

## Status of Resolution of Audit Findings

December 2010

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 1003750

**Finding Number:** 001

**Finding:** The Department of Social and Health Services' Children's and Economic Services administrations paid foster care and child care providers who had not cleared background checks.

**Resolution:** The Department partially concurs with this finding. The finding involved Children's Administration (CA) and the Economic Services Administration (ESA). Each administration provided a response to address the recommendations of the auditor.

Children's Administration

In May 2010, CA reviewed in FamLink, the Department's automated case management information system, each exception identified during the audit and made necessary corrections.

CA is in the process of forming a workgroup to address the audit recommendations. By January 2011, CA will work with the Department's Background Check Central Unit to ensure the communication and training materials to be developed as a result of this finding include accurate information about processing background checks.

Also, CA is currently evaluating its background check policy to ensure it is aligned with current state law and agency rules; developing communication and/or training on background check requirements; and developing additional training around tracking background check information in FamLink.

Economic Services Administration

An automated feature was added to the Barcode system in December 2009 so it now searches for a current background check. If the system cannot find a current background check for the provider, an edit is sent to the caseworker notifying them that a background check could not be found. The edit tells the caseworker to verify that the provider has a current background check before authorizing child care services.

In September 2010, ESA sent a memo to staff reminding them to obtain completed background checks on providers and document their efforts in the electronic case record. The memo addressed the concerns listed in the recommendations made by the auditor. Also, ESA corrected the exceptions identified during the audit.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

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**Audit Report:** 1003750

**Finding Number:** 002

**Finding:** The Department of Social and Health Services does not adequately monitor access to critical systems to prevent unauthorized access or misuse.

**Resolution:** The Department concurs with this finding. Several of the Department's administrations addressed systems access for which they are responsible. Specifically, Central Contract Services (CCS) resolved all exceptions identified during the audit related to the Agency Contracts Database (ACD). The Economic Services Administration (ESA) resolved exceptions identified during the audit related to the Automated Client Eligibility System, Support Enforcement Management System, Electronic Jobs Automated System, and Social Service Payment System.

In June 2010, the Department implemented a process to ensure access to critical systems is terminated when employees are terminated. The Human Resources Department (HRD) distributes a report weekly to the Information Systems Services Division (ISSD), CCS, ESA, and the chief financial officer's (CFO) designees that lists employees terminated the previous week. Based on the report, access is updated as follows:

- ISSD is responsible for removing reported individuals from the Active Directory, mainframe security, virtual private network remote access, and secure email.
- Program staff designated by the CFO is responsible for removing building access and access to systems not covered by ISSD for those employees on the list.
- In June 2010, CCS began using the list to remove access to ACD.
- ESA uses an automated process to compare the ESA list of employees against the HRD list. Access to ESA related systems is deleted if it is determined an individual no longer is employed at ESA or no longer requires access. In September 2010, ESA implemented an additional automated reconciliation process that compares employment changes with system access accounts on a monthly basis.
- Three days after receiving the weekly list, ISSD staff and program staff send an email to the senior director of HRD confirming access has been terminated for employees on the list or providing justification for why it was not eliminated (i.e. the employee was rehired). The senior director monitors responses to confirm reports are returned and signed off. Reports are maintained by HRD.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

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Department of Social and Health Services (DSHS)

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**Audit Report:** 1003750

**Finding Number:** 003

**Finding:** Western State Hospital does not have adequate internal controls at the Local Funds Office to prevent unauthorized access or misuse of the patient funds or the petty cash funds.

**Resolution:** By November 2009, the Department implemented all corrective action based on the recommendations made by the auditors. The recommendations and actions are as follows:

*Establish controls over patient funds and petty cash funds to ensure they are safeguarded from loss or misuse.*

- The Department implemented the use of two patient fund drawers and one petty cash drawer.
- Each drawer is keyed, with an individual cashier responsible for each drawer.
- If the regular cashier is not available, the key to the drawer is logged out to a substitute cashier.
- Each drawer is balanced daily.

*Segregate duties such as preparing, recording, and reconciling account activity to ensure loss or misuse is prevented or detected in a timely manner.*

- Staff in the Local Funds Office prepare and record account activity.
- Accounting staff in the Appropriated Funds Office reconcile and audit the local fund account activity. For both patient funds and petty cash, access to the database used to record patient activity is restricted to Local Funds Office staff.
- Patient funds are reconciled daily; petty cash is reconciled weekly; and both bank accounts are reconciled monthly, in compliance with the *State Administrative and Accounting Manual*.

*Safeguard all money received by restrictively endorsing checks and using locking bags when transporting.*

- Checks are restrictively endorsed upon receipt.
- Locking bags are now used when transferring checks from one office to another.

*Patient funds and petty cash should not be comingled.*

- Patient funds and petty cash funds are maintained in separate locked drawers.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

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Department of Social and Health Services (DSHS)

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**Audit Report:** 1003750

**Finding Number:** 004

**Finding:** The Department of Social and Health Services does not perform timely reconciliations of the State Payroll Revolving Account, resulting in losses and errors.

**Resolution:** The Department concurs with this finding. The Department developed a corrective action plan based on the recommendations of the auditors. All action items outlined in the Department's plan commenced by May 1, 2010. Reconciliation of discrepancies from Fiscal Year 2008 and prior is an ongoing activity as resources are available.

The corrective action items developed by the Department are correcting the deficiencies concerning overpayments, insurance deductions, and garnishments. The specific action items include:

- **Overpayments:** The Department's headquarters Payroll Office has prioritized and will continue to prioritize overpayment identification, reconciliation, and collection within available resources.
- **Insurance Deductions:** The Department developed and continues to refine procedures to reconcile insurance deductions. Reconciliation of the current activity in the insurance premium account will continue to be a priority for the Department.
- **Garnishments:** The Department developed a database in 2008 to appropriately handle garnishments. The database allows the Department to manage garnishments and their distribution. The \$19,000 residual amount from 2006 noted in the finding has been researched with the appropriate authorities and disbursed accordingly.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

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**Audit Report:** 2009 F

**Finding Number:** 002

**Finding:** The Department of Social and Health Services is not complying with federal requirements for allocating employee leave buyouts.

**Resolution:** The Department concurs with this finding. During 2009, the Department appropriately transferred slightly over \$4.1 million to the termination leave base. Staff who was learning the transfer process relied upon procedures that did not adequately describe the transfer requirements. As a result, the 2009 liquidation portion of the prior year termination leave charges was inadvertently not transferred. The liquidation portion represents about 8% of the total termination leave charges for 2009.

In February 2010, the Office of Accounting Services updated procedures to reflect all parts of the termination leave transfer.

The Department submitted documentation to each granting agency regarding questioned costs. Repayment of the questioned costs is dependent on the granting agency's review of the Department's documentation. Responses from each granting agency are pending.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

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Department of Social and Health Services (DSHS)

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**Audit Report:** 2009 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 law.

**Resolution:** The Department partially concurs with this finding. This finding was similar to the finding issued for Fiscal Year 2008. As a result of the 2008 finding, the Department planned to amend the Temporary Assistance to Needy Families (TANF) State Plan by eliminating the requirement to sanction 16- and 17-year-old children who are not in school. Also, the Department planned to revise the state rule and WorkFirst Handbook to reflect the change made to the State Plan. However, the Department was unable to implement these changes by the end of Fiscal Year 2009.

The Department proceeded with plans to modify the state rule, and the final state rule was adopted on July 14, 2009. In accordance with the Administrative Procedures Act, it became effective 31 days later. The WorkFirst Handbook was revised to reflect the rule change and also became effective August 14, 2009. The revisions eliminate both the requirement to sanction dependent 16- and 17-year-olds who are not in school and the requirement that these 16- and 17-year-olds attend school. The TANF State Plan was amended in November 2009 to reflect these changes.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

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**Department of Social and Health Services (DSHS)**

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**Audit Report:** 2009 F

**Finding Number:** 012

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

**Resolution:** Refer to page 59 for the joint response from the Departments of Early Learning and Social and Health Services on this finding.

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**Audit Report:** 2009 F

**Finding Number:** 013

**Finding:** The Department of Social and Health Services, Children's Administration, does not ensure the eligibility of foster care payment recipients prior to paying them.

**Resolution:** The Department concurs with this finding. The Department performed a comprehensive review to identify all cases that were paid using a source of funds not consistent with the eligibility of the client. These cases were corrected in FamLink, the Department's automated case management information system, which then automatically processed a correction to adjust the funding according to the correct eligibility information. FamLink uses eligibility information on the case to determine the correct source of funds and does not rely on a manual determination from the worker.

On March 1, 2010, the Department released the second phase of FamLink. This allows for additional edits that complement current controls. Two examples of the new system edits are ensuring a valid license is on file before allowing payment for a licensed service and not allowing an in-home service to a child that is in an out-of-home placement.

By June 30, 2010, all exceptions identified during the audit were addressed and funding implications determined. This was done through a process described above where eligibility information found in the payment history file in FamLink was not consistent with the source of funds codes used.

By December 31, 2010, any federal funds drawn down inappropriately will be refunded through the biweekly draw process facilitated by the Department's Office of Accounting Services.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

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**Department of Social and Health Services (DSHS)**

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**Audit Report:** 2009 F

**Finding Number:** 014

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

**Resolution:** The Department partially concurs with this finding. Monitoring of cases for children turning 18 is an area in which the Department is trying to improve. The Department does not agree with attaching questioned costs to cases where a scheduled review has not been done. The intent of a five-year review is not to verify eligibility, but to communicate with the adoptive parent and revisit their adoption agreement. There is no risk in overpayments associated with a five-year review. Exceptions identified in the audit where a five-year review was not conducted did not result in an overpayment, and reviews are no longer required by state law. Given this, the Department incurred no liability for not having performed them.

The Department took the following actions in response to the auditor's recommendations:

- During March 2010, the Department provided training on internal control procedures to staff in offices where internal control exceptions were noted. Program managers met with staff and developed a process that limits payments to children under 18 years old. This process will be used until FamLink, the Department's automated case management information system, is updated to alert staff when a child reaches seventeen and a half years of age.
- By December 31, 2010, the Department will review the cases for exceptions identified because of the ineligibility of the client. Where overpayments were made, corrections will be processed in FamLink, which will automatically return any federal portion of the payment.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

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Department of Social and Health Services (DSHS)

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**Audit Report:** 2009 F

**Finding Number:** 015

**Finding:** The Department of Social and Health Services' internal controls are inadequate to ensure it refunds the appropriate amount to the federal Medicaid program when overpayments to providers are found.

**Resolution:** The Department concurs with this finding. The Aging and Disability Services Administration (ADSA) and the Health and Recovery Services Administration (HRSA), currently known as the Medicaid Purchasing Administration (MPA), were both involved with this finding.

ADSA agrees with the information in the audit related to Home and Community Based waiver services. The information will be used to review all adjustments and ensure the correct Federal Medical Assistance Percentage (FMAP) rate is charged in the future. Due to administrative and budget-related actions, any adjustments that may be necessary will not be made until the end of December 2010.

MPA acknowledges that the Medicaid Management and Information System (MMIS), in place during the course of the audit, was not capable of identifying the correct FMAP rate for prior year adjustments. ProviderOne, which replaced MMIS, was implemented May 9, 2010. The new system has the capability to calculate the correct FMAP adjustment rate based on the original date of payment. In July 2010, MPA processed a correction for claims covering the period of October 1 through December 31, 2008. This resulted in an adjustment of \$351,299 in favor of the Department.

By December 30, 2010, MPA will complete adjustments for the January 1, 2009 through May 8, 2010 period. The delay is due to the implementation of ProviderOne and the availability of data in the new data warehouse. The necessary claims are being identified now and the appropriate accounting adjustments to the federal share will be included on the current quarter federal report.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

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Department of Social and Health Services (DSHS)

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**Audit Report:** 2009 F

**Finding Number:** 016

**Finding:** The Department of Social and Health Services did not have adequate controls to ensure it complied with federal requirements for allocating employee salaries and wages and other administrative costs in accordance with its Public Assistance Agency Cost Allocation Plan.

**Resolution:** The Department concurs that certain administrative costs were incorrectly allocated from May through August 2009; however, the Department does not concur with the questioned costs of \$12,163,750. The Department realized the error on August 18, 2009, and took action to correct the misallocation of funds. The cost allocation base information was updated immediately and correcting transactions were processed by the end of September 2009, before the federal claim was processed. Therefore, the Department believes no incorrect federal funds were drawn as a result of the error.

A written procedure was developed and implemented to mitigate the occurrence of future cost allocation base update errors. The procedure requires an Economic Services Administration fiscal staff person to conduct an internal review of cost allocation forms used to update base information prior to submission to the Office of Accounting Services for input. The procedure also requires an internal review of the information entered into the automated cost allocation system to verify that the information was input accurately.

The Fiscal Year 2009 statewide single audit has been distributed at the federal level. The Department is waiting to hear from federal agencies if any questioned costs need to be adjusted or repaid.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

**Audit Report:** 2009 F

**Finding Number:** 017

**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 concur with this finding for the following reasons:

- Most clients do not have 60 months of financial documents available to provide. This is a very onerous request to make of clients, most of whom have not transferred assets in order to qualify. The process that the client or Department would have to go through to provide that much history would be lengthy and expensive, and it would not meet the federal requirement that policies and procedures for determining eligibility must be conducted in a manner consistent with simplicity of administration and be in the best interests of applicants and recipients.
- The Department would have to pay banks and other financial institutions to provide archived documents that the clients no longer have per WAC 388-490-0005(7). The length of time it would take to request and then review a minimum of 60 financial documents, with the possibility of hundreds more if there are multiple accounts, would make it impossible to meet the Department's standard of promptness for Medicaid applications with existing staff. Many additional staff would be required. Requiring all clients to provide 60 months of bank statements would not be cost-effective.
- Requiring clients to provide five years of financial documents would only pertain to bank accounts that are declared. The Department does not have a system in place to identify undeclared bank accounts and other types of undeclared transfers which is the primary reason for reliance on self-declaration.

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 asset transfers that it becomes aware of through the written application, the subsequent interview, or other means. The Department is continuing the following processes:

- Staff routinely checks online county assessor systems to see if clients have transferred property within the county they reside in based on any known addresses. Most counties limit searches to addresses.
- If the bank statements from the last three or six months contain payments or credits that present red flags, staff looks as far into this as necessary to resolve the issue.
- If the client declares a transfer, staff requests and obtains verification and thoroughly evaluates that transfer to ensure it is consistent with Medicaid rules.
- If the interview is inconsistent with the application, staff evaluates and probes inconsistencies as necessary.
- If staff learns of possible transfers through other means, they always follow up and verify.

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The Department submitted policies and procedures to the Centers for Medicare and Medicaid Services (CMS) Region 10 in June 2009 requesting an opinion as to whether or not the federal guidelines were being met. In its December 2009 response, CMS indicated states have flexibility on implementing the five year look-back provision according to the general "rules of reason."

The Department believes the response from CMS validates the position that asking for financial documents for the entire look-back period is not required. The Department believes the methods described above meet the "rules of reason" test referred to by CMS in their email.

**Agency Contact:**

Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

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**Department of Social and Health Services (DSHS)**

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**Agency: 300**

**Audit Report:** 2009 F

**Finding Number:** 018

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

**Resolution:** The Department concurs with this finding. The Department does not have a process that provides Medicaid recipients with information on the number of hours billed to the Department by individual providers. The Department is in the process of procuring a Provider Compensation System (PCS) that will improve the verification process. The PCS will be a subsystem of ProviderOne, the new Medicaid Management Information System. It will generate monthly notices to all recipients informing them how many hours were paid to the provider on their behalf during the previous month. The recipients will be instructed to notify the Department if they notice a discrepancy in the hours provided versus the hours billed and paid.

Until the new system is implemented, the Department will rely on the following controls which are currently in place to ensure Medicaid recipients receive the services for which Medicaid is billed:

- Case managers complete an assessment that results in an authorization of hours that cannot be exceeded by a provider invoice.
- Recipients receive a copy of the service summary that tells them the number of hours of service they are eligible to receive. Recipients are advised that they can choose when those hours are provided and direct the individual provider when to provide them. Case managers also advise recipients to contact them if they are not receiving the hours (or care) for which they are eligible.
- Recipients are expected to keep copies of time sheets for their individual providers and case managers periodically review these time sheets and verify with the recipient that authorized services were provided. Case managers are instructed to document the review of time sheets 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.

Additionally, the Department took the following actions:

- In April 2010, the Department sent a letter to all currently authorized individual providers reminding them of their responsibilities as a contracted provider. Specifically, they were reminded of their obligation to maintain records and respond to inquiries to produce documentation.

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- Staff reviewed the document titled "Acknowledgement of My Responsibilities as the Employer of My Individual Providers" with all recipients who employ an individual provider. This activity was completed by October 31, 2010.

**Agency Contact:**

Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

**Audit Report:** 2009 F

**Finding Number:** 019

**Finding:** The Department of Social and Health Services, Health and Recovery Services Administration, does not comply with state law and the federal Deficit Reduction Act of 2005, thereby increasing the likelihood that the state is paying claims that should have been paid by liable third parties.

**Resolution:** Health and Recovery Services Administration is currently known as the Medicaid Purchasing Administration (MPA). MPA believes it is in compliance with state law and the federal Deficit Reduction Act of 2005. MPA meets this standard by making data available to all insurers to use for third-party liability (TPL) reporting and by matching data directly with those insurers most likely to provide third-party coverage to Medicaid recipients.

MPA's position was corroborated by an independent review. In November 2009, Health Management Systems (HMS) performed an assessment of the MPA's coordination of benefits (COB) operations, including recommendations addressing applicable legislation and state statutes. HMS is currently engaged with 40 Medicaid agencies to conduct TPL identification and recoveries. HMS brings a depth of subject matter expertise in Medicaid TPL best practices as well as a thorough understanding of current technologies and capabilities within the industry. The report indicated the following points (emphasis added):

- "In 2007, Washington passed Substitute House Bill 1826, updating its Medicaid data matching and recovery regulations as required by Section 6035 of the federal Deficit Reduction Act (DRA) of 2005. As a result, Washington's federal DRA compliant laws are fragmented across several sections of state statute . . . ."
- "However, despite the fragmentation, *Washington's law is compliant with the requirements set forth in the DRA . . . .*"
- "Current state statute instructs *health insurers* to determine joint-beneficiaries – those enrolled in both Medicaid and commercial health insurance."
- "The current language instructs DSHS to focus on the carriers with the highest probability of coverage. It does make sense for DSHS to focus efforts on carriers with large populations. However, these carriers should not be the sole focus."
- "Although improvements can be made to the State's data sharing and matching laws, it should be noted that *Washington has some of the strongest recovery language in the nation.*"

While MPA believes it currently meets legal requirements, the Department is further enhancing data-matching activities with the implementation of the new ProviderOne system which replaced the Medicaid Management Information System in May 2010.

Beginning in July 2010, MPA is now able to send an electronic COB eligibility inquiry to health plans who have signed trading partner agreements with the Department. The trading partners can respond electronically to eligibility inquiries to indicate the availability of third-party health care coverage at a particular time.

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MPA has no authority to compel insurers to sign a trading partner agreement. For those insurers or carriers who may not have their systems ready to participate electronically, MPA continues working with them using the methods currently in place.

**Agency Contact:**

Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

**Audit Report:** 2009 F

**Finding Number:** 020

**Finding:** The Department of Social and Health Services, Health and Recovery Services Administration, does not perform a quarterly retrospective drug use review of pharmaceutical claims data to identify patterns of fraud or abuse as required by federal and state law.

**Resolution:** Health and Recovery Services Administration is currently known as the Medicaid Purchasing Administration (MPA). This audit area continues to be one in which the auditors and MPA disagree on the intent and focus of the federal requirements. MPA's focus is on the appropriateness of prescribing physicians' drug selection; the auditors' focus is on the usefulness of the utilization review in detecting fraud. MPA has previously requested the Centers for Medicare and Medicaid Services (CMS), Region 10, review MPA's efforts to comply with this regulation and will continue to work with the auditors to verify compliance.

MPA believes that it is in full compliance with the federal rules for retrospective drug utilization review (DUR). Retrospective reviews are conducted for this purpose every quarter. An analysis is completed for each of the measures cited in the federal regulations, and the results of that analysis are reported to CMS. These results are reported on forms CMS specifically created for reporting the results, including overutilization, abuse, and misuse.

MPA's Pharmacy Policy Section uses pharmacy claim data to determine which drugs or classes of drugs will be the focus for each quarter. Predetermined standards are used along with a professional drug advisory committee to monitor all the measures, including overutilization, abuse, and misuse of any medication for that quarter. If "abuse" and/or "misuse" is identified in the process, the suspected abuser is referred to MPA's internal resources: Office of Patient Review and Coordination, the Quality Management Team Unit, the Payment Review Program Unit, and the Office of Payment Review and Audit (OPRA). MPA has designated OPRA as its contact point for referrals to the Medicaid Fraud and Control Unit (MFCU).

MPA's pharmacy administrator attended in-service trainings hosted by CMS to understand the DUR requirement and ensure MPA has activities in place that will support compliance. The pharmacy administrator contacted CMS in September 2009 to confirm that Washington Medicaid was in compliance with the federal requirements regarding retrospective and prospective DUR. The CMS pharmacist sent an email that, MPA believes, verifies Washington's compliance. The email states, in part:

*CMS finds that you are conducting your DUR program in accordance with Section 1927 (g) of the Social Security Act. You were acting appropriately to refer identified outliers to your internal audit and integrity section for further investigation. It is their responsibility to refer the case(s) on to MFCU if indeed fraud or abuse has been determined. The DUR program is designed to educate physicians and pharmacists*

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*and patients on therapeutic appropriateness, over and under utilizations, therapeutic duplication, drug-disease contraindications, drug-drug interactions as well as clinical abuse and misuse.*

In February 2010, MPA's pharmacy consultant attended the American Drug Utilization Review Symposium and met with CMS staff who confirmed that Washington was compliant with the federal regulations regarding retrospective DUR.

**Agency Contact:**

Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
[siegeaj@dshs.wa.gov](mailto:siegeaj@dshs.wa.gov)

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**Department of Social and Health Services (DSHS)**

**Agency: 300**

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**Audit Report:** 2009 F

**Finding Number:** 021

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

**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. The Department is in the process of procuring a Provider Compensation System (PCS) that will improve the verification process. PCS will be a subsystem of ProviderOne, the new Medicaid Management Information System. When implemented, the new system will generate monthly notices to all recipients informing them how many hours were paid to the provider on their behalf during the previous month. The recipients will be instructed to notify the Department if they notice a discrepancy in the hours provided versus the hours billed and paid.

Until the new system is implemented, the Department will:

- Inform recipients during annual assessments, as well as at the time of contracting with an individual provider, they are responsible for supervising their care provider. If a recipient is unable to do so, agency managed personal care may be available or the recipient and case manager can identify a representative who will monitor services. If a representative is not available, by policy the case manager who monitors the provision of services makes more frequent contacts with the recipient.
- Inform recipients that, as the employer, they can terminate their provider. Also, the Department has the authority to terminate payment if there is a good faith belief that services are not being provided as authorized to a Medicaid recipient.
- Staff is expected to review a sample of time sheets and this expectation was reinforced by a Management Bulletin issued in 2009.

The Department provides the recipient a document titled "Acknowledgement of My Responsibilities as the Employer of My Individual Providers" that explains the above information. Also, 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.

In April 2010, the Department sent a letter to all currently authorized individual providers reminding them of their obligation to maintain records and respond to inquiries to produce documentation.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

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**Audit Report:** 2009 F

**Finding Number:** 022

**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:** Health and Recovery Services Administration is currently known as the Medicaid Purchasing Administration (MPA). MPA does not concur with this audit finding. MPA believes there are sufficient controls in place to assure that managed care rates are set based on the verified managed care organizations' (MCO) actual costs of care. Actuarially certified, proprietary cost information is submitted directly to the MPA's actuary from the MCOs. MPA's actuary verifies the information submitted by comparing it to audited financial statements submitted to the Office of the Insurance Commissioner and encounter data submitted to the Department. The actuary also does analysis of prior years, compares MCOs to each other, and resolves outliers that arise from its analyses with the MCOs.

In addition, the MCOs each have compliant fraud and abuse controls to prevent provider fraud. These controls provide reasonable assurance that the data used in rate setting is accurate and complete. This assertion is supported by the fact that MPA has had no findings regarding rate setting in two Centers for Medicare and Medicaid Services (CMS) reviews and has had its rates consistently approved by CMS with their full understanding of the Department's rate setting methodology.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

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**Audit Report:** 2009 F

**Finding Number:** 023

**Finding:** The Department of Social and Health Services is not complying with staffing requirements in its Medicaid Eligibility Quality Control project agreement.

**Resolution:** In August 2009, the Department's Economic Services Administration (ESA) submitted a request for a one-year extension of the Medicaid Eligibility Quality Control pilot project to the Centers for Medicaid and Medicare Services (CMS). ESA noted in the request that the number of staff required to manage the project was reduced. CMS approved the request and notified ESA in October 2009.

ESA requested an extension at the reduced staffing level for federal Fiscal Year 2010, and again CMS approved the request. This process will be repeated annually as long as the pilot program continues.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

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**Audit Report:** 2009 F

**Finding Number:** 024

**Finding:** The Department of Social and Health Services, Health and Recovery Services Administration, does not have a system in place to adequately compensate for an inherent control weakness that is susceptible to errors and abuse.

**Resolution:** Health and Recovery Services Administration is currently known as the Medicaid Purchasing Administration (MPA). MPA concurs with the auditor's recommendation to strengthen controls over the entry of claims into the pharmacy point of sale (POS) system and will continue to explore and pursue these changes via the established system change control process. Some controls have already been identified that have the potential to provide enhanced information to pharmacies via POS. These changes are dependent upon additional information in the Coordination of Benefits (COB) portion of ProviderOne which was implemented in May 2010. MPA is also exploring the feasibility of other cost-avoidance methods including contracting with vendors for some COB eligibility reviews at the point of adjudication.

By December 2010, the ProviderOne System will be stabilized enough to allow providers to send and receive eligibility inquiries. MPA staff will also be able to perform these eligibility checks with other payers. When MPA staff verifies third-party liability (TPL) information from payers, they will update recipient's TPL information in ProviderOne.

MPA does not concur with the statement in the audit finding that, due to the lack of risk analysis and adequate post-payment audits, MPA cannot reasonably assure improper payments will be identified and recovered. This statement contradicts the State Auditor's Office report, *State Government Performance Review: Opportunities for Washington*, dated December 2009. In the Government Reform, Medicaid Pharmacy Overpayments section of that report, the auditor found that the Department "uses a risk assessment to prioritize and target pharmacy claims with high potential for a return of investment." The report further states that the risk assessment process is effective in identifying high-risk payments, but current MPA resources are limited and an opportunity for funding additional auditors was identified.

MPA has submitted a budget decision package requesting additional resources to increase its post-payment audit efforts and to investigate and determine available third-party resources. The decision package includes vendor services that will assist in automated data matching and leverage advanced technology to identify third-party resources and maximize cost avoidance and recoveries.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

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Department of Social and Health Services (DSHS)

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**Audit Report:** 2009 F

**Finding Number:** 025

**Finding:** The Department of Social and Health Services, Health and Recovery Services Administration, internal controls are inadequate to ensure errors identified by the Medical Eligibility Quality Control Unit are reviewed adequately and in a timely manner.

**Resolution:** Health and Recovery Services Administration, currently known as the Medicaid Purchasing Administration (MPA), concurs with this finding. In November 2008, MPA took action to establish internal controls and ensure errors identified by Medicaid Eligibility Quality Control (MEQC) audits are corrected by field offices in a timely manner by designating a program manager to process and monitor corrective actions for MEQC audits. The process is as follows:

- The MEQC program manager notifies MPA's audit liaison and MPA's regional representative of all MEQC audits;
- The MPA audit liaison notifies the regional representative within a specified time when an audit is outstanding and informs the representative that the field must take corrective action on the audit within a specified period of time; and
- All corrective actions are monitored by the MPA audit liaison and reported back to the MEQC program manager on a monthly basis until corrective actions are completed.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSSH)

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**Audit Report:** 2009 F

**Finding Number:** 026

**Finding:** The Department of Social and Health Services, Aging and Disability Services Administration, does not adequately monitor subrecipients to ensure Medicaid expenditures are allowable and supported.

**Resolution:** The Department concurs with this finding. During the time frame of this audit, Aging and Disability Services Administration (ADSA) resources were used to operate and train one Area Agency on Aging (AAA) while it received certification and became operational. Also during this time, ADSA staff worked with other AAAs to resolve findings from prior years' monitoring. Due to this workload, subrecipient monitoring, which was scheduled to begin in 2009, was delayed until 2010.

Approximately 98 percent of the referenced \$425 million for the 13 AAAs is for client services and the administration of those services. While fiscal and contract subrecipient monitoring did not occur during this time frame, all AAAs received in-depth monitoring of Medicaid case management, nursing services activities, and client services between May 2008 and December 2009. The monitoring is performed by a quality assurance unit within ADSA.

ADSA developed and implemented fiscal and contract subrecipient monitoring in state Fiscal Year 2010. This monitoring encompasses the programmatic and fiscal activities of the AAAs. As of November 2010, the Department conducted on-site reviews of four AAAs.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

**Audit Report:** 2009 F

**Finding Number:** 027

**Finding:** The Department of Social and Health Services did not ensure Medicaid services provided to undocumented aliens were allowable under its Alien Emergency Medical program.

**Resolution:** The Department does not concur with this finding. The Aging and Disability Services Administration (ADSA) and the Health and Recovery Services Administration, currently known as the Medicaid Purchasing Administration (MPA), were both involved in this finding. Each administration responded separately.

Aging and Disability Services Administration

Seventeen of the exceptions noted in the finding were for undocumented alien clients who received services from ADSA; however, they did not receive services under the Alien Emergency Medical (AEM) program. Fifteen of the clients received personal care services, 14 of these were minors who received those services from the Division of Developmental Disabilities. The minors were eligible for services under the state-funded "Categorically Needy Scope of Care," which is allowed by state law and Department rule.

Three of the above were undocumented clients who received long-term care services. The services were authorized through an "exception to rule." State-funded programs paid for the services these clients received.

All 17 of the ADSA clients were eligible for services that were 100% state funded. For this reason, the federal share identified by the auditor was not impacted.

Currently, tracking and maintaining cost adjustments to the federal share expenditures is a manual process requiring the use of spreadsheets to track the services received by individual clients. State dollars are transferred back to reimburse the Medicaid programs after expenditures are identified. This process will become automated when the ProviderOne phase two project is implemented, currently scheduled for late 2012.

ADSA has taken the following actions as a result of this finding:

- In June 2010, procedures were developed that ensure Medicaid funds for undocumented clients are used appropriately and are properly reported on the federal Medicaid reporting form.
- The federal Department of Health and Human Services was contacted to determine if any unallowable costs need to be reimbursed. Some questioned costs need to be reimbursed, and these adjustments will be completed by December 31, 2010.

Medicaid Purchasing Administration

MPA maintains that emergent conditions cannot be accurately identified using procedure codes. Many procedures can be used to treat both emergent and non-emergent conditions. MPA insists that the true indicator as to whether treatment was provided for an emergent condition is the diagnosis code, not the procedure code.

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On a quarterly basis, MPA identifies, by claim types and diagnoses codes, costs that are allowable for federal match and transfers those costs to earn federal match. All medical related costs for individuals who are covered under the AEM program are charged to state-only dollars.

**Agency Contact:**

Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

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**Audit Report:** 2009 F

**Finding Number:** 028

**Finding:** The Department of Social and Health Services' internal controls are inadequate to ensure the federal share of overpayments made to Medicaid providers are refunded to the federal government in a timely manner.

**Resolution:** The Department does not concur with this finding. The Department had a similar finding in Fiscal Year 2008. The Department discussed its process with the Centers for Medicare and Medicaid Services (CMS) auditor. The CMS auditor did not raise internal control concerns regarding the Department's accuracy and timeliness for refunding the federal share of overpayments to the federal government.

While the Department does not concur with the finding, significant staff training was completed within the last year. The training included the establishment of an internal monitoring process that ensures that the return of the federal share of overpayments is completed monthly and prior to the state's fiscal month close.

The Department will request that Health and Human Services (HHS) review the process identified in this audit finding during the federal clearing house audit process to ensure HHS is satisfied the overpayments have been properly refunded.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

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**Department of Social and Health Services (DSHS)**

**Agency: 300**

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**Audit Report:** 2009 F

**Finding Number:** 029

**Finding:** The Department of Social and Health Services did not ensure all individuals who receive Medicaid benefits have valid Social Security numbers.

**Resolution:** The Department partially concurs with this finding. This finding involved Economic Services Administration (ESA), Children's Administration (CA), and the Health and Recovery Services Administration (HRSA) which is currently known as the Medicaid Purchasing Administration (MPA). The following actions were taken in response to the audit recommendations:

ESA, CA, and MPA followed up on the exceptions identified in the audit.

- By September 2010, ESA reviewed and took appropriate action on all exceptions identified during the audit, and all actions were documented in the Automated Client Eligibility System.
- By the end of March 2010, CA took action on exceptions for which the administration was responsible. In reviewing the exceptions, CA determined only three of the nine identified for CA were actually claiming Medicaid. The three exceptions had a temporary SSN of 123456789 which is used by CA to get services started before the valid SSN is available. CA corrected the three cases and verified the SSNs.
- MPA resolved all exceptions identified during the audit. Cases were corrected and SSNs were verified in the state online query system. Also, ProviderOne, the new Medicaid payment system which was implemented in May 2010, allows certain cases to be closed and benefits removed from the client's medical services card when an individual has not provided a valid SSN within 60 days.

MPA staff in the Foster Care Medical Team (FCMT) continues to work with CA staff to identify and correct cases involving children with no SSN in out-of-home placement. FCMT staff works a "No SSN" list on a weekly basis and follows up with CA staff via email to request resolution on children in foster care without an SSN. A summary email is sent to the CA liaison at 30 days and 60 days when there is no SSN reported. Children in out-of-home placement are moved to state-only medical when there is no SSN provided and "good cause" cannot be established.

All financial staff from ESA and MPA were required to complete an interactive training module on SSN verification procedures. Training was completed in October 2010.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

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**Audit Report:** 2009 F

**Finding Number:** 030

**Finding:** The Department of Social and Health Services, Aging and Disability Services Administration, did not evaluate or re-evaluate the level of in-home care services for some clients at least annually.

**Resolution:** The Department concurs with this finding. The auditor determined that 618 out of 57,597 assessments appeared to be late. Due to staff reductions, the Department was not able to complete a line by line review of all 618 assessments. However, this equates to a compliance rate of 98.9% for assessments that were completed within the required time frame. The Department feels this is well within an acceptable threshold given the routine reasons why an assessment could be late, such as the client's inability to meet with the case manager to do the assessment or delays in locating a provider of personal care.

In May 2010, the Department contacted the Centers for Medicare and Medicaid Services, Region 10, to discuss questioned costs and whether or not they need to be repaid. The Department was informed the questioned costs will be addressed when the audit is reviewed.

**Agency Contact:** Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

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**Audit Report:** 2009 F

**Finding Number:** 031

**Finding:** The Department of Social and Health Services' internal controls are inadequate to ensure non-emergency medical transportation expenditures are allowable and adequately supported.

**Resolution:** The Department's Health and Recovery Services Administration is currently known as the Medicaid Purchasing Administration (MPA). MPA does not concur with this finding, but is making improvements to oversight of transportation brokers as described below.

During July 2010, MPA took the following actions:

- Trained staff involved in contract monitoring to ensure contract monitoring activities are recorded in the Agency Contracts Database (ACD).
- Developed a formal monthly desk review and on-site contract monitoring document to ensure monitoring activities are documented, properly recorded in the ACD, and that hard copies of monitoring documents are being maintained.
- MPA Contracts Services Steering Committee reviewed current transportation contracts in preparation for writing the request for proposal (RFP) for a new contract. Also, in conjunction with the steering committee review, an internal contract review process explored ways to improve monitoring activities.
- The Non-Emergency Medical Transportation (NEMT) and Division of Behavioral Health and Recovery workgroup investigated ideas to reduce transportation costs associated with transporting clients needing regular methadone treatment and improving the monitoring of trips provided under the Regional Support Network contracts. The workgroup is exploring the pilot ideas with counties. Pilot ideas were also shared with the Contracts Steering Committee. The feasibility of these ideas is under consideration.
- Developed a formal process allowing Clinical Utilization Management and Patient Review and Coordination staff to review medically complex client cases that are associated with increased transportation costs. Complex client cases are forwarded to medical staff for review.

By January 2011, MPA will take the following actions:

- Develop a database that will allow MPA to receive trip data from transportation brokers. Also, it will allow MPA staff to review individual trips to ensure they are authorized and appropriate. The information received by this trip database will substantially increase the program oversight activities of MPA staff, facilitating these important activities during this period of restricted travel. More specificity is not possible at this time because the data has not yet been received, but it is anticipated that additional monitoring protocols will result from this effort. Transportation staff will work with staff from both Information Technology's database administration support and Medicaid integrity office to best utilize the new trip-level detail.

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- Participate in developing and implementing an RFP that will result in a new contract that will better define allowable medical appointments and client and service eligibility. The new contract will be performance based.
- Review and strengthen contract language, policies, procedures, and guidelines to ensure robust monitoring. MPA's NEMT staff developed stronger monitoring language, policies, procedures, and guidelines and included them in the transportation contracts beginning January 1, 2011. Examples include additional broker reports on subcontract monitoring and inspections, an increased percentage of vehicle inspections, and an increased percentage of broker verification of provided trips to ensure contract requirements are met.
- Develop working agreements/memorandums of understanding with partner agencies to better define what constitutes allowable trips.

**Agency Contact:**

Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov

**Audit Report:** 2009 F

**Finding Number:** 032

**Finding:** The Department of Social and Health Services, Health and Recovery Services Administration's, internal controls are inadequate to ensure controlled substances prescribed for Medicaid clients are authorized and allowable.

**Resolution:** Health and Recovery Services Administration is currently known as the Medicaid Purchasing Administration (MPA). MPA does not concur with this finding and is of the opinion there are no federal or state statutes that require a payer (e.g. state) to validate the Drug Enforcement Administration (DEA) number of a prescriber. Therefore, MPA does not believe the lack of an edit that validates DEA for Schedule II-V drugs constitutes inadequate internal controls or renders the payments unallowable.

MPA believes that responsibility for compliance with controlled substance requirements lies with the prescribing provider and the dispensing pharmacies. There are no provisions in the federal 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. Below is a portion of the federal regulation which clearly states that the prescribing practitioner is responsible for assuring that the prescription conforms in all essential respects to the law and regulation:

*(a) A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription....*

MPA 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. While MPA considered this to be an essential validation to add to the POS, it was not implemented because of any federal or state requirement. Rather, MPA implemented this because Schedule II drugs are subject to the highest risk of abuse and it was prudent to provide this additional validation to guard against the potential for fraud and abuse.

Upon implementation of the new POS, the Schedule II edit occurs via a work-around that allows prescribers to submit either the DEA or National Provider Identifier (NPI) of the prescriber, and the POS ensures that the link between the two is valid. Because of the complexity of the work-around and because there is no national source for validation of NPI to DEA, the initial change request is currently on hold and the edit for Schedule II drugs will continue to function via the work-around.

In addition to the POS edit that validates the DEA for Schedule II drugs, MPA has a set of robust program integrity activities including pharmacy utilization review, pharmacy rules-based algorithms that identify improper payments, and data-mining activities that identify

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

**Agency Contact:**

Alan Siegel  
Department of Social and Health Services  
PO Box 45030  
Olympia WA 98504-5030  
(360) 664-6027  
siegeaj@dshs.wa.gov