

## Status of Resolution of Audit Findings

December 2011

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 1004476

**Finding Number:** 001

**Finding:** The Department of Social and Health Services, Children's Administration, did not comply with documentation requirements designed to ensure it properly charged administrative costs to the federal Social Services Block Grant.

**Resolution:** The Department concurs with this finding and agrees the timeliness of reporting time study information is directly related to its accuracy.

Children's Administration (CA) is utilizing the Random Moment Time Study (RMTS) process within FamLink (a case management system) to ensure only those surveys meeting all requirements are being used for cost allocation. The new FamLink RMTS system is programmed to accept only surveys that meet the required criteria (i.e., case number associated to certain activity codes, time frame deadlines, etc.).

In addition, CA implemented approved protocols and established procedures that allow for analytical reviews in order to address any deficiencies in the system or sampling data. RMTS program specialists have the responsibility of ensuring the samples fall into these protocols and procedures which are based on both verbal and written communication from U.S. Department of Health and Human Services through CA management. Data is also extracted and periodic reports are run from FamLink to ensure the system is sampling workers correctly and that surveys are being filled out and compiled accurately.

The audit revealed 12 samples were out of compliance. However, out of the 12 samples it was determined that only three surveys were considered disallowable. Based on approved protocol and guidelines within the CA RMTS program and national statistical standards set by federal agencies through the Division of Cost Allocation, the remaining three samples are considered statistically insignificant and, therefore, would not result in disallowed costs.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

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**Audit Report:** 1005061

**Finding Number:** 001

**Finding:** The Department of Social and Health Services does not consistently prevent, identify, track or pursue collection of payroll overpayments, resulting in loss of public funds.

**Resolution:** The Department concurs with this finding. The Department has several ongoing processes in place to help ensure staff process payroll overpayments appropriately, including the following:

- Payroll staff in headquarters regularly communicates with time keepers, Human Resources staff and payroll processing staff to ensure they have timely and accurate information.
- The Department recently consolidated payroll services and is continually reviewing, evaluating and refining the payroll processes for effectiveness and to ensure overpayments are identified and tracked with follow up.
- The Department updated the identification and tracking process with an overpayment code report. This allows for logging and tracking of overpayments.

In addition, the Department has taken or will take the following actions:

In April 2011, the Chief of Staff and Senior Director of Human Resources distributed a memo to appointing authorities (individuals with delegated authority to hire, fire and recommend disciplinary action) that outlined expectations of supervisors and managers regarding the completion of payroll forms.

In June 2011, the Department:

- Developed an auditing process used by the Human Resources Management System (HRMS) processing unit and staff located in institutions, who are responsible for inputting data into HRMS. The audit process is intended to detect incorrect entries and correct them before payroll processes.
- Reviewed and updated previous internal assessments of Office of Financial Recovery program compliance with the auditors' best practices.

The Department is re-establishing regular time and attendance training and developing payroll processing training. The training will be provided to and coordinated with institutional payroll staff. Three of the re-established time and attendance classes were held in October and November 2011, including one in Spokane. The Department's expectation is to provide the class on a quarterly basis at a minimum.

By February 2012, the Department will re-evaluate and restore resources to reach and maintain timely tracking and reconciliation of payroll records with general ledger activity.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

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**Audit Report:** 1005061

**Finding Number:** 002

**Finding:** The Department of Social and Health Services overpaid \$70,761 for client support and services and risks making overpayments in the future.

**Resolution:** This finding involved the Aging and Disability Services Administration (ADSA), Children's Administration (CA), and the Economic Services Administration (ESA). All three administrations concur with the finding and are taking corrective action.

### Aging and Disability Services Administration

ADSA will take the following actions to address the audit finding:

- In December 2011, ADSA will develop criteria to identify duplicate payments that could support a report aimed at reducing or eliminating duplicate payments. ADSA will also develop reports based on the criteria identified.
- In January 2012, ADSA will test the new reports, verify their effectiveness and move them into production.

### Children's Administration

In December 2010, CA established edits in FamLink (a case management system) that will help prevent overpayments and identify potential overpayments. The new edits are working according to design. CA has also begun new initiatives to instill a new approach to payment integrity that involves statewide consistency in practice and a more concerted collaboration with its Technology Services to actively and timely look for known situations that have lead to overpayments.

The overpayments identified during the audit were reviewed. Those confirmed to be overpayments were referred to the Department's Office of Financial Recovery (OFR) for collection.

### Economic Services Administration

ESA worked with internal and external stakeholders, including the Department of Early Learning, and has taken the following actions to prevent duplicate child care payments:

- The Working Connections Automated Program (WCAP) system within Barcode (DSHS child care program tracking system) is being updated to collect historical payment authorization information. WCAP will use this historical information to prevent services for the same child from being paid twice. This functionality is targeted for release in January 2012.
- Staff was retrained on how to accurately process payments through the Social Service Payment System in error-prone payment situations (i.e., situations that may result in duplicate payments). Training was completed in September 2011.

On an ongoing basis ESA is:

- Requiring supervisors and lead workers in the Statewide Provider Unit to review the Duplicate Payment Report monthly to identify duplicate child care payments. When a duplicate child care payment is identified, the Provider Team will issue an

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overpayment notice to OFR, requesting collection of the overpaid amount from the child care provider.

- Requiring Working Child Care Connections (WCCC) supervisors and lead workers to perform audits on one percent of cases on a monthly basis. When a duplicate child care payment is identified during an audit, an overpayment notice is sent to OFR, requesting collection of the overpaid amount from the child care provider.
- Working with the Department's Payment Review Program to run annual algorithm reports. The reports identify potential duplicate payments for licensed family homes and child care centers. Confirmed duplicate payments are passed on to OFR, requesting collection of the overpaid amount from the child care provider.

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**Audit Report:** 1005061

**Finding Number:** 003

**Finding:** The Department of Social and Health Services did not comply with state contracting laws and its own policies to ensure public funds were used appropriately.

**Resolution:** This finding involved the following administrations: Aging and Disability Services Administration (ADSA); Children's Administration (CA); Economic Services Administration (ESA); Juvenile Rehabilitation Administration (JRA); and the Division of Vocational Rehabilitation (DVR). All administrations concur with the finding except DVR which only partially concurs. Each administration provided individual corrective action plans and responses to the finding.

### Aging and Disability Services Administration

ADSA has taken or will take the following actions:

- Since September 2009, ADSA has used a reporting system that captures payments made against signed contracts in the Agency Contracts Database (ACD), initiated quarterly regional meetings that provide training and technical assistance on state and Department contracting policy and procedures, and ensured all headquarters-based contracts had a risk assessment and monitoring plan on file.
- The Risk Assessment and Monitoring Plan (RAMP) workgroup completed a risk assessment for each contracted service and drafted contractor risk assessment and monitoring tools for the regions to use for their contracts.
- The RAMP workgroup is creating standardized procedures and training intended to ensure a risk assessment and monitoring plan is completed on all contractors and is maintained in the contract file. The workgroup presented risk assessment and contractor tools to the regional field service administrator and began the discussion of procedures. These discussions will continue through February with the final procedures planned for release in March 2012.
- ADSA's contract manager will continue holding quarterly GoTo meetings and monitoring input into the ACD.

### Children's Administration

In February 2011, new contract managers received mandatory training from Central Contract Services (CCS), the Department's contract unit, and contract staff participated in teleconferences regarding contract requirements and policies.

As required by policy, contract staff saves risk assessments and monitoring plans for each contract to the CA shared drive annually to allow others to refer to them. Staff enters monitoring activities, as stated in their respective monitoring plans for their contracts, into the ACD per Department policy. All activities are monitored and verified by supervisors.

### Economic Services Administration

In July 2010, ESA distributed a memo to staff informing them that, prior to receiving access to the ACD, staff must undergo the appropriate contracts training offered through the CCS. On a quarterly basis, the ESA contracts officer pulls a report directly from the

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ACD, comparing staff listed as ESA program management and contract contacts to the CCS training roster, to ensure they have received the mandatory ACD training.

In December 2010, ESA updated its Contract Monitoring Plan to state that on-site monitoring visits will be entered into the ACD. Also, monitoring reports will be imported into the ACD Document Management Screen. All other documentation will be maintained in the office of record contract file.

Department policy was revised to require each division's monitoring activities to adhere to that division's yearly Monitoring Plan. The plan addresses compliance for staff who conduct on-site contractor monitoring and document findings and other relevant information into the ACD. Each division's contract officer is responsible for checking the ACD for completed on-site monitoring documentation.

### Juvenile Rehabilitation Administration

In May 2011, JRA clarified with contract managers/monitors the Department's expectations regarding contract monitoring activities that need to be entered into the ACD.

JRA's Grants and Contracts manager will ensure all JRA staff responsible for managing or monitoring contracts has the required CCS contracts training and documentation of that training with CCS. JRA is tracking completion and reporting progress to management on a quarterly basis. The target date for completion is March 2012.

JRA identified high usage medical providers and is working to develop the necessary contracts with these and other medical providers that are currently being utilized. This work includes conducting research on contracting language, developing a standard contract template, and negotiating and executing the contracts. Due to the unique nature of the Administration's client population, potential complexity of negotiating these contracts, and available staff resources, the estimated completion date is March 2012.

### Division of Vocational Rehabilitation

By April 2011, DVR reviewed all existing contracts to ensure risk assessments and monitoring activities were conducted and recorded in the ACD. Risk assessments and monitoring activities are ongoing. For new contracts, a risk assessment is developed during the intake phase. Monitoring activities occur on a daily basis for those contracts where the risk assessment identified the contractor or services as high risk.

By April 2012, DVR will examine client service payments without contracts in the ACD and identify the necessary steps to meet the Office of Financial Management (OFM) and Department policy requirements. This will be done in coordination with CCS, OFM, and the Attorney General's Office.

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**Audit Report:** 2010 F

**Finding Number:** 002

**Finding:** The Department of Social and Health Services, Economic Services Administration, did not comply with federal regulations regarding support of salaries and wages paid to employees.

**Resolution:** The Department concurs with this finding.

The Department's Economic Services Administration (ESA) has taken action to correct the deficiencies identified in the audit. The following describes the actions:

In January 2011, ESA's Operation Support Division (OSD) updated their Business Center Process Manual that is used by Community Services Division (CSD) Business Center staff. The updates to the manual reflect federal requirements. Quarterly reviews are now a requirement. OSD headquarters staff held a conference call with CSD regional business managers to explain this process change.

In February 2011, ESA staff notified the Department's Office of Accounting Services (OAS) office chief that the Department's policy regarding time certifications needs to be brought into compliance with the federal requirements. The Department's policy on time certifications has been revised by OAS and referred to the Department's Accounting Policy Management Board where further revisions were made. The policy is scheduled for executive review in December 2011.

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**Audit Report:** 2010 F

**Finding Number:** 003

**Finding:** The Department of Social and Health Services did not issue retroactive food assistance payments in accordance with federal law.

**Resolution:** The Department completed the corrective action plan resulting from the audit finding, as follows:

- The Department refined the process to refer overpayments to the Office of Financial Recovery. This was completed in March 2011.
- By April 2011, the Department took action on the exceptions identified during the audit. Where appropriate, the Department established overpayments for unallowable payments.
- By May 2011, the Department retrained field staff on the proper calculation of retroactive payments.

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**Audit Report:** 2010 F

**Finding Number:** 006

**Finding:** The Department of Social and Health Services, Division of Behavioral and Health Services, does not ensure Justice Assistance Grant subrecipients are registered in the Central Contractor Registration database as required by federal regulation.

**Resolution:** The Department concurs with this finding.

In April 2011, the Department initiated the following process to ensure that any future federal funds that include the requirement to register in the Central Contractor Registration (CCR) database will be monitored by Department staff:

- The Department will confirm the requirement is included in the award instructions received from any federal agency.
- The Department will use the CCR to review the status of any potential subrecipient. If the subrecipient is listed in the CCR, the Department will proceed with a contract. If the subrecipient is not listed, the Department will require the potential subrecipient to register.
- The Department will confirm the registration is completed before issuing a contract to the subrecipient.

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## Status of Resolution of Audit Findings

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**Audit Report:** 2010 F

**Finding Number:** 007

**Finding:** The Department of Social and Health Services did not provide adequate information to its Justice Assistance Grant subrecipients, nor did it monitor subrecipients' use of those funds.

**Resolution:** The Department concurs with this finding.

In April 2011, the Department began:

- Ensuring that federal funds listed in any subrecipient contract includes the grant name and federal award number, and that the amount of federal funds associated with the contract is listed on the contract's face sheet. Also, the Department will highlight the amount of federal funds noted on internal documents and the contract itself.
- Reviewing the monitoring protocols used by the Division of Behavioral Health and Recovery staff that is responsible for contracts to ensure the protocols comply with subrecipient monitoring requirements and Department policy.

Also, according to current business practice, the Department continues to:

- Review and approve monthly invoices from counties.
- Have the counties monitor prevention/treatment services available from their providers.
- Monitor county records during the biennial review of the county community services contracts. Records reviewed include billing documents and supporting documentation of services rendered.

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**Audit Report:** 2010 F

**Finding Number:** 023

**Finding:** The Department of Social and Health Services is not complying with federal requirements for suspension and debarment for the federal Vocational Rehabilitation Program.

**Resolution:** The Department concurs with this finding. The Division of Vocational Rehabilitation (DVR) was the program within the Department that received the finding.

By the end of December 2011, DVR is anticipating that work with Central Contract Services (the Department's contracts unit) and the Attorney General's Office to review terms and conditions will be completed. A recommendation will be made on suspension language that should be added to terms and conditions. Also, DVR will begin including a review of a contractor's suspension and debarment status as part of their monitoring of contractors.

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**Audit Report:** 2010 F

**Finding Number:** 024

**Finding:** The Department of Social and Health Services is not complying with federal requirements for time and effort documentation for the Vocational Rehabilitation Program.

**Resolution:** The Department partially concurs with this finding in that the time certifications from October 2009 to March 2010 did not include staff who left employment during this certification period.

The Department does not concur with the questioned costs. Thirty-five employees out of 350 division employees did not have certifications from October 2009 to March 2010. During the course of the audit, 33 of the employees were certified as having worked 100 percent on Vocational Rehabilitation grant activities. Since then, the remaining two employees have been certified.

The Department has taken the following actions to ensure payroll certifications are completed:

- In January 2011, supervisors were informed they have to double check the certifications to ensure they include all staff who worked during the certification period.
- In May 2011, time certifications were developed using salary and benefit expenditure information from the state's payroll system allowing certifications to be reconciled to payroll costs charged to the grant.

The Department was informed by the federal grantor that the questioned costs are not required to be reimbursed.

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**Audit Report:** 2010 F

**Finding Number:** 028

**Finding:** The Department of Social and Health Services requested federal grant funding in excess of its immediate needs.

**Resolution:** The Department concurs with this finding. The errors occurred as a result of the American Recovery and Reinvestment Act (ARRA) funds adjustments which caused inadvertent "draw downs" of federal funds over a four quarter period. The draw downs were not noticed immediately because the Department's Grants Management System (GMS) does not interface with the federal Payment Management System (PMS).

Economic Services Administration (ESA) was the administration responsible for errors with ARRA funds. In October 2010, ESA contacted the Department's Office of Accounting Services (OAS). OAS is responsible for preparing and submitting the Cash Management Improvement Act annual report of interest liability to the Office of Financial Management. All inappropriately received federal funds were returned in October 2010.

In April 2011, the Department developed a quarterly reconciliation procedure to ensure that the GMS and the PMS data match. OAS has agreed to send quarterly PMS reports to staff assigned responsibility for the quarterly reconciliation.

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

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**Audit Report:** 2010 F

**Finding Number:** 031

**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 76 for the joint response from the Departments of Early Learning and Social and Health Services on this finding.

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**Audit Report:** 2010 F

**Finding Number:** 032

**Finding:** The Department of Social and Health Services, Children's Administration, is not ensuring the eligibility of clients receiving adoption assistance payments.

**Resolution:** The Department concurs with this finding. The Department believes control procedures are in place to avoid payments for adopted children over ages 18 and 21. The process works very well in most regions across the state.

The Department has taken the following actions to address the deficiencies identified during the audit:

- In January 2011, a memo was sent to staff that described the established procedures that are to be followed for monitoring case files and ensuring eligibility requirements are met.
- In April 2011, all exceptions were processed. As part of the review process, the overpayments were processed automatically returning the federal share of the payment.

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**Audit Report:** 2010 F

**Finding Number:** 035

**Finding:** The Department of Social and Health Services did not have adequate internal controls to accurately identify and claim all eligible Children's Health Insurance Program expenditures.

**Resolution:** This finding involved the Aging and Disability Services Administration (ADSA) and 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. Both ADSA and MPA concur with this finding.

The specific actions ADSA and MPA have taken are:

- In March 2011, a Children's Health Insurance Program (CHIP) work group was established that is comprised of MPA, ADSA, and other Department staff as needed. The purpose of the group is to communicate availability of funding and regulation changes and to establish a system to identify CHIP-eligible costs.
- In April 2011, the CHIP work group:
  - Evaluated CHIP regulation revisions and their impact on the ability to claim CHIP funds.
  - Developed a process/procedure for communicating the status of CHIP funding availability on a routine basis.
- In May 2011:
  - The work group established a process for identifying CHIP clients and transferring CHIP-eligible expenditures when necessary.
  - MPA established a routine process to identify all Medicaid-eligible costs for CHIP reimbursement.
- In August 2011:
  - ADSA established a routine process to identify all Medicaid-eligible costs for CHIP reimbursement.

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**Audit Report:** 2010 F

**Finding Number:** 036

**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 billed.

**Resolution:** The Department concurs with this finding. The Department has plans to implement the Provider Compensation System (PCS) by the end of 2012 which will allow for an automated review process. PCS will be a sub-system of ProviderOne and is designed to generate intermittent, random notices to 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.

Until PCS is implemented, 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. 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.
- 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 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 time sheets for their individual providers. Case managers periodically review these time sheets and verify with the client that authorized services have been 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.

In June 2011, the Department's Aging and Disability Services Administration (ADSA) conducted a pilot review of randomly selected individual provider time sheets within the Division of Developmental Disabilities. This review will go ADSA-wide within the next year. The review found most individual providers were compliant with time sheet requirements. For those that were not, action was taken ranging from issuing a warning to processing an overpayment to terminating the individual provider's contract.

State of Washington

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**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 Aging and Disability Services Administration (ADSA) and 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. Both ADSA and MPA concur with this finding.

ADSA has taken or will take the following actions to correct the deficiencies identified during the audit:

- In July 2011, ADSA trained field staff on how to identify client citizenship and assign correct Social Service Payment System (SSPS) codes when authorizing services.
- SSPS codes were established for state-only clients in August 2011. Authorizations for existing clients are being corrected.
- Because Medicaid funding is no longer allowable for emergency services for ADSA clients, expenditures are transferred quarterly to state-only funding until new authorizations using state-only SSPS codes are established.
- Staff reviewed clients on the list of exceptions identified by the auditors to determine whether or not they are eligible for Medicaid. If they are not eligible, costs were transferred to state-only funding. ADSA is working on correcting SSPS codes on all authorizations.

MPA has taken the following actions:

- In January 2010, a procedure was developed and implemented where the client's eligibility is federally verified at the time of application. An interface with the Social Security Administration is used to confirm social security numbers (SSN) and citizenship status.
- In June 2011:
  - A process was developed to move claims for Medicaid services provided to nonqualified aliens from Medicaid to state only. The process entails periodic identification of non-citizens with invalid SSNs. This list is then passed to financial staff who identifies the non-emergent Medicaid claims data from ProviderOne and perform an accounting adjustment to shift these dollars to state-only funds.
  - MPA followed up on the questioned cost relating to managed care insurance premiums, dental services, and other services including physician visits, prescription drugs, family services and vision identified as being provided to nonqualifying aliens and coordinated with the Centers for Medicare and Medicaid Services (CMS) to determine if any related Medicaid funds must be returned. MPA is awaiting the CMS response.

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**Audit Report:** 2010 F

**Finding Number:** 039

**Finding:** The Department of Social and Human Services, Aging and Disability Services Administration, did not ensure the level of in-home care services for some clients was evaluated at least annually.

**Resolution:** The Department partially concurs with this finding. The Department reviewed the 10 exceptions identified by the auditors as being at least five months late. The Department determined two of the 10 clients had annual assessments completed within the required time frames; however, due to computer anomalies, they were coded as late. There was documentation in both clients' Service Episode Record that documented the situation. The other eight clients remained eligible for services during the time their assessments were out of date. There are routine reasons an assessment may not be included within the required time frame. Some examples are the client's inability to meet with the case manager, delays in locating a provider of personal care, and delays caused in obtaining specialized medical equipment or making environmental modifications. Also, a client may have been admitted to a nursing facility or hospital or had a break in service that nullified the annual assessment due date.

During this audit cycle, the Department completed 59,570 assessments. The auditors identified 662 assessments as being more than 30 days late. If these 662 were actually late, this amounts to a compliance rate of 98.9 percent which is well within an acceptable threshold given the routine reasons why an assessment could be late. The Department has set a benchmark of 100 percent for compliance with assessment timeliness.

The Department took the following actions to address the recommendations of the auditors:

- In February 2011, the Department reviewed the Quality Assurance Monitoring Tool used in the quality assurance cycle. The tool ensures the level of care assessment for clients receiving in-home care is performed at least once every twelve months.
- In June 2011, the Department contacted the U.S. Department of Health and Human Services (HHS). The HHS analyst informed the Department questioned costs will be reviewed after the audit results are received through the federal clearinghouse.

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**Audit Report:** 2010 F

**Finding Number:** 041

**Finding:** The Department of Social and Health Services did not ensure all Medicaid providers were eligible to participate in the program.

**Resolution:** The Department concurs with this finding. Medicaid dollars were used to reimburse an excluded party who happened to be a parent provider. The excluded party (parent provider) provided the client services, as authorized, and was paid for those services. During the audit period, parent providers were exempt by state law from background checks. This exemption will change in 2012 when all providers, including parent providers, will be required to be fingerprinted as part of the background check process.

The Department has taken or will take the following actions in response to the audit finding:

- In June 2011, the Department contacted the federal grantor. A journal voucher was processed that transferred expenditures from federal to state. The funding was returned on the third quarter 2011 federal claim report.
- By March 2012, the Aging and Disability Services Administration will develop a process to identify excluded and debarred providers.

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

**Agency: 300**

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**Audit Report:** 2010 F

**Finding Number:** 042

**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 there are not adequate controls in place to ensure Medicaid payments to in-home service providers were allowable and supported. The Department is anticipating the Provider Compensation System (PCS) will be implemented by the end of 2012. PCS is a sub-system of ProviderOne that will generate intermittent notices to clients informing them of the number of hours providers were paid in the previous month. This will assist clients in determining if the hours an individual provider worked are the same as the hours they were paid.

Until the PCS is implemented, the Department has the following controls in place:

- As part of their client assessment, case managers authorize a certain number of hours a provider can provide care. These hours cannot be exceeded by a provider invoice because the Social Service Payment System will not process payments in excess of the authorized hours.
- Clients are informed they need to retain copies of their provider's time sheets. This will allow case managers to periodically review a sample of client's time sheets and verify services were provided.
- During 2010, the Department:
  - Reviewed with clients their responsibilities as the employer of their individual providers. This will continue with new clients.
  - Sent individual providers a written notice of their obligation to keep a record of in-home services provided to Department clients.
  - Began auditing randomly selected samples of individual providers' time sheets to determine that services billed are consistent with time sheet documentation submitted.

The Department has taken the following corrective actions as a result of this finding:

- In April 2011, the Department developed and provided a training module to the case management staff of the 13 Area Agencies on Aging. The training focused on the requirement that case managers review client's time sheets and verify authorized hours have been provided.
- Also in April, the Department revised the Case Management Program training curriculum to include an emphasis on review of time sheets.
- In June 2011, the Department:
  - Audited a random sample of individual providers' time sheets to determine if services billed are consistent with time sheets.
  - Contacted the U.S. Department of Health and Human Services (HHS) and was told by the HHS analyst that questioned costs would not be reviewed until the audit results were received through the clearinghouse.

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- In August 2011, the Department sent written notification to individual providers regarding their obligation to keep a record of in-home services they provide to Aging and Disability Services Administration clients.

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**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 Children's Administration (CA), Economic Services Administration (ESA), and 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. Each administration provided individual responses.

Children's Administration

CA concurs with this finding. Only two of the exceptions identified during the audit were related to CA. In February 2011, CA initiated the process to obtain the correct social security numbers (SSN) for the two clients.

Economic Services Administration

ESA concurs with this finding. By March 2011, ESA took actions to address the exceptions identified during the audit.

Additionally, in conjunction with the Medicaid Purchasing Administration, ESA has requested enhancements to their automated systems. The enhancements, which are expected to be implemented by January 2012, will include:

- Automation of the State Online Query (SOLO) SSN verification process at the time of application.
- System generated edits and assignments to ensure accurate processing and follow-up of cases with missing or invalid SSNs.

Medicaid Purchasing Administration

MPA partially concurs with this finding. MPA is of the opinion that the audit sample of the total caseload of 1.1 million clients was not valid. This sample consisted only of cases that might be in error – in effect, inflating the number of potential errors that might exist within the total Title XIX and Title XXI caseloads. By comparing to the total 1.1 million cases, the audit team initially found 8,727 potential errors, a 7.9 percent potential error rate. But of that number of potential errors, the audit team found only 410 actual errors, or a 0.047 percent error rate. In addition, only 84 of the cited errors were under Medicaid's control, resulting in a Medicaid error rate of only 0.009 percent.

During July 2010, MPA took action on the 84 exceptions identified as belonging to MPA. The cases were either corrected or closed. Of the cases, 72 (86 percent) were Take Charge family-planning-only. In the past, these clients have received one medical identification card covering a 12-month certification period. Beginning in May 2010, however, the Medicaid payment system changed to ProviderOne. This system only shows one month of a client's eligibility, which enables the Department to close Take Charge certifications when needed. This new functionality in ProviderOne will eliminate the Take

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Charge problem since the Department regularly terminates these cases when eligibility ends, rather than waiting until the end of the certification period as before.

During September 2010, MPA staff received training in the procedures for requiring and verifying SSNs. Also in September, MPA began auditing two percent of Take Charge cases and 10 percent of Medical Eligibility Determination Services applications. These audits are reviewed monthly.

MPA shares monthly reports on cases that lack SSNs or have invalid SSNs with ESA, allowing workers in either administration to correct them quickly. Staff has now been trained on the need for SSNs and how to verify them through the State Online Query. In addition, the Eligibility A-Z manual has been updated with the most current procedures.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

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**Audit Report:** 2010 F

**Finding Number:** 045

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

**Resolution:** The Department does not concur with this finding. The Department disagrees with the auditors for the following reasons:

- Most clients do not have proof of all financial activities that occurred during the last five years, which would be all of their financial statements from banks and other financial institutions. 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 an agency's policies and procedures for determining eligibility must be conducted in a manner consistent with simplicity of administration and in the best interests of applicants and recipients.
- The Department would have to pay banks to provide archived statements 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 bank statements, with the possibility of hundreds more if there are multiple accounts at different banks, 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.
- Unless transfers were made with the intent of qualifying for long-term care benefits, the Department cannot impose a transfer penalty. RCW 74.08.080(2)(g) states that "the burden is on the department to prove by a preponderance of the evidence that the person knowingly and willingly assigned or transferred the resource at less than fair market value for the purpose of qualifying for medical assistance." Applicants who have or had enough resources to consider transferring assets are usually applying for public assistance for the first time. If transfers occurred between 2 - 5 years prior to applying, the Department finds that those persons were usually unaware of Medicaid policies at that time because they were in reasonably good health, were not contemplating future long-term care needs, and were simply helping family members. If they were transferring assets to qualify that long ago, it is often difficult to prove. Generally, specific planning for future Medicaid eligibility occurs within a few months of the application.
- Requiring clients to provide five years of bank statements would only pertain to bank accounts that are declared. No system is 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. Applicants complete the DSHS Application for Benefits. This form specifically asks if the applicant or applicant's spouse has sold, traded, given away, or transferred a resource in the last five years, and if so, what and when. The application states that the person signing it is declaring an

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understanding that they can be criminally prosecuted for making a false statement or failing to report something. The signature certifies and declares under penalty of perjury under the laws of the State of Washington that the information given is true and correct.

In addition, the Department is taking the following actions:

- Staff routinely checks online county assessor systems to see if clients have transferred property within the county they reside in.
- 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 that 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.

The Department submitted policies and procedures to the Centers for Medicare and Medicaid Services (CMS) in June 2009 asking for an opinion as to whether or not federal guidelines were being met. CMS responded on December 22, 2009. CMS indicated that states have flexibility in implementing the 5-year look-back provision according to the "general rules of reason."

The Department believes the CMS response validates the position that asking for bank statements 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.

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**Audit Report:** 2010 F

**Finding Number:** 046

**Finding:** The Department of Social and Health Services, Economic Services Administration, does not have adequate controls to ensure sufficient action is taken to correct errors identified by the Medical Eligibility Quality Control Unit.

**Resolution:** The Department concurs with this finding. In April 2010, the Department formalized monitoring procedures for assigning, tracking and following up on the correction of errors identified through the Medical Eligibility Quality Control (MEQC) reviews.

The specific procedures are as follows:

1. Upon completion of an MEQC project review, the MEQC Unit creates a spreadsheet (problem report) identifying potential errors.
2. This spreadsheet is uploaded to the Barcode system and sent to the MEQC program manager at the Medicaid Purchasing Administration (MPA) for distribution to the field.
3. The MPA MEQC program manager classifies the problem report by Community Services Division, Customer Service Center district (region), based on where the client resides.
4. Each district-specific report is sent to the appropriate district contact (a supervisor in the district office) for correction.
5. The district contact (supervisor) assigns the case errors to staff in the district call center for correction.
6. The district contact reports back to the MPA MEQC program manager upon completion of the corrections. Corrections are then reported back to the MEQC unit.

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**Audit Report:** 2010 F

**Finding Number:** 049

**Finding:** The Department of Social and Health Services did not have adequate controls to ensure the federal share of overpayments made to Medicaid providers are refunded to the federal government in an accurate and timely manner.

**Resolution:** The Department concurs with this finding. While the Department's Office of Financial Recovery (OFR) has found that monthly reminders to Administrations have not been effective in ensuring timely overpayment referrals, OFR will comply with current policy while working to change the policy and implement effective refund practices. Policy revisions have been made and are under review. The Department anticipates the review will be completed by the end of December 2011.

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**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 Aging and Disability Services Administration (ADSA) and 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. Both ADSA and MPA concur with this finding.

Aging and Disability Services Administration (ADSA)

ADSA will continue its work to strengthen processes to provide a timelier and more consistent way to inform field staff about deceased clients. Currently, field staff receive this information from a variety of sources, including relatives, death notices in the papers, and Automated Client Eligibility System-Social Security data exchange matches. There is no Departmental or legal requirement to notify field offices. The availability and consistency of this information will improve when phase two of ProviderOne is completed, tentatively scheduled for the summer of 2013. At that time staff should have uniform access to the same data sources for information about client deaths.

ADSA took the following action in April 2011:

- Provided the Payment Review Program (PRP) the client list with dates of death. This assisted the PRP in determining if there are algorithm improvements that will assist in strengthening procedures for identifying deceased beneficiaries.
- Established overpayments for those payments identified after the audit began.

In November 2011, ADSA reimbursed federal share costs to the federal grantor.

Medicaid Purchasing Administration (MPA)

The audit identified transactions totaling \$3,266 in payments made through the Medicaid Management Information System (MMIS) that were paid after the date of death. In January 2011, the date of death was documented in MMIS and the payments have been recouped.

The audit recommended that MPA "continue to strengthen procedures for identifying deceased beneficiaries to prevent overpayments in the future." MPA continues to be a stakeholder in a Department of Health (DOH) initiative that will provide online access to DOH death data. The initiative will provide death data in a timelier manner, but has yet to be implemented. DOH remains dependent upon counties for receipt of death data, resulting in a delay in receiving the information. Due to this delay, DSHS will continue its successful post-pay review activities by using the quarterly DOH death data file to identify and recoup claims paid for deceased clients.

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**Audit Report:** 2010 F

**Finding Number:** 054

**Finding:** The Department of Social and Health Services, Aging and Disability Services Administration, billed approximately \$600,000 to the Medicaid program for services provided to ineligible individuals.

**Resolution:** The Department concurs with this finding. Department staff within Aging and Disability Services Administration (ADSA) was not aware of the correct process and client eligibility criteria for charging funds to the State Children's Health Insurance Program (SCHIP) grant. ADSA worked with other administrations within the Department, including the Medicaid Purchasing Administration (MPA) and the Economic Services Administration, to ensure that expenditures are properly charged to the SCHIP grant and not Medicaid.

In August 2011, the Department:

- Obtained reports from MPA that assisted in identifying eligible SCHIP clients.
- Established Social Service Payment System codes for state-only and SCHIP-enhanced clients and moved unidentified clients to state only until correct funding determinations can be made.
- Established a routine process for identifying and transferring SCHIP-eligible expenditures.
- Worked with the Centers for Medicare and Medicaid Services and the Department's Office of Accounting Services. The outcome was that some of the expenditures were moved to the SCHIP 2010 grant. A journal voucher was completed that moved all eligible CHIP expenditures. Ineligible expenditures were moved to state-only funding.

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**Audit Report:** 2010 F

**Finding Number:** 057

**Finding:** The Department of Social and Health Services, Aging and Disability Services Administration, Division of Behavioral Health and Recovery, did not comply with the federal requirement for independent peer reviews for the Substance Abuse Prevention and Treatment Block Grant.

**Resolution:** The Department concurs with this finding.

The Department created the Behavioral Health Advisory Council (BHAC). The BHAC was developed jointly by the Mental Health Policy Council and the Chemical Dependency Citizen's Advisory Council. The BHAC is responsible for facilitating and overseeing the peer review process. Eight chemical dependency professionals and eight treatment agencies volunteered to act as peer reviewers.

The Department trained the peer reviewers in the peer review process. Peer reviews of treatment programs were held during July and August 2011. The BHAC submitted the final report to the Substance Abuse and Mental Health Services Administration on December 1, 2011.

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