
State Health Care Authority (HCA)

Agency: 107

Audit Report: 2012 F

Finding Number: 042

Finding: The Health Care Authority does not have adequate controls to ensure Medicaid is the payer of last resort.

Resolution: The Authority disagrees with this finding and maintains that adequate controls are in place to assure that Medicaid is the payer of last resort. The following items demonstrate the priority of the work and items that the Authority has put in place to strengthen third-party liability controls.

- The Office of Program Integrity (OPI) has dedicated 1.8 full-time auditors to reviewing pharmacy third-party liability claims for inappropriate use of override codes. The data retrieval has been improved with a better data query, which has reduced the audit time required. In addition, OPI has implemented audits that identify aberrant patterns and requests providers to perform a self audit of their claims.
- The Authority has also strengthened coordination of benefits controls by contracting with Health Management Systems (HMS) to provide supplemental third-party liability recoveries for the Authority. The Authority is in month 26 of the HMS contract. To date \$9.1 million in supplemental recoveries has been posted.
- The OPI has analyzed other potential changes to the system, including an edit that would require a valid date in the other payer date field if an override code were present on the claim. Since these fields are contained in different segments of the claim transaction, they are not easily configurable, and this system edit is not considered cost effective at this time. However, the OPI will continue to look for ways to enhance third-party liability controls.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2012 F

Finding Number: 043

Finding: The Health Care Authority does not have adequate controls to ensure providers meet initial and ongoing eligibility requirements to participate in the Medicaid program.

Resolution: The Authority is now in compliance with this requirement. Regarding licensing, the Provider Enrollment Unit ensures providers have appropriate licenses when first determining eligibility, as well as throughout their enrollment with the Medicaid program. A direct link with the Department of Health (DOH) has been established to automatically update licensing information, which ensures the Provider Enrollment Unit has each provider's most current license information. If a DOH license has expired, ProviderOne ends the taxonomy associated with the provider's file, preventing any further payment to the provider.

As of March 25, 2011, the Patient Protection and Affordable Care Act (ACA) introduced new screening procedures for providers and suppliers. The ACA identifies Durable Medical Equipment (DME) providers as moderate to high-risk business partners who require unscheduled, unannounced site visits. The Authority has finalized written policies and procedures to comply with the ACA. Site visits are now being conducted and new staff has been approved to carry forward this assignment and increased duties in the future.

The Authority ensures that newly enrolled DME providers have a physical location as a prerequisite of enrollment with the Authority.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2012 F

Finding Number: 044

Finding: The Health Care Authority did not have adequate controls to ensure violations of Medicaid laws and regulations by providers are identified and referred to the Medicaid Fraud Control Unit (MFCU), risking the loss of public resources.

Resolution: The Authority does not concur with this finding. The Authority maintains that adequate controls are in place to ensure that violations of Medicaid laws and regulations are identified and referred to the Medicaid Fraud Control Unit (MFCU) in a timely manner. The analysis completed by the auditors focused on cases that are entered and tracked through the Authority's Case Tracking System and assigned to Surveillance and Utilization Review (SUR) staff.

The entry of cases into the Case Tracking System should not be considered, by itself, a suspicion of fraud or abuse because all complaints are entered. Rather, the system is used to track a variety of cases with appropriate time frames for follow-up for each type of case. Cases that have sufficient evidence to justify an allegation of fraud require the entry of additional information to indicate that the case has been referred to the MFCU. Cases are tracked until resolved.

Some cases are entered in the case tracking system as placeholders and reminders for staff to follow up with additional review. In addition, there has historically been no consistent criterion for utilization of the drop down labeling in the system so the categories may not be consistent. The Authority complies with the provisions of federal regulations regarding preliminary investigations and full investigations. The Authority complies with all federal reporting requirements related to numbers of investigations and detailed processes for conducting each type. A Case Tracking Report can be generated upon request that will show the preliminary and full investigations.

In short, this finding identifies inconsistencies in the Authority's use of its Case Tracking System rather than any actual deficiency in identification of fraud or referral to MFCU. The auditor's scrutiny assisted the Authority in identifying the need for more consistency in the use of the Case Tracking System. However, it is wrong to conclude that the Authority does not have control of its caseload and does not refer all appropriate cases to MFCU based upon the length of time a case has been open in the Case Tracking System. Processes are in place to prioritize the work of SUR investigators, ensuring that the Authority is addressing those cases with the highest potential for fraud, waste, and abuse and is properly utilizing resources to focus on cases that yield the highest return on investment. In September 2013, the Office of Program Integrity hired a payment review program manager who will help streamline processes and provide consistency in how the cases are tracked in the Case Tracking System.

State of Washington

Status of Audit Resolution

December 2013

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2012 F

Finding Number: 045

Finding: The Health Care Authority's inadequate internal controls over claims from Federally Qualified Health Centers led to payments of more than \$1.4 million for charges improperly calculated and claimed.

Resolution: The Authority agrees with this finding.

Currently, the internal controls for Federal Qualified Health Centers (FQHC) overpayments and improper billings rely more heavily on post-pay claims review and recoupment rather than denial at the point of claim submission.

The Authority will make the appropriate updates to the system and billing guides for FQHCs so that the system edits will prevent overpayments and improper billings at the point of claim submission. This will include denial of claims without a qualifying encounter service being billed for the same client on the same day, as well as multiple billings for one client for the same day that should be included in one encounter billing.

The Authority will work with its internal audit staff to recoup the improperly paid claims and will work with the U.S. Department of Health and Human Services to determine treatment of questioned costs.

As of October 2013, system modifications have been designed, but need to be input into the system and tested before being moved into production. The Washington Administrative Code and Medicaid Provider Guide (MPG - formerly known as the Billing Instructions) changes have been requested.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2012 F

Finding Number: 046

Finding: The Health Care Authority improperly claimed \$48,365.31 in federal reimbursement for the Medicaid program.

Resolution: The Authority agrees with this finding and concurs that 162 claims were erroneously paid after the clients' dates of death.

The Authority has reviewed and recouped all the payments identified by the auditors as paid to deceased persons.

The Authority continues to strengthen procedures to improve the immediate documentation of a client's death. For managed care and fee-for-service payments, ProviderOne does capture and recoup paid claims when notified of a date of death through the Automated Client Eligibility System, the eligibility source system. In addition, the Authority will continue to receive death data from the Department of Health to assist with the proper identification of client death information. The Authority will continue to refine post payment processes to capture this information for timely recoveries.

The Authority has reviewed all payments to ineligible people cited by the auditors and concurs with the auditor's findings. The Authority has corrected any case errors and will arrange repayment of any federal funds received in error by January 2014.

The Authority will strengthen training processes already in place by sending a social security number (SSN) verification reminder memo to Community Services Division staff. The Authority will continue to pursue enhancements to verification procedures that promote SSN accuracy. The Authority anticipates SSN accuracy will improve under health care reform because clients will input their own SSNs and will get instant feedback if an input error is made.

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State Health Care Authority (HCA)**Agency: 107**

Audit Report: 2012 F

Finding Number: 047

Finding: The Health Care Authority's internal controls are insufficient to ensure payment rates for its Healthy Options managed care program are accurate.

Resolution: The Authority continues to disagree with this finding but will take the following actions in an effort to resolve the repeat findings on this issue:

- The Authority will use encounter data submitted from the Managed Care Organizations (MCOs) for the next rate-setting activities. The MCOs will no longer submit encounter data directly to the Authority's actuary.
- With the implementation of a new Medicaid payment system and a new Fraud and Abuse Detection System, Washington Medicaid has launched a Managed Care Program Integrity Initiative. The purpose of the initiative is to assess the quality and completeness of encounter data provided by MCOs and to conduct analyses that identify potential fraud, waste, and abuse. If encounter data problems are identified, the Authority will prepare a report with actionable information for the plans. Subsequent encounter data validation runs will determine progress by the MCOs in remediating the identified issues.
- The Authority is also participating with the auditors in the performance audit of the MCOs.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2012 F

Finding Number: 048

Finding: The Health Care Authority did not complete the required automatic data processing (ADP) risk analysis and system security reviews of ProviderOne, the new Medicaid Management Information System, risking the loss of Medicaid program assets and jeopardizing Medicaid program integrity.

Resolution: The Authority partially agrees with this finding. The Authority considers the safeguarding of personally identifiable and protected health information a top priority and has required controls in place. However, the Authority agrees that additional independent review will strengthen the Authority's ability to ensure that the ProviderOne vendor has effective controls in place.

For automatic data processing assets under its direct control, the Authority has implemented security controls consistent with the Washington State Office of the Chief Information Officer (OCIO) Security Standards, federal regulations, the Health Insurance Portability and Accountability Act Security Rules, and other guiding and regulatory documents. Examples of controls include but are not limited to the following:

- Utilization of services provided by Consolidated Technology Services to secure the network perimeter.
- Implementation of user device endpoint protection to guard against malware and other threats.
- Encryption of confidential data where appropriate.
- Development of applications which protect against common exploits.
- Active management of user access controls.
- Implementation of password standards consistent with OCIO requirements.
- Appropriate response to security incidents.

As of September 2013, the ProviderOne vendor provided the Authority with Service Organization Control (SOC) examination reports from subcontractors.

The ProviderOne vendor will complete documentation for SOC controls by December 31, 2013.

The ProviderOne vendor will undergo the SOC examination the first quarter of calendar year 2014 and every two years thereafter.

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State Health Care Authority (HCA)**Agency: 107**

Audit Report: 2012 F

Finding Number: 049

Finding: The Health Care Authority does not comply with the data-sharing requirements of 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 Authority continues to disagree with this finding.

The Authority maintains that it is in compliance with the Deficit Reduction Act of 2005 and applicable state law. The Authority 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.

The Authority's position on compliance was further corroborated by an independent review conducted by Health Management Systems (HMS) in March 2010. The review stated that HHS's review of the Department of Social and Health Services (the Medicaid Agency at the time) "confirms a strong Medicaid TPL program..." This report also noted areas of industry best practices that the Authority could explore to enhance its cost avoidance and recovery. As a result of this review, the Authority entered into a contract with HMS to strengthen and improve its efforts in the area of TPL recoveries as HMS provides for enhanced data-matching to better identify a client's medical insurance coverage. The contracted activities include conducting electronic data exchanges with health insurers, and verifying and updating the insurance eligibility of Medicaid recipients for billing liable third parties on behalf of the Authority.

Additionally, in 2013 the Authority implemented the Payer Initiated Eligibility Benefit (PIE) Transaction tool developed by the Centers for Medicare & Medicaid Services. PIE was developed as the national standard for payers to share information with Medicaid agencies.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2012 F

Finding Number: 050

Finding: The Health Care Authority did not adequately monitor subrecipients to ensure Medicaid Administrative Match expenditures are allowable and subrecipients obtained federal compliance audits.

Resolution: The Authority agrees with the finding and has implemented the following corrective actions:

To improve oversight, the Medicaid Administrative Match program added a fiscal component to its monitoring of school districts and local health jurisdictions. Beginning June 1, 2012, the Authority uses a random sampling process to select time study participants for the time frame being monitored. The Authority compares the actual salaries and benefits of those selected through this process to salaries and benefits claimed for those participants.

The Authority also reviews direct and indirect claimed costs for the same period monitored.

Additionally, effective November 2012, all contract monitoring tools have been updated to include verification of compliance with subrecipient audit requirements as part of the Authority's onsite desk monitoring process. One staff member has been assigned the task of tracking receipt of needed audits from subrecipients, reviewing them, and ensuring audit findings are addressed.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2012 F

Finding Number: 051

Finding: The Health Care Authority does not perform the federally required retrospective drug use review of pharmaceutical claims data to identify patterns of fraud or abuse.

Resolution: The Authority continues to disagree with this finding.

The Authority performs ongoing periodic review of pharmaceutical claims data to identify fraud, waste, or abuse, which satisfies federal requirements. The Authority performs claim review and analysis in multiple offices including but not limited to the Office of Program Integrity (OPI) mentioned in the finding. The Authority does not assert that the claims analysis performed by OPI satisfies federal conditions on its own. Analysis performed in OPI, by the Quality Management Team, and the Patient Review and Coordination Program work together to satisfy federal requirements.

The auditors were provided with information in October 2012, detailing three claim review and analysis algorithms performed by OPI during state fiscal year 2012. Two of these three are not mentioned in this finding despite their details having been submitted to the auditors.

Additional analyses were performed by OPI during the same period that were not detailed for the auditors because they did not result in opportunities for recoupment (i.e., additional reviews were performed which looked for but did not find significant fraud, waste, abuse, or billing errors).

In addition to the work of OPI, the agency's Quality Management Team performed 175 claim analyses of individual prescribers in federal fiscal year 2012, and the Patient Review and Coordination program performed 4,249 individual client claim analyses.

The Authority is very interested in working with the auditors to provide additional information or clarification to eliminate this repeat audit finding in the future.

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Status of Audit Resolution

December 2013

State Health Care Authority (HCA)

Agency: 107

Audit Report: 2012 F

Finding Number: 052

Finding: The Health Care Authority cannot be sure it is properly claiming Children's Health Insurance Program (CHIP) funds.

Resolution: The Health Care Authority agrees with the finding and has taken corrective action.

The Authority developed a report using data from the Medicaid Management Information System to identify claims by Recipient Aid Category and Federal Poverty Level based on net income. The report was implemented for state fiscal year 2013 beginning with the quarterly transfer for July-September 2012, which was processed in January 2013.

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State Health Care Authority (HCA)**Agency: 107**

Audit Report: 2012 F

Finding Number: 053

Finding: The Health Care Authority's inadequate internal controls over claims for dental services led to more than \$648,000 in overpayments to providers.

Resolution: The Authority has or will take the following corrective action:

- Fluoride treatment for children. The Authority agrees that the Medicaid billing guide, Washington Administrative Code (WAC) and the ProviderOne system are not aligned. It is the Authority's intent to allow fluoride with applicable age/annual limits, per client, per provider consistent with the Medicaid provider guide. An update to the WAC is in progress. No recovery is necessary.
- Dental Cleanings. The Authority found system issues that have been corrected, and the Authority's Division of Program and Payment Integrity is in the process of recouping overpayments.
- Dental X-rays. The Authority agrees that the billing guide and WAC are not aligned with the ProviderOne payment system. It is the Authority's intent to pay for necessary diagnostic X-rays per client, per provider. The Authority is in the process of updating the WAC and billing guides, and any payments made outside of these limitations will be identified and recouped by the Authority.
- Oral Evaluation Services. The Authority agrees that there were system issues for most of the overpayments. The Authority is in the process of updating the WAC and billing guide to allow for additional evaluations for clients managed by the Department of Social and Health Services' Aging and Disability Services Administration.
- Limited Visual Evaluations and Family Oral Health Education. The Authority paid both services with a miscellaneous code, and was unable to set up automated system limitations. However, the Authority now has new codes with edits for the limited visual evaluation as of January 1, 2013, and has set up system limits for both services. The Authority has submitted requests to the Office of Payment Integrity to identify overpayments and recoup funds.

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State Health Care Authority (HCA)**Agency: 107**

Audit Report: 2012 F

Finding Number: 054

Finding: The Health Care Authority does not have adequate controls in place to verify services billed by providers with Medicaid beneficiaries in accordance with federal laws, risking the loss of Medicaid resources.

Resolution: The Authority does not agree with the finding and disagrees that the Medical Service Verification (MSV) process lacks adequate controls.

Historically, the MSV process has proven to have no value in detecting fraud. The Authority prioritizes its program integrity and surveillance and utilization review resources in areas that have been proven to yield a higher return on investment. For example, the toll free hotline, hot tips and statistical studies have the potential to develop into a significant case and yield higher returns than MSVs. Therefore, the Authority maintains a position that spending resources on MSV processing actually reduces its ability to focus on program integrity activities that increase controls.

Of the 30 MSVs noted in the audit as "lacking follow-up," the Authority maintains that resources dedicated to these MSVs were appropriate given the process and the dollar values at stake:

- Thirteen (including three that were paid at zero and a fourth with 39 cents at risk) were not followed up because the amounts paid did not warrant the purchase of translation services (average of \$68 per MSV).
- Another six (with an average of less than \$12 per MSV) were not followed up because the clients could not be located.
- Of the 11 remaining, 10 MSVs (with an average paid amount of \$28) received no follow-up when, for instance, clients checked every box, checked no boxes, or completed the form when the service in question was provided to another member of the household.

The audit also identified 20 surveys sent to clients that should have been excluded. The Authority notes that the Centers for Medicare and Medicaid Services (CMS) manual suggests that states review "a sample of at least 400 recipients each month." In 2012, the Authority reviewed an average of more than 700 MSVs per month, 75 percent more than suggested. In terms of fraud detection, the Authority believes this exceptional number of MSV reviews more than compensates for the 20 MSV cases that should have been excluded.

The Authority will continue to refine its selection process for MSV reviews and will continue to meet federal MSV requirements. A system change request is in process for refining the universe of claims included so that only categories that meet federal MSV requirements are selected.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 2012 F

Finding Number: 055

Finding: The Health Care Authority did not ensure that all individuals who received Medicaid benefits had valid Social Security numbers.

Resolution: The Authority concurs with this finding. The Authority will continue to send monthly "NO SSN" reports to Community Services Division for correction. Many of the 206 clients with no social security number (SSN) identified in the audit have had their Medicaid terminated or they received Medicaid for services for which a SSN is not required, such as labor and delivery or alien emergency medical services.

The Authority's foster care medical team has changed processes to add the SSN for children in adoption support. Of the 14,000 children in adoption support, approximately 90 percent now have a SSN listed in the Automated Client Eligibility System (ACES). Before this change, the SSN had been verified but it was not input in ACES.

The Authority has sent a memo outlining procedures for verifying SSNs in order to ensure that staff involved in the verification process are following the correct SSN verification procedures.

The Authority will continue to pursue enhancements to verification procedures that promote SSN accuracy. The Authority anticipates SSN accuracy will improve under Health Care Reform due to the client inputting their own SSN and getting instant feedback if an input error is made.

The Authority will pay back the federal share for any payments made on ineligible persons by January 2014.

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Status of Audit Resolution

December 2013

State Health Care Authority (HCA)

Agency: 107

Audit Report: 2012 F

Finding Number: 056

Finding: The Health Care Authority did not have adequate controls to ensure the federal share of overpayments to Medicaid providers is refunded to the federal government in a timely manner.

Resolution: As part of the Authority's process for auditing providers to identify overpayments, draft audit reports are issued as a preliminary step. The draft reports are subject to modification based upon provider responses. Accordingly, the Authority did not consider preliminary recovery amounts identified in draft audit reports to be "discovery," and was not sending draft audit reports to Office of Financial Recovery (OFR).

The Office of Program Integrity contacted OFR to let them know the Authority would be adding the date of the draft letter to the account allocation code sheet, effective January 16, 2013. This met with OFR's approval and this action has been completed.

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State Health Care Authority (HCA)**Agency: 107**

Audit Report: 1008984

Finding Number: 001

Finding: The Authority does not have assurance the vendor has effective controls to protect the ProviderOne system from unauthorized changes.

Resolution: The Authority does not concur with the finding statement but agrees that additional independent review will strengthen the Authority's ability to ensure that the vendor has effective controls in place.

The Authority recognizes the significance and the priority of internal controls and takes its responsibility seriously. The Authority has a robust set of change control processes in place that control both internal system changes and vendor changes. The Authority believes that the change control processes in place minimize the likelihood of unauthorized alterations and errors and adequately provide for the analysis, implementation and testing of all changes requested and implemented. The Authority asserts that the change control processes in place meet best practice standards and are effective in the prevention of unauthorized changes to ProviderOne production programs. The processes include control of documentation and authorization of all change requests, impact assessments, change logs, release management, configuration management, and version control.

While robust change control processes are in place, the Authority also recognizes the value of an independent audit of internal system controls. While neither expected nor required by the federal government for any Medicaid payment system, to strengthen the Authority's ability to monitor vendor controls, Washington state has now added a requirement for external examinations in the form of Service Organization Control (SOC) reports to the ProviderOne vendor contract. This will be implemented in phases, and once complete will provide the Authority with additional independent testing of the ProviderOne vendor's control policies and procedures. This audit will assist in validation of effective control processes and/or the identification of opportunities for improvement. Dates for completion of phases are as follows:

- On March 31, 2013, the ProviderOne vendor provided the Authority the required examination reports from subcontractors.
- On July 31, 2013, the ProviderOne vendor completed documentation for the first phase of controls.
- By December 31, 2013, the ProviderOne vendor will complete documentation for the second phase of controls.
- Starting in the first quarter of calendar year 2014 and every two years thereafter the ProviderOne vendor will undergo the required examination.

State of Washington

Status of Audit Resolution

December 2013

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State Health Care Authority (HCA)**Agency: 107**

Audit Report: 1008984

Finding Number: 002

Finding: The Authority does not have assurance the vendor has effective controls to safeguard ProviderOne data files.

Resolution: The Authority does not concur with the finding statement but agrees that additional independent review will strengthen the Authority's ability to ensure that the vendor has effective controls in place to safeguard ProviderOne data files.

The Authority recognizes the necessity of effective data file safeguards. During ProviderOne implementation, the Department of Social and Health Services (the Medicaid Agency at the time) reviewed and approved the vendor's database security procedures, and conducted a physical inspection of the data center to ensure that system software, application and data files met all security standards. In addition, audit trails are maintained and reviewed by the ProviderOne vendor and provide a record of all system and database activity to ensure that the database has not been modified outside of authorized processes. The Authority asserts that the database procedures in place meet best practice standards.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 1008984

Finding Number: 003

Finding: User access privileges were not restricted to ensure separation of incompatible duties.

Resolution: The Authority partially concurs with this finding. While ProviderOne user security profiles were established and thoroughly reviewed prior to implementation, the Authority agrees that assessing the compliance and operating effectiveness of existing controls is necessary on an ongoing basis. The Authority is currently outlining a set of enterprise security principles on which to base decisions related to separation of duties and will follow with development of an internal annual process for review of user security profiles.

It should be noted that the auditors provided the Authority with the same recommendation and associated details at the conclusion of a 2011 ProviderOne review. The Authority reviewed all of the profile combinations that were noted as incompatible and provided the auditors with a list of completed resolutions in the spring of 2012.

The Authority believes that the establishment of appropriate balance between user needs and security requires a careful analysis of the criticality and sensitivity of information resources available and the tasks performed by users. There are some combinations of user security profiles that have been assessed by the Authority as low risk and, due to resource constraints, are impractical to maintain a separation of duties.

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 1008984

Finding Number: 004

Finding: The Authority did not have an adequate process to verify the state's accounting system received all batches of transactions from ProviderOne from January 1 through June 30, 2012.

Resolution: The Authority concurs with the finding. The Authority recognizes the significance and the priority of internal controls and takes them very seriously. The Authority recognizes that a complete and adequate control process requires duplicate business validations of the transfer of transactions from ProviderOne to the state accounting system. While the two-step validation was lacking, the Authority did perform daily validations and had controls in place to ensure the accuracy of the ProviderOne to the state accounting system interface.

In January 2012, the ProviderOne system was enhanced to produce two interface files: one for Department of Social and Health Services (DSHS) transactions and one for the Authority's transactions. This enhancement was necessitated by the merger of DSHS/Medicaid with the Authority. At the time of the system change, DSHS continued their established accounting process that validated the DSHS transactional data in ProviderOne to the state accounting system interface. However, the Authority finance department was not aware of this requirement and, therefore, did not institute a similar process for the Authority transactional data in ProviderOne to the state accounting system interface.

While the accounting validation step was missing, the Authority continued to validate the daily interface at the technical/system level so controls were in place to assure the accuracy of the interface.

Once the Authority realized that the second accounting validation step was not in place and that the auditors did not consider the technical validation processes to be adequate, the Authority immediately instituted the accounting validation step, including the completion of daily reconciliations from January 1, 2012, to present. The results of that reconciliation confirmed the results of the technical process above and verified that all ProviderOne transactions had been properly accounted for in the state accounting system.

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Status of Audit Resolution

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State Health Care Authority (HCA)

Agency: 107

Audit Report: 1008984

Finding Number: 005

Finding: Disaster recovery procedures have not been tested in more than three years.

Resolution: The Authority concurs with the finding and notes that annual disaster recovery testing is required under the ProviderOne contract and was completed by the ProviderOne vendor prior to the Authority's receipt of this finding. The Authority will continue to take corrective actions to ensure that ongoing annual disaster recovery testing timelines are monitored and met.

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