Economic Services Administration (ESA) Fiscal Services Office began incorporating a review of the FMAP rate in the administration's monthly cost allocation review process and began notifying OAS if any changes are needed based on the results. This will ensure the correct federal/state split of child support collections.

In October 2008, a journal voucher was prepared to move questioned costs from federal expenditures to state expenditures by reducing the subsequent federal draw.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 013

Finding: The Department of Early Learning and the Department of Social and Health Services do not have adequate internal controls over direct payments to childcare providers.

Resolution: In July 2008, the Department of Early Learning (DEL) and the Department of Social and Health Services (DSHS) implemented a process to reconcile childcare payments to childcare provider attendance records to determine the payments were supported by appropriate documentation. The Departments documented their respective responsibilities in the October 8, 2008, service level agreement.

On a monthly basis, licensed child center and childcare licensed family home payment files are randomly selected from the Social Service Payment System (SSPS) by DSHS. DEL sends a written request to the providers to obtain attendance records from providers and provides them to DSHS to reconcile with the SSPS payment files. If a discrepancy is found, DSHS follows DEL policy to write an overpayment notice. If providers fail to provide DEL with the requested attendance records, DSHS finds the case in error and writes an overpayment notice.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 014

Finding: Child Care public funds were misappropriated at the Department of Social and Health Service's Economic Services Administration.

Resolution: Finding of fraud. Refer to page 96.

Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 016

Finding: The Department of Social and Health Services does not have internal controls to ensure Child Welfare Services complies with earmarking compliance requirements.

Resolution: The Department concurs with this finding and understands the "assurance" required by the change to the Social Security Act as signed into law September 28, 2006. Until October 2009, the Department had a manual process in place for allocating costs to the child welfare grant. Journal vouchers were created by staff and approved by the senior finance manager who, prior to approving the journal voucher for processing, verified that only ten percent of the total costs (the maximum allowed by the new law) charged to the grant were administrative costs. This process remained in place for all charges incurred prior to updating the automated cost allocation system.

Beginning with the October 2009 plan, the Department allocates charges incurred for the child welfare program automatically to the grant. This is done through the use of a formal structure within the automated cost allocation plan that allows knowledgeable staff to establish a path for appropriate eligible expenditures to be charged. This means charges are allocated to the grant as payments are made and do not need to be transferred to the grant as adjustments.

In August 2009, the Children's Administration discussed the amounts charged to the 2008 grant with the federal grantor. The grants for federal fiscal years 2007 and 2008 were adjusted as part of the final claim process and administrative expenditures claimed were within the ten percent limit. Thus, the federal grantor did not disallow any costs.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 017

Finding: The Department of Social and Health Services, Children's Administration, is not following established internal controls over the eligibility of clients receiving adoption assistance payments.

Resolution: The Department took or will take the following actions regarding staff compliance with internal controls surrounding adoption support:

- In March 2009, the Department reviewed internal adoption support processing and documentation procedures with region staff. Emphasis was on program eligibility, review, and documentation requirements specified in state laws and regulations. Since the audit, new staff have taken over these duties and received training for the duties which included an explanation of these requirements.
- In April 2009, the Department utilized program requirements as well as lessons learned from the audit to share with staff in all regions and adoption support program managers to enhance overall documentation of eligibility and payment/benefits. A statewide conference call was held with all adoption support coordinators to discuss requirements and information from the audit.
- Starting in May 2009, regional adoption support supervisors began spot-checking current adoption support files on a quarterly basis as a way to verify guidelines are followed. Spot-checking will be an ongoing part of the supervisors' tasks.
- By July 2009, all regions trained adoption support staff in guidelines for internal operations for eligibility determinations and internal controls around them.

With respect to the questioned costs, the Department took or will take the following actions:

- In February 2009, the Department obtained the list of files reviewed during the audit.
- In November 2009, the Department submitted documentation to the grantor that outlines corrections to individual case deficiencies and asked for direction on whether or not federal shares of these transactions needed to be returned. Administration for Children and Families in Region 10 is currently working with the Department to determine if any federal funding should be repaid based on the finding.

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Status of Audit Resolution

December 2009

Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 018

Finding: The Department of Social and Health Services, Office of Financial Recovery and Health and Recovery Services Administration, does not have internal controls to ensure that interest penalty collections are refunded to the federal government.

Resolution: In November 2008, the Department remitted the 2008 state fiscal year federal portion of the interest to the Centers for Medicare and Medicaid Services (CMS) through the federal draw process.

In March 2009, the Department created an interest report to calculate the federal share of the interest and implemented a process for remitting the federal share to CMS each month through the federal revenue draw process. The transaction is a credit to the federal draw, which reduces the Department's next assistance draw by the amount of the interest. The transaction detail is included on the federal claim form each quarter.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 019

Finding: Public funds were misappropriated at the Department of Social and Health Services' Division of Developmental Disabilities.

Resolution: Finding of fraud. Refer to page 97.

Status of Audit Resolution

December 2009

Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 020

Finding: The Department of Social and Health Services did not have adequate internal controls to ensure the federal share of overpayments made to Medicaid providers are refunded to the federal government.

Resolution: In April 2009, the Office of Financial Recovery (OFR) and Office of Accounting Services (OAS) updated the Department's overpayment procedures to identify the title and position numbers of the managers and supervisors who have responsibility and authority for each aspect of the overpayment refunding process. OAS trained grants management staff on the process of repayment of prior-prior biennium recoveries. Current and prior biennium recoveries are treated as a reduction of expenditure (for current period recoveries) or as a liquidation of a receivable (for prior biennium recoveries.)

In July 2009, the Department worked with the appropriate staff of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Region 10, to ensure that they are satisfied that the state has refunded the federal share of overpayments that had not been remitted timely. CMS Region 10 staff provided written confirmation of satisfaction that the state refunded the federal share of overpayments in question, and CMS is satisfied that the process changes will preclude future occurrences.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 021

Finding: The Department of Social and Health Services, Health and Recovery Services Administration's internal controls are inadequate to identify and recover Medicaid overpayments to pharmaceutical providers made when billing codes are used inappropriately.

Resolution: The Department does not concur with this finding, but the Health and Recovery Services Administration (HRSA) will continue working with the Washington State Pharmacy Association (WSPA) to prevent inappropriate payments for pharmacy claims that are not allowable under the Medicaid program.

HRSA is now performing an ongoing risk analysis and assessment to determine the appropriate level of post payment audit coverage for third party liability (TPL) claims. This effort has resulted in a plan being devised and implemented to ensure that audits are focused on the most aberrant providers. On a quarterly basis, paid claims data is run to identify providers with the highest usage of manual override codes. The providers are ranked by paid amount and those with the highest dollars are prioritized and reviewed by the Office of Program Integrity (OPI). In state fiscal years 2007-2009, OPI conducted an average of three TPL audits per quarter, resulting in the identification and issuance of \$1.4 million in overpayment notices to providers. As of November 2009, the Department has recouped \$1.28 million of these overpayments.

Following ProviderOne implementation, scheduled for March 2010, the Department plans to add a new TPL edit and to enhance the pharmacy point-of-sale system. These changes incorporate additional controls to identify and recover overpayments or, in some cases, to prevent them.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 022

Finding: The Department of Social and Health Services does not have adequate internal controls to ensure new applicants meet federal citizenship requirements before receiving Medicaid benefits.

Resolution: In May 2008, the following measures were initiated:

- Citizenship verification and identity processes were developed by the Health and Recovery Services Administration (HRSA) to ensure accurate eligibility decisions for all applicants 19 years of age and older and for all non-pregnant applicants under the age of 19.
- HRSA provided citizenship verification and identity training related to eligibility for non-pregnant applicants under the age of 19 to medical eligibility staff.
- HRSA began requiring citizenship verification and proof of identity (with a 90-day grace period) for all non-pregnant applicants under the age of 19 prior to Medicaid approval.

In July 2008, the following measures were initiated:

- HRSA provided citizenship verification and identity training related to eligibility for applicants 19 years of age and older to medical eligibility staff.
- HRSA began requiring citizenship verification and proof of identity for all applicants 19 years of age and older prior to Medicaid approval.
- HRSA began providing a weekly report of approved new applicants that did not have correct citizenship codes in the Automated Client Eligibility System to field staff for review. If citizenship had not been verified, the client's Medicaid coverage was terminated.

In September 2008, manual accounting entries were completed by the Division of Rates and Finance to fund expenditures with state funds for enrollees who had not satisfied federal requirements. These adjustments were processed in February 2009 for claims that had been paid for services during July 2008 through December 2008. The accounting adjustments affected payments for services provided to all clients who had been identified as "non-cooperative" and therefore ineligible for that period. These ongoing adjustments are completed quarterly.

The federal Children's Health Insurance Program Reauthorization Act legislation, passed in April 2009, allowed for all Medicaid applicants to be given a reasonable period of time to provide citizenship verification and to receive Medicaid benefits during this period of time. Applicants who declare they are citizens can receive Medicaid while they work with the Department to obtain citizenship verification. If clients fail to cooperate with the Department in obtaining verification, their Medicaid coverage is terminated.

State of Washington

Status of Audit Resolution

December 2009

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 023

Finding: The Department of Social and Health Services does not have adequate internal controls to ensure people receiving Medicaid benefits have valid Social Security numbers.

Resolution: Beginning in February 2007, Health and Recovery Services Administration (HRSA) has been sending "No Social Security Number (SSN)" reports to the Community Services Division (CSD) of the Economic Services Administration (ESA), Aging and Disability Services Administration (ADSA), and staff within HRSA. The "No SSN" report lists individuals who have received services without a valid SSN and provides supervisors with a report to monitor and audit staff to ensure SSNs are requested, received, and verified.

Beginning August 2008, HRSA's Medical Eligibility Determination Services staff enter and verify all SSNs for HRSA non-adoption support cases. Supervisors consistently perform random audits to confirm that verification of all SSNs is occurring.

The audit testing revealed 79 clients for whom the Department could not provide evidence of a correct SSN. The administrations involved in the audit reviewed these clients and all cases were resolved by February 2009.

In January 2009, HRSA and Children's Administration (CA) developed a policy regarding staff responses to SSN mismatch alerts. HRSA and CA staff received training on the new policy in February 2009.

In March 2009, the following measures were taken:

- ESA/CSD developed a policy that established clear expectations for supervisors regarding their monitoring of staff responses to SSN mismatch alerts. These were shared with CSD financial coordinators who shared the information with their financial supervisors.
- ESA distributed a memo to field offices instructing them to consistently review the SSN alerts they receive.
- HRSA sent a "Do You Know" document to staff reminding them to consistently and properly resolve SSN mismatch alerts. This document was also meant to remind supervisors and office chiefs how important it is for HRSA staff to resolve SSN problems as part of their normal business practices.

In July 2009, the HRSA foster care Medicaid team performed a one-time review of all active caseloads for non-federally verified SSNs, which included adoption support cases. If an SSN was not found, HRSA worked with the foster care health program manager at CA to get a verified SSN for the child. In each case where a SSN was not verified, termination procedures were initiated.

State of Washington

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December 2009

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Status of Audit Resolution

December 2009

Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 024

Finding: The Department of Social and Health Services, Health and Recovery Services Administration's internal controls are insufficient to ensure payment rates to its Healthy Options managed care providers are based on accurate data.

Resolution: The Department does not concur with the finding and will not be taking additional corrective action. The Department is of the opinion that the process currently in place is sufficient.

Although the Department does not directly review costs reported by managed care organizations (MCO) to the Department's actuaries, there is a significant and sufficient verification of the accuracy and completeness of the information. Each MCO must have the submitted information certified in writing as accurate and complete by an independent actuary. The Department's actuary then validates the information submitted by comparison to the audited financials submitted to the Office of the Insurance Commissioner. The actuary also compares costs between MCOs and resolves outliers.

The rate-setting methodology and rates have been approved by the Centers for Medicare and Medicaid Services (CMS) annually as a part of contract approval. Additionally, in an audit of Healthy Options, CMS had no findings concerning rate setting.

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Status of Audit Resolution

December 2009

Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 025

Finding: The Department of Social and Health Services, Health and Recovery Services Administration, does not comply with the state law (RCW 74.09A) and the federal Deficit Reduction Act of 2005 to identify all third parties liable for payment of Medicaid services.

Resolution: The Department believes that it is in compliance with the Deficit Reduction Act of 2005. Health and Recovery Services Administration (HRSA) meets this standard by making data available to all insurers to use for third party liability reporting and by matching data directly with those insurers most likely to provide third party coverage to Medicaid recipients. In September 2009, the Department sent letters to all 4,024 active third party payers on file in the Medicaid Management Information System (MMIS) reminding them of the Department's willingness to perform data matches.

While the Department believes it meets legal requirements now, with the implementation of the new ProviderOne system, which will replace MMIS, the Department will further enhance data matching activities. The anticipated go-live date for ProviderOne is March 2010.

After the system is implemented and the Centers for Medicare and Medicaid approves the data elements jointly agreed to by the state and insurers, HRSA will be able to send an electronic coordination of benefits eligibility inquiry to health plans who have signed trading partner agreements with the Department. The trading partners will be able to respond electronically to eligibility inquiries to indicate the availability of third party healthcare coverage as of a particular date. For those insurers or carriers who may not have their systems ready to participate electronically, HRSA will continue working with them using the methods currently in place.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 026

Finding: The Department of Social and Health Services does not have adequate internal controls to ensure non-emergency medical transportation expenditures are allowable and adequately supported.

Resolution: The Department does not agree that it lacks adequate internal controls to ensure that the state's non-emergency transportation (NEMT) expenditures are legitimate, allowable, and adequately supported, or that the Department does not monitor transportation brokers to ensure all Medicaid rules are followed and costs are appropriate. The Department performs the following activities in line with its administrative policy for risk assessment and contract monitoring:

- The Department requires all NEMT brokers, by contract, to annually complete and provide the state with copies of independent audits. Seven of eight brokers are required to complete federal single audits. The eighth broker is very small and must meet single audit requirements. All brokers are in compliance with this annual audit requirement.
- Department staff performs annual pre contract risk assessments for all brokers. These contracts are defined as client service contracts and not subrecipients, which would require a higher standard of fiscal monitoring.
- Department staff review monthly broker invoices, back-up documentation, and reports before the invoices are approved for payment.
- Program managers review monthly for service delivery patterns and trends including use of low-cost modes of transportation as well as cost per trip.
- Review of billing packet and reports is noted in the Department's automated contracts database.
- Program managers monitor and respond to "daily operations" activities including inquiries, complaints, and all client incident/accident reports.
- The team of program managers prioritizes, based on risk assessment and historical information, which brokers need onsite reviews for consultation, technical assistance, and compliance monitoring to ensure broker activities comply with state and federal regulations.
- Annually, the program managers rotate on-site reviews of the eight brokers. Each broker is reviewed every other year for specific issues or general contract compliance. Six of eight total brokers were visited in 2008. These onsite reviews include direct observation, documentation review, and interviews with broker managers, bookkeepers, and direct-service staff.
- Annually, program managers review broker service delivery and service expenditures in detail, looking at multiyear historical data and reviewing broker regions against others of similar size and characteristics. This in-depth review is done in preparation for contract/budget negotiations for the next contract year in order to negotiate the best value for the state.

Status of Audit Resolution

December 2009

HRSA has submitted a state plan amendment (SPA) to CMS to move nonemergency medical transportation from administrative match to medical match. As part of the SPA process, CMS is providing directions about the program structure necessary to receive medical match funding. In addition, HRSA staff are working with the Department of Justice Office of Inspector General to refine program audit and monitoring processes and relevant contractual language.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 027

Finding: The Department of Social and Health Services, Aging and Disability Services Administration, Home and Community Based Services division, does not have internal controls to ensure Medicaid payments to in-home service providers are allowable and supported.

Resolution: While the Department maintains that state law assigns the responsibility for scheduling, tracking, and timekeeping of in-home service providers to the client receiving the services, in response to this finding:

- In March 2009, the Department issued a management bulletin to Area Agencies on Aging and the Division of Developmental Disabilities that addressed the statutory mandate to review a sample of timesheets to verify that services provided are allowable and documented on the timesheets. Case managers are instructed to document their review of timesheets and discussion of service verification with clients in a "Service Episode Record."
- In October 2009, the Department issued a written communication to clients on employer responsibilities including time tracking and record keeping. Between November 1, 2009, and October 31, 2010, the form will be distributed and reviewed during the initial and annual assessments with all clients who employ an individual provider (IP). After October 31, 2010, the form must be distributed and reviewed with new clients who select an IP and with current clients who switch to an IP from a homecare agency or residential setting.

In addition, the Department is in the process of procuring a system that will send clients a notice of the allowable services they are to receive and how to report if they do not receive those services. The new system is not expected to be implemented for approximately two years. Until then, Aging and Disability Services Administration will continue to ensure that clients:

- Understand they are responsible for supervising their care provider and ensuring the services provided are allowable. If a client is unable to supervise their care provider, agency-managed personal care may be available, or the client and case manager identify a representative who will monitor services. If a representative is not available, by policy the case manager who monitors the provision of services contacts the client more frequently.
- Have been given information on how to contact their case manager if there are concerns about service delivery, and are informed that they can and should report problems with providers.
- Understand that, as the employer, they can terminate the services of their provider. The Department also has the authority to terminate payment in the event there is a good faith belief that services are not being provided as authorized to a Medicaid client.

Status of Audit Resolution

December 2009

The Social Service Payment System will not process payments in excess of hours authorized. A provider is therefore unable to claim and be reimbursed for hours that exceed those authorized by the case manager.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 028

Finding: The Department of Social and Health Services, Health and Recovery Services Administration, does not have adequate internal controls to ensure all controlled substances prescribed for Medicaid clients are authorized and allowable.

Resolution: The Department does not agree with this finding for the following reasons:

1. There are not any federal or state statutes that require a payer (e.g. state) to validate the Drug Enforcement Administration (DEA) number of a prescriber. Therefore, the Department disagrees that the lack of an edit that validates the DEA number for Schedule III - V drugs constitutes inadequate internal controls or that the lack of such validation renders the payment unallowable.
2. The Department believes that responsibility for compliance with controlled substance requirements lies with the prescribing provider and the dispensing pharmacies. There are not any provisions in the Controlled Substance Act or the state Uniform Controlled Substance Act that could be interpreted as a requirement relating to payment of claims for controlled substances.

A controlled (scheduled) drug is one whose use and distribution is controlled because of its abuse potential. Scheduled drugs are rated in the order of their abuse. Schedule II drugs are drugs with a high potential for abuse. The Department has the following controls in place regarding DEA numbers and Schedule II drugs:

- While not a federal or state requirement, the Department implemented a pharmacy point-of-sale (POS) edit in July 2002 for the purpose of validating the DEA number of the prescribing physician for Schedule II drugs.
- In addition to the edit in the POS that validates the DEA number for Schedule II drugs, the Department has a set of robust program integrity activities that includes pharmacy utilization review, pharmacy rules-based algorithms that identify improper payments, and data mining activities that identify patterns outside the norm.

In the absence of any requirement to validate DEA numbers for controlled substances, the Department considers that this set of program integrity activities provides adequate controls to ensure that controlled substances are authorized and allowable.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 029

Finding: The Department of Social and Health Services, Health and Recovery Services Administration, does not perform a quarterly retrospective drug use review as required by federal law.

Resolution: The Department maintains that it is in compliance with federal regulations pertaining to retrospective and prospective Drug Utilization Review (DUR). Federal regulations stipulate the Department must perform quarterly retrospective DUR via use of predetermined standards to monitor a number of measures related to drug use.

The Department conducts these retrospective reviews as required every quarter. For each of the required measures, an analysis is completed and the results of that analysis are reported to the Centers for Medicare and Medicaid Services (CMS) Region 10. These results are reported on forms CMS specifically created for reporting the results of the analysis on each of these measures, including overutilization, abuse, and misuse.

Additionally, the Department utilizes algorithms, conducts provider modeling, conducts audits, and uses client specific prior authorization processes to identify inappropriate use of drugs.

The Department's focus has been on the appropriateness of physician prescribing which includes both therapeutics and misuse and abuse of drugs, while the auditors focused on the usefulness of utilization review in detecting fraud. While fraud detection is required by federal law, there are other divisions within the Health and Recovery Services Administration (HRSA) that specifically address fraud. The pharmacy administrator routinely refers clients, pharmacies, and prescribers that come to light through the retrospective DUR to the appropriate division within HRSA for investigation.

The Department believed it had presented reports to the auditors which document its compliance with the federal regulations and will continue to work with the auditors to understand what additional documentation is needed to demonstrate compliance. HRSA received a confirmation on October 2, 2009, from CMS that the state's annual DUR reports for both 2007 and 2008 were compliant with the federal requirements for retrospective and prospective review. This was reported to the auditor on October 5, 2009. The Department is also working with the auditors to coordinate a meeting with CMS by January 2010 to review the Department's efforts to comply with the applicable federal regulations.

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Status of Audit Resolution

December 2009

Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 030

Finding: The Department of Social and Health Services, Economic Services Administration, Medicaid Eligibility Quality Control Unit (MEQC), did not retain documentation to support the results of its federally required audits of Medicaid client eligibility.

Resolution: In response to this finding, the Medicaid Eligibility Quality Control (MEQC) unit took the following actions:

- In July 2008, the MEQC unit received records retention training from the Department's records officer.
- In August 2008, beginning with the Division of Developmental Disability waiver cases, the MEQC Unit converted to electronic recordkeeping, with staff entering data directly into an electronic database. All paper forms are now imaged and stored electronically. Each project has a unique database, and all databases are backed up every night.
- In January 2009, the MEQC Unit developed a formal records retention procedure in accordance with state and federal records retention requirements.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 031

Finding: The Department of Social and Health Services, Aging and Disability Services Administration, does not have adequate controls in place to ensure all assets applicants own are counted when Medicaid eligibility is determined.

Resolution: The Department does not agree that federal rules require verification of financial statements for the previous five years unless a transfer has been declared or there are inconsistent facts in the record or other problems with the application.

The Department agrees that the financial documents reviewed for most applications do not provide a complete picture of the applicant's financial circumstances during the five years prior to the month of application. However, with the majority of the applications, this is not necessary because assets and asset transfers are not an issue. In addition, there is currently no infrastructure that would allow the Department to run an asset check on any applicant without specific information as to what the asset is and where the asset is located. Currently, the only means that the Department has of obtaining that information is through the applicant's self-declaration on the application and the interview with the client.

The practice the Department has been operating under for more than two decades relies on self-declaration by the client for any asset transfers or sales within the five-year look back period and the client's signature attesting to the accuracy of the application. Federal requirements for medical assistance applications state that an agency's policies and procedures for determining eligibility must be conducted in a manner consistent with simplicity of administration and the best interests of applicants and recipients. The Department is committed to ensuring that Medicaid clients are financially eligible for the program benefits that they receive and will continue to pursue and verify any declared asset transfers that it becomes aware of through the interview process or as declared by the applicant to ensure that they were appropriate transfers and not done to qualify for Medicaid.

The Department provided details of its policies and procedures related to transfers of assets to the Centers for Medicare and Medicaid (CMS), Region 10, on June 11, 2009, and asked for their comments and opinions on whether the Department's current methods comply with federal guidelines. A follow-up email was sent in November 2009, but CMS has not yet responded. The Department will continue to pursue a determination from CMS and, when it is received, will take appropriate action.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 032

Finding: The Department of Social and Health Services does not have internal controls in place to ensure errors identified by the Medical Eligibility Quality Control Unit (MEQC) are reviewed adequately and in a timely manner.

Resolution: In July 2008, the Medicaid Eligibility Quality Control (MEQC) program developed a discrepancy report log to help staff track discrepancies in eligibility determinations and claims and to ensure that the appropriate representatives in the Health and Recovery Services Administration received the problem and information reports. This log describes each error and identifies the case, the community services office involved, the survey number, and the date the report was sent to the regional representative who is responsible for monitoring the log and ensuring cases are corrected. The discrepancy reports are stored electronically in a system called Barcode and can be viewed by appropriate personnel.

When each MEQC audit is complete, MEQC staff review the discrepancy report log along with information in the Automated Client Eligibility System to determine whether eligibility staff has completed corrective action on individual cases. Corrective action is completed on an average of 82% of discrepancies at the time of review. After review, a log of all cases with outstanding corrective action is sent to the appropriate representative for follow-up.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 033

Finding: The Department of Social and Health Services, Health and Recovery Services Administration, does not have adequate internal controls to ensure its verification process complies with federal intent.

Resolution: Even though the Department does not agree with the finding, the following actions have been or will be taken to improve the verification process:

- In February 2009, the Department began sending surveys on approximately 500 claims selected using specific sampling criteria approved by the Department and supplied by the current Medicaid Management Information System (MMIS) vendor on a monthly basis.
- Upon implementation of the ProviderOne system, which will replace MMIS in March 2010, Health and Recovery Services Administration (HRSA) will automatically generate approximately 2,500 manual survey verifications each month.

While the verification process has not proven to be fruitful for identification of fraud, waste, or abuse in the Medicaid program, the Department believes the processes discussed below, which are currently in place, are much more effective:

- The Department has a toll-free hotline to solicit information on Medicaid provider fraud, waste, and abuse. On a monthly basis, HRSA receives an average of eight referrals that warrant further investigation based on calls received on the hotline.
- The Department has an email address for external clients, stakeholders, and internal state staff to report Medicaid provider complaints. On a monthly basis, HRSA averages 11 referrals that warrant further investigation based on emails.
- Additionally, the Department has a set of robust program integrity activities including utilization review and data mining activities. The Payment Review Program (PRP) runs proactive data analyses on paid claims to identify providers who appear to be billing aberrantly for certain services or whose billings vary greatly from their peers. Over the last nine years, thousands of overpayments, audits, and Medicaid Fraud Control Unit referrals have resulted from these data reviews.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 034

Finding: The Department of Social and Health Services, Aging and Disability Services Administration, Home and Community Based Services Division, does not have adequate controls in place to ensure Medicaid recipients have received the services for which Medicaid is being billed.

Resolution: The Department concurs that it does not have a process that provides Medicaid recipients with information on the number of hours billed to the Department by individual providers (IP). The Department is in the process of procuring a system that will improve the verification process. Specifically, the new system will generate monthly notices to all clients informing them how many hours were paid to the provider on their behalf during the previous month. The clients will be instructed to notify the Department if they notice a discrepancy in the hours provided versus the hours billed.

The new system is not expected to be implemented for approximately two years. In the meantime, the Department will rely on the following controls that are currently in place:

- Case managers complete an assessment that results in an authorization of hours that cannot be exceeded by a provider invoice.
- Clients receive a copy of the service summary that tells them the number of hours of service they are eligible to receive. Clients are advised that they can choose when those hours are provided and direct the individual provider when to provide them. Case managers also advise clients to contact them if they are not receiving the hours (or care) for which they are eligible.
- Clients are expected to keep copies of timesheets for their IPs and case managers periodically review these timesheets and verify with the client that authorized services have been provided. Case managers are instructed to document the review of timesheets and the discussion of service verification in a "Service Episode Record."
- The Department, through its Payment Review Program, runs algorithms to detect possible fraudulent claims. Overpayments are initiated and referrals are made to the Medicaid Fraud Control Unit as indicated by findings.
- The Social Service Payment System will not process payments in excess of hours authorized. A provider is therefore unable to claim and be reimbursed for hours that exceed those authorized by the case manager.

Status of Audit Resolution

December 2009

In September 2009, the Department completed a revision of a written communication titled "Acknowledgement of My Responsibilities as the Employer of My Individual Providers." Staff have been instructed to review this form with all clients who employ an individual provider. By October 31, 2010, the form will be reviewed with all clients who employ an IP.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 035

Finding: The Department of Social and Health Services, Aging and Disability Services Administration, did not ensure evaluations or re-evaluations of level of care for clients receiving in-home care services have been performed at least once every 12 months.

Resolution: The Department addressed this finding as an opportunity to provide additional training and direction to staff on the assessment process with emphasis on changing the assessment status to "current" upon completion. This information was provided to all applicable staff through the distribution of a factsheet.

The Department will continue its monitoring process to ensure level of care assessment for clients receiving in-home services is completed at least once every twelve months. The Department includes comprehensive monitoring as part of the quality assurance monitoring cycle. A minimum of six percent of the active caseload is monitored on an 18-month cycle. Each file is reviewed for assessment timeliness and the monitoring tool includes the question, "Did the annual assessment occur within 12 months of the previous assessment?"

Currently, the Department has set a benchmark of 90% for compliance with assessment timeliness. Results are measured against this benchmark during each quality monitoring cycle. During the 2006-2007 internal monitoring cycle, 95% compliance was achieved. The Department does not set the benchmark for assessment timeliness at 100% because there are routine reasons that an assessment may not be completed on time. Two examples of these reasons include the client's inability to meet with the case manager to do the assessment and delays in locating a provider of personal care.

After the statewide single audit is distributed at the federal level, federal agencies will be in a position to work with ADSA to determine if the questioned costs identified in the audit need to be adjusted or repaid.

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Department of Social and Health Services (DSHS)

Agency: 300

Audit Report: 2008 F

Finding Number: 036

Finding: Department of Social and Health Service, Health and Recovery Services Administration, does not have adequate controls to ensure providers meet ongoing eligibility requirements to participate in the Medicaid program.

Resolution: This finding noted concerns about respiratory therapists, adult day health providers, and durable medical equipment (DME) providers. The Department concurs with this finding and is improving the monitoring of these providers' licenses as follows:

In February 2009, Health and Recovery Services Administration (HRSA) began receiving changes to provider enrollment information from the Adult Day Health Providers program, which is administered by the Aging and Disability Services Administration (ADSA). HRSA received a current listing of all providers contracting with ADSA and currently enrolled with HRSA and other administrations. HRSA will be notified by the ADSA program manager when there are changes in the licensure of a provider.

In March 2009, HRSA modified WAC 388-530 removing the requirement that all DME providers must have appropriately trained and qualified staff to be eligible as a Medicaid provider. The public hearing was held January 27, 2009, and the rule was filed with an effective date of March 1, 2009.

In May 2009, HRSA sent letters to sixteen respiratory therapists requesting documentation of current licensure and status. In June 2009, HRSA reviewed the documentation and licenses requested. As a result, one provider contract was terminated.

In March 2010, the ProviderOne system is scheduled to be implemented. ProviderOne will retain the information on licenses and will automatically generate reminder letters to providers thirty days prior to their license expiration. ProviderOne will also prevent payment if a provider's license is expired at the time of service.

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