

Status of Resolution of Audit Findings

December 2011

State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 033

Finding: The Department of Social and Health Services spent approximately \$2.7 million of federal Children Health Insurance Program (CHIP) money on unallowable administrative activities.

Resolution: This finding involved the Medicaid Purchasing Administration (MPA) which was previously an administration within the Department of Social and Health Services. Effective July 1, 2011, MPA was transferred to the State Health Care Authority. MPA concurs with this finding.

In February 2011, MPA established communication with program, fiscal and budget staff to ensure the operation, maintenance and fiscal review of the CHIP program includes all appropriate parties.

MPA developed internal financial procedures and monthly fiscal reports to monitor the CHIP expenditures to ensure the Administration does not exceed the administrative cap.

MPA implemented a process for the full recovery of the CHIP funds from the local health jurisdictions and recovered all the funds by July 2011. MPA coordinated repayment of the federal portion with the Centers for Medicare and Medicaid Services.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 034

Finding: The Department of Social and Health Services does not have adequate procedures to ensure compliance with earmarking requirements for the Children's Health Insurance Program.

Resolution: This finding involved the Medicaid Purchasing Administration (MPA) which was previously an administration within the Department of Social and Health Services. Effective July 1, 2011, MPA was transferred to the State Health Care Authority. MPA concurs with this finding.

MPA has taken the following actions to correct the deficiencies identified in the audit:

- In March 2011, MPA implemented processes and procedures to monitor, on a monthly basis, all Children's Health Insurance Program (CHIP) expenditures to ensure the Administration does not exceed the CHIP administrative cap.
- Monthly CHIP expenditure reports will be maintained tracking all CHIP expenditures for fiscal review. MPA recovered the CHIP administrative funds submitted to the local health jurisdictions in July 2011.
- MPA has coordinated with the Centers for Medicare and Medicaid Services to repay the federal portion.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 035

Finding: The Department of Social and Health Services does not have adequate procedures to ensure compliance with earmarking requirements for the Children's Health Insurance Program.

Resolution: This finding involved the Medicaid Purchasing Administration (MPA) which was previously an administration within the Department of Social and Health Services. Effective July 1, 2011, MPA was transferred to the State Health Care Authority. Refer to page 51 for the joint response from the State Health Care Authority and Department of Social and Health Services on this finding.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 037

Finding: The Department of Social and Health Services does not have an adequate process to identify ineligible Medicaid expenditures for nonqualified aliens at the time of payment, resulting in \$187,557 in questionable costs.

Resolution: This finding involved the Medicaid Purchasing Administration (MPA) which was previously an administration within the Department of Social and Health Services. Effective July 1, 2011, MPA was transferred to the State Health Care Authority. Refer to page 54 for the joint response from the State Health Care Authority and Department of Social and Health Services on this finding.

State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 038

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

Resolution: This finding involved the Medicaid Purchasing Administration (MPA) which was previously an administration within the Department of Social and Health Services. Effective July 1, 2011, MPA was transferred to the State Health Care Authority. MPA does not concur with the finding and will continue to work to clarify the issue.

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 disagrees that the lack of an edit that validates DEA for Schedule II – Schedule V drugs constitutes inadequate internal controls or that the lack of such validation renders the payment unallowable.

MPA believes that responsibility for compliance with controlled substance requirements lies with the prescribing provider and the dispensing pharmacies. The Controlled Substance Act (21 USC Sec. 821) and the State Uniform Controlled Substance Act (RCW 69.50) do not regulate payment for controlled substances and there are no provisions in either that could be interpreted as a requirement relating to payment of claims for controlled substances. Title 21 CFR Section 1306.04 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.

This finding indicates that since the previous 2009 finding, MPA has developed procedures to verify DEA for Schedule II drugs. That statement is incorrect. The automated edit procedure has been in place since 2002 when MPA implemented a pharmacy Point of Sale (POS) edit for the purpose of validating the DEA number of the prescribing physician for Schedule II drugs. MPA considered this to be an essential POS validation because Schedule II drugs are subject to the highest risk of abuse. MPA considered it prudent to provide this additional validation to guard against the potential for fraud and abuse.

MPA implemented a new pharmacy Point of Sale (POS) in October 2008. The POS design allowed the Administration to require and utilize the National Provider Identifier (NPI) as the prescriber identifier. The POS was designed to utilize a national file that associated the NPI to the DEA number, theoretically allowing a match of the NPI to DEA that enforces the Schedule II edit. However, at implementation it was discovered that the national file that associated NPI to DEA was not complete and did not meet the business

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needs of matching NPI to DEA. As a result, the Schedule II edit in POS is based on a work-around. The POS maintains a "prescriber network" of known NPI/DEA associations, and it is updated by MPA staff as new associations become known. The work-around includes manual updates to a "blocked prescriber list" that identifies prescriber DEA numbers prevented from prescribing Schedule II drugs.

There continues to be no complete external source of data that provides the NPI to DEA crosswalk. As a result, the work-around within the POS does not provide any external data file that can be utilized for analysis or that allows staff to query the data and match DEA with NPI. So while the POS automatically associates the NPI with DEA for adjudication, external review of the NPI/DEA associations requires manual lookup to document the association. MPA performed the following detailed claims analysis and responded to the auditors as follows:

- Transactions with an invalid DEA number (4,071 records): MPA reviewed the first 100 records in POS and found 100 percent were active in the POS prescriber file with valid DEA numbers. The prescriber file does not currently include DEA end dates.
- Transactions with an NPI number (9,946 records): A manual review of 50 records found 47 associations of NPI to valid DEA numbers. In three instances, only the NPI was in the prescriber network file. These three claims were paid because the NPI was not on the blocked Schedule II list.
- Auditors were provided with access to the POS as well as instruction on the screens showing how the NPI/DEA associations could be located.

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

MPA continues to research the availability of a complete external file that accurately and completely associates NPI to DEA. Other states are faced with similar difficulties in utilizing the NPI for prescriber identifier.

MPA will continue to work with the U.S. Department of Health and Human Services to determine if any questioned costs need to be reimbursed.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 040

Finding: The Department of Social and Health Services, Medicaid Purchasing 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: The Medicaid Purchasing Administration (MPA), previously an administration within the Department of Social and Health Services, was transferred to the State Health Care Authority effective July 1, 2011. MPA does not concur with the finding.

MPA continues to believe that it is in compliance with the Deficit Reduction Act (DRA) 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.

In January 2011, MPA signed a contract with Health Management Systems to perform automated data matches of MPA enrollment data against health insurance carrier files. This is intended to enhance TPL information in ProviderOne, MPA's primary provider payment processing system.

By January 2012, MPA will implement in ProviderOne the data exchange format published by the Centers for Medicare and Medicaid Services in June 2010. This new format serves as a tool to enable all states and all payers to use and comply with the DRA data exchange requirements. MPA is moving forward to incorporate this tool into ProviderOne to enhance cost avoidance and recovery activities.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 043

Finding: The Department of Social and Health Services did not ensure that all individuals who received Medicaid benefits had valid Social Security numbers.

Resolution: This finding involved the Medicaid Purchasing Administration (MPA) which was previously an administration within the Department of Social and Health Services. Effective July 1, 2011, MPA was transferred to the State Health Care Authority. Refer to page 60 for the joint response from the State Health Care Authority and Department of Social and Health Services on this finding.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 044

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

Resolution: The Medicaid Purchasing Administration (MPA), previously an administration within the Department of Social and Health Services, was transferred to the State Health Care Authority effective July 1, 2011. MPA does not concur with the finding.

MPA believes there are sufficient controls in place to assure managed care rates are set based on the verified managed care organizations' (MCO) actual costs of care.

The controls MPA has in place are:

- Actuarially certified, proprietary cost information is submitted directly to MPA's actuary. The actuary verifies the information submitted by comparing it to audited financial statements submitted to the Office of the Insurance Commissioner and to encounter data submitted to MPA.
- 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 rate-setting methodology.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 047

Finding: The Department of Social and Health Services, Medicaid Purchasing Administration, does not have adequate controls in place to ensure all individuals who receive Medicaid benefits are financially eligible.

Resolution: The Medicaid Purchasing Administration (MPA), previously an administration within the Department of Social and Health Services, was transferred to the State Health Care Authority effective July 1, 2011. MPA partially concurs with this finding.

The total children's medical caseload for July 1, 2009, through March 31, 2010, was 384,033. Two hundred cases were sampled and 15 cases were cited with exceptions. MPA agrees that two of the 15 cases lacked income documentation to determine if the clients were eligible for medical coverage. To address this, MPA took the following actions in January 2010:

- Staff was trained on income eligibility determinations and required documentation. Classroom instruction was and continues to be provided with handouts that can be used at the worker's desk to reinforce class learning. Specific training and handouts are provided on self-employment and corporations.
- Policy and procedure manual sections were updated with requirements on income calculations and documentation.
- Medicaid Eligibility Quality Control focused audits are performed on income eligibility requirements, calculations and documentation to ensure staff follow rules and procedures.

MPA disagrees with the other thirteen cases, which contained procedural errors, even though the clients remained eligible for medical benefits. The procedural errors amounted to weak verification of determining reportable household income for self-employed individuals. Additionally, per RCW 74.09.402 (WAC 388-416-0015), children's medical cases remain open for a 12-month continuous certification period, regardless of changes other than death, moving out of Washington State or aging out of the program. This means that any increase in income during the audit certification period would not affect the children's eligibility during those 12 months.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 048

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: This finding involved the Medicaid Purchasing Administration (MPA) which was previously an administration within the Department of Social and Health Services. Effective July 1, 2011, MPA was transferred to the State Health Care Authority. MPA concurs with this finding.

MPA acknowledged that on-site monitoring of activities for the transportation brokers was not completed according to the monitoring plan for 2010. This was primarily due to budget restrictions. Also, the workload required for the re-procurement of non-emergency medical transportation (NEMT) contracts was considerable.

To address this finding, MPA is reviewing broker subcontractors' monitoring schedules, broker incident/accident reports and broker invoice packets. MPA is also reviewing and resolving broker complaints.

Additionally, MPA took or will take the following actions:

- The broker's fleet inventory reports were reviewed in February 2011.
- The Trips database was developed and tested in March 2011. This database allows for improved monitoring capabilities. The database also allows MPA to match a client's trip to a covered medical service.
- By the end of December 2011, desk audits of all NEMT brokers will be completed, along with site visits of those brokers.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 050

Finding: The Department of Social and Health Services paid Medicaid providers for services that were not provided to Medicaid beneficiaries.

Resolution: This finding involved the Medicaid Purchasing Administration (MPA) which was previously an administration within the Department of Social and Health Services. Effective July 1, 2011, MPA was transferred to the State Health Care Authority. Refer to page 66 for the joint response from the State Health Care Authority and Department of Social and Health Services on this finding.

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December 2011

State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 051

Finding: The Department of Social and Health Services, Health and Recovery Services Administration, does not have adequate procedures to ensure Medicaid is the payer of last resort for pharmacies.

Resolution: The Health and Recovery Services Administration was renamed the Medicaid Purchasing Administration (MPA). MPA, previously an administration within the Department of Social and Health Services, was transferred to the State Health Care Authority effective July 1, 2011. MPA does not concur with this finding, but will take the following actions to strengthen internal controls:

MPA plans to enhance functionality related to third party payers in ProviderOne by December 2012 through implementation of a change request. Until then, MPA will continue to allow providers to make eligibility checks with ProviderOne that include known third party payer information.

In June 2010, the Centers for Medicare and Medicaid Services announced recommended transmission formats for sharing eligibility and benefit information. The formats are the Payer Initiated Eligibility/Benefit Transaction and the Accredited Standards Committee. MPA will be pursuing implementation of these transaction formats.

On an ongoing basis, as resources are available, MPA will retrospectively examine pharmacy claims for the use of third party liability override codes.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 052

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

Resolution: The Medicaid Purchasing Administration (MPA), previously an administration within the Department of Social and Health Services, was transferred to the State Health Care Authority effective July 1, 2011. MPA does not concur with this finding. MPA does ensure that all requirements for Durable Medical Equipment (DME) providers are met.

Although MPA does not concur with this finding, the following actions are being taken to improve services:

- MPA made a change request to the ProviderOne vendor, CNSI, to allow a data exchange of professional and facility license information between MPA and the Department of Health. This data exchange was implemented in July 2011. The next step is to test the update in the ProviderOne system which will prevent payments associated with expired licenses. Testing is in its final stage with an estimated implementation by January 2012.
- Business licenses were not captured in the Medicaid Management Information System (the system that preceded ProviderOne). The business license field is new to the ProviderOne system. It is a requirement for enrollment to document the business license dates. ProviderOne automatically sends the provider a letter 30 days prior to the expiration date of a business license. The provider is required to then send the Provider Enrollment Unit proof of an updated license. There is currently no edit in place to deny claims on business license end dates. This edit will be put into place by February 2012.
- Beginning in April 2011, new federal regulations require states to perform pre- and post-enrollment site visits of newly enrolling DME providers and current DME providers as their enrollment is updated. Regulations allow that states may accept the results of Medicare's or another state Medicaid agency's screening results (i.e. if the provider is already a Medicare provider and Medicare has done the pre- and post-enrollment site visit). MPA is taking all steps necessary to comply with these new federal requirements.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 053

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

Resolution: The Medicaid Purchasing Administration (MPA), previously an administration within the Department of Social and Health Services, was transferred to the State Health Care Authority effective July 1, 2011. MPA does not concur with this finding.

MPA believes that it is in full compliance with the federal rules for retrospective drug utilization review. The Centers for Medicare and Medicaid Services (CMS) has provided previous validation that MPA's retrospective Drug Utilization Review reports meet all federal requirements.

MPA will submit its required annual Drug Utilization Review report to CMS for federal fiscal year 2010.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2010 F

Finding Number: 055

Finding: The Department of Social and Health Services, Medicaid Purchasing Administration, did not ensure managed care premium payments were paid only for Medicaid eligible clients, resulting in the loss of approximately \$1 million of public funds.

Resolution: The Medicaid Purchasing Administration (MPA), previously an administration within the Department of Social and Health Services, was transferred to the State Health Care Authority effective July 1, 2011. MPA concurs with this finding.

MPA conducted a thorough analysis of the data submitted by the auditors and concluded that the small group of cases cited was accurately described. The findings were a result of limitations within the legacy Medicaid Management Information System.

With the implementation of ProviderOne in May 2010, this limitation was resolved. Currently, MPA has established business rules that will cancel enrollment of ineligible clients when their eligibility changes between cutoff and premium payment.

By June 2012, MPA will refund the federal dollars identified in the audit to the Centers for Medicare and Medicaid Services.

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