



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX-43
Seattle, Washington 98121

Date: February 2, 2007

From Associate Regional Administrator
Division of Medicaid and Children's Health
CMS Seattle, Region 10

Subject: Audit Clearance Document: CIN: A-10-06-85755

To: Director, Office of Audit, Analysis and Information, Office of Strategic Operations
And Regulatory Affairs, Division of Audit Liaison, CMS

Attached is the final clearance document for an Office of Management and Budget (OMB) Circular A-133 audit performed on the State of Washington for the fiscal year ended June 30, 2005.

This action serves to clear and close the audit findings as indicated in this report.

If you have any questions regarding this report please contact Treva Wornath at (206) 615-2357.

Karen S. O'Connor

Attachment

OIG CLEARANCE DOCUMENT DATE: (leave blank)
Monetary[X] and/or Non-monetary[X]

Original [X]

Amended []

Page 2 of 34

Report Identification Number: A-10-06-85755

Issue Date: 09/01/2006

Drafter: TWornath

File Name: WA-A-10-06-85755.doc

File Code: 1116 OIG-A133 Audits

Final:

Original [X]

Amended []

Page 4 of 34

Report Identification Number: A-10-06-85755

Issue Date: 09/01/2006

Cognizant OPDIV CMS - Region 10

Program: Medicaid

Other OPDIVs _____

Auditee: State of Washington, Office of Financial Management, 300 Insurance Building,
 P.O. Box 43113, Olympia, Washington 98504-3113

Grant/Contract Nos. _____

Common Accounting No. _____ Appropriation No. _____

Cognizant Finance Officer: Director, Accounting Management Group, Office of Financial
 Management, Center for Medicare and Medicaid Services, N3-11-17, 7500 Security
 Boulevard, MD 21244-1850.

Amounts Recommended for Financial Adjustment:

<u>Recommendation Code</u>	<u>Recommended Amount</u>	<u>Sustained Amount</u>	<u>Adjusted Amount</u>	<u>Receivable Amount</u>
302348101	\$ 47,970	0	0	0
335930100	\$ 0	0	0	0
302908101	\$ 0	0	0	0
399922100	\$ 0	0	0	0
306908100	\$ 14,603,182	0	0	0
302930100	\$ 134,805	0	0	0
336901100	\$ 1,258,343	0	0	0
306901100	\$ 1,585,070	0	0	0
399923100 (A)	\$ 288,819	0	0	0
306905100	\$ 208,587	0	0	0
310920100	\$ 7,805	0	0	0
306922100	\$ 10,475,283	0	0	0
302908102	\$ 0	0	0	0
302901101	\$ 1,725,509	0	0	0
302935100	\$ 406,997	406,997	406,997	0
305908100	\$ 48,589	0	0	0
335901100 (A)	\$ 3,069	0	0	0
306901101	\$ 7,836	7,836	7,836	0
302906100	\$ 35,398	35,398	35,398	0
099009100 (A)	\$ 786,705	0	0	0
Total	\$ 31,623,967	450,231	450,231	0

Original [X]

Amended []

Page 5 of 34

Report Identification Number: A-10-06-85755

Issue Date: 09/01/2006

(A) We concur with the recommendation and have revised the recommended amount to reflect only the Federal share.

302348100 05-01. Elective Medical Procedures. This is a material weakness and a material instance of noncompliance. We recommend procedures be developed and implemented to ensure unallowable elective medical procedures are not charged to Federal programs and 2) the unallowable costs be determined and returned.

302348101 05-01. Elective Medical Procedures. This is a material weakness and a material instance of noncompliance. We recommend procedures be developed and implemented to ensure the unallowable costs be determined and returned.

335926100 05-02. Abuse and Neglect Investigations. This is a material weakness and a material instance of noncompliance. We recommend procedures be developed and implemented to ensure alleged violations and complaints of abuse and neglect are properly investigated in a timely manner and the investigations performed are supported by adequate documentation.

310913100 05-03. Intermediate Care Facility Certification Surveys. This is a material weakness and a material instance of noncompliance. We recommend procedures be strengthened to ensure certification surveys are performed and documented in compliance with Federal regulations.

335930100 05-04. Intermediate Care Facility Sanctions. This is a material weakness and a material instance of noncompliance. We recommend procedures be developed and implemented to ensure facilities are properly sanctioned for noncompliance with Federal health and safety requirements hearing are held of providers to appeal findings of noncompliance.

399913100 05-04. Intermediate Care Facility Sanctions. This is a material weakness and a material instance of noncompliance. We recommend procedures be developed and implemented to ensure hearings are held for providers to appeal findings of noncompliance.

310901100 05-05, 05-06, 05-07, 04-12. Hospital Surveys. This is a material weakness, a material instance of noncompliance, and a repeat finding. We recommend procedures be strengthened to ensure hospital surveys are performed and documented in compliance with Federal regulations and the state plan.

Original [X]

Amended []

Page 6 of 34

Report Identification Number: A-10-06-85755

Issue Date: 09/01/2006

- 302908100 05-08, 04-05. Undocumented Aliens. This is a material weakness, a material instance of noncompliance, and a repeat finding. We recommend procedures be developed and implemented to ensure non-emergency medical services provided to undocumented aliens are not charged to the Federal program.
- 302908101 05-08, 04-05. Undocumented Aliens. This is a material weakness, a material instance of noncompliance, and a repeat finding. We recommend procedures be developed and implemented to ensure unallowable costs are determined and returned.
- 399922100 05-09, 04-21. CMS-64 Report. This is a material weakness, a material instance of noncompliance, and a repeat finding. We recommend procedures be developed and implemented to ensure allowable expenditures are properly reported.
- 306908100 05-10, 04-07. Basic Health Plus Program. This is a material weakness, a material instance of noncompliance, and a repeat finding. We recommend procedures be strengthened to ensure 1) eligibility determinations of Medicaid recipients are performed and documented in compliance with Federal regulations and 2) participant eligibility is accurately determined and periodically reviewed for any changes in status that would affect eligibility.
- 302930100 05-11. Anabolic Steroids. This is a material weakness and a material instance of noncompliance. We recommend procedures be developed and implemented to ensure expenditures charged to the Federal program are allowable and are supported by adequate documentation.
- 336901100 05-12. Reviewing Pharmaceutical Claims. This is a material weakness and a material instance of noncompliance. We recommend procedures be strengthened to ensure retrospective drug use reviews are performed and documented in compliance with Federal regulations.
- 335935100 05-13, 04-18. Reporting Adult Victims of Residential Abuse. This is a material instance of noncompliance and a repeat finding. We recommend procedures be strengthened to ensure allegations of residential abuse are investigated and reported in a timely manner.

Original [X]

Amended []

Page 7 of 34

Report Identification Number: A-10-06-85755

Issue Date: 09/01/2006

- 302901100 05-14, 04-14. Durable Medical Equipment Providers. This is a material instance of noncompliance and a repeat finding. We recommend procedures be strengthened to ensure durable medical equipment claims are allowable.
- 306901100 05-15, 04-02. Deceased Individuals. This is a material weakness, a material instance of noncompliance, and a repeat finding. We recommend procedures be developed and implemented to ensure payments are only made on behalf of eligible living beneficiaries with valid social security numbers.
- 399923100 05-15, 04-02. Deceased Individuals. This is a material weakness, a material instance of noncompliance, and a repeat finding. We recommend procedures be developed and implemented to ensure data is accurately entered into the State Online Query System.
- 399908100 05-16. Surety Bond Requirement. This is a material weakness and a material instance of noncompliance. We recommend procedures be developed and implemented to ensure surety bond requirements are met.
- 399922101 05-16. Surety Bond Requirement. This is a material weakness and a material instance of noncompliance. We recommend procedures be developed and implemented to ensure compliance is accurately reported.
- 306905100 05-17. Home Health Agencies. This is a material instance of noncompliance. We recommend procedures be strengthened to ensure provider eligibility is properly determined and adequately documented.
- 399905100 05-18. Background Checks. This is a material instance of noncompliance. We recommend procedures be strengthened to ensure criminal background checks are properly performed and documented.
- 310920100 05-19. Home Health Care Providers. This is a material instance of noncompliance. We recommend procedures be developed and implemented to ensure providers are properly certified unless specifically exempted in accordance with the terms of the waiver.
- 306922100 05-20. Social Security Numbers. This is a material instance of noncompliance. We recommend procedures be developed and

Original [X]

Amended []

Page 8 of 34

Report Identification Number: A-10-06-85755

Issue Date: 09/01/2006

implemented to ensure valid social security numbers are obtained and recorded in a timely manner.

332922100

05-21, 04-20. Healthy Options Payment Rates. This is a material instance of noncompliance and a repeat finding. We recommend procedures be strengthened to ensure payment rates are based on accurate information.

302908102

05-22, 04-08. Proshare Payments to Public Hospital Districts. This is a material instance of noncompliance and a repeat finding. We recommend procedures be developed and implemented to ensure the Proshare payment method is in compliance with Federal regulations.

302901101

05-23, 04-13. Motorized Wheelchairs. This is a material weakness, a material instance of noncompliance, and a repeat finding. We recommend procedures be developed and implemented to ensure motorized wheelchair expenditures are in compliance with program requirements.

302935100

05-24. Final Settlement Amounts. This is a material weakness and a material instance of noncompliance. We recommend procedures be developed and implemented to ensure provider overpayments are identified and returned in a timely manner.

305922100

05-25. Federal Financial Participation Rate. This is a material weakness and a material instance of noncompliance. We recommend procedures be developed and implemented to ensure the Federal portion of uncashed and cancelled warrants is properly calculated and returned.

204901100

05-26, 04-17. Uncashed Warrants. This is a material weakness, a material instance of noncompliance, and a repeat finding. We recommend procedures be strengthened to ensure uncashed warrants are properly monitored and are canceled in a timely manner.

305908100

05-26, 04-17. Uncashed Warrants. This is a material weakness, a material instance of noncompliance, and a repeat finding. We recommend the Federal share is returned.

335901100

05-27, 04-09. Nursing Home Health and Safety Standards. This is a material instance of noncompliance and a repeat finding. We recommend procedures be strengthened to ensure nursing homes

Original [X]

Amended []

Page 9 of 34

Report Identification Number: A-10-06-85755

Issue Date: 09/01/2006

receiving Federal funds are in compliance with program health and safety standards.

306901101 05-28, 04-03. Social Security Numbers for Deceased Individuals. This is a material weakness, a material instance of noncompliance, and a repeat finding. We recommend procedures be strengthened to ensure payments are only made on behalf of living beneficiaries with valid social security numbers.

302906100 05-33. Duplicate Payments. We recommend procedures be developed and implemented to ensure duplicate payments are not made to providers and overpayments are recovered and returned.

099009100 05-42. Medicaid Expenditures Transferred to SCHIP. We recommend procedures be developed and implemented to ensure only allowable expenditures are transferred to the Federal program.

Actions Taken on Recommendations:

302348100 C 05-01. Elective Medical Procedures. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure unallowable elective medical procedures are not charged to Federal programs.

By policy, the State intends to pay only for medically necessary services. The Department implemented a new medical necessity WAC 388-501-0165 in December 2005. All cases with a diagnosis of transgender will be reviewed according to the amended medical necessity WAC. Health and Recovery Services Administration (HRSA) will be adding trans-gender surgery as a non-covered service in their new Certificate of Coverage WAC because evidence-based criteria deems hormone therapy and psychotherapy as effective, lower risk and lower cost treatment for the condition of gender dysphoria. This project is designed to clarify which service categories are covered, covered with limitations and non-covered. Clients may enter into Medicaid with chronic diseases and/or medical equipment paid for by the client or another health plan. The State will authorize payment for devices or previous procedures that fail or require repair when medically necessary. The State will continue to take cases to Fair Hearing and the

Board of Appeals as appropriate and necessary to sustain coverage decisions.

CMS concurs with action taken by State to ensure that procedures are developed and implemented to prevent unallowable elective medical procedures being charged to Federal programs. CMS will verify that WAC 388-501-0165 is implemented appropriately.

This serves to clear and close finding and recommendation.

302348101 N

05-01. Elective Medical Procedures. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure the unallowable costs be determined and returned.

CMS has received costs documentation from the state for review. To close this finding, CMS will confirm and recover the amount of costs determined to be unallowable.

This serves to clear finding and recommendation.

335926100 C

05-02. Abuse and Neglect Investigations. CMS does not concur with OIG recommendation that procedures be developed and implemented to ensure alleged violations and complaints of abuse and neglect are properly investigated in a timely manner and the investigations performed are supported by adequate documentation. The State Auditor's Office is in error when finding that the State does not have an adequate process in place for ensuring complaints are investigated in accordance with federal law.

The State requires facilities to follow 42 CFR 483 Subpart I in order to protect individuals from abuse, neglect, and mistreatment. Residential Care Services, a division in the Aging and Disability Services Administration, conducts complaint investigations according to procedures established in the CMS State Operations Manual. The State reviews the investigations performed by the facilities to determine if investigation was conducted in a thorough manner. Complaints that name a perpetrator, and where it appears that criminal activity has occurred in a Medicaid certified long-term care facility, including ICFs/MR, are referred to the Medicaid Fraud Control Unit in the Office of the Attorney General.

CMS Survey and Certification has oversight authority for the State's regulation of ICFs/MR. See 42 CFR Part 431, Subpart M, which sets forth the functions the State Agency performs for the State Medicaid Agency. See 42 CFR Part 488, Subpart E, which provides the definitions for survey types, such as "abbreviated surveys" (referred to as complaint surveys). The State's response to the finding is appropriate. CMS Survey and Certification concurs with the actions taken by the State to ensure that alleged violations and complaints of abuse and neglect are properly investigated in a timely manner, and investigations are supported by adequate documentation.

This serves to clear and close finding and recommendation.

310913100 C

05-03. Intermediate Care Facility Certification Surveys. CMS does not concur with OIG recommendation that procedures be strengthened to ensure certification surveys are performed and documented in compliance with Federal regulations. The State Auditor's Office is in error when finding that the State is making payments to ICFs/MR with no reasonable assurance that the services provided are meeting federal health and safety standards.

As authorized by 42 USC § 1302, the Secretary of the Department of Health and Human Services has adopted regulations consistent with the requirements of the Social Security Act. Under these rules:

Providers of Intermediate Care Facilities for the Mentally Retarded must meet all of the certification requirements of 42 CFR 483 Subpart I; and State agencies must conduct certification surveys in accordance with 42 CFR 488.26(c), including subsection (5) (d), which states, "the state survey agency must use the survey methods, procedures and forms that are prescribed by CMS."

The CMS State Operations Manual (SOM), Appendix J – Guidance to Surveyors: Intermediate Care Facilities for Persons with Mental Retardation, Part 1, prescribes the survey methods, procedures and forms to be followed by the State Agency when certifying or recertifying facilities. In accordance with the SOM, a "Fundamental Survey" is conducted to determine the quality of services and supports received by individuals, as measured by outcomes for individuals and the essential components of a system which must be present for the outcomes of active treatment to occur. Certain requirements are designated as fundamental and are reviewed first. The remaining

requirements (that are not designated as fundamental) are supporting structures or processes that the facility must implement. A decision that a provider is in compliance with the fundamental requirements indicates an outcome-reviewed compliance with the non-fundamental requirements and associated conditions of participation. The State Operations Manual attempts to provide consistent instructions for Intermediate Care Facilities for the Mentally Retarded (ICF/MR), indicating specific requirements for conducting surveys. CMS Survey and Certification considers the State to be in compliance with Federal regulation by following the survey process identified in the CMS State Operations Manual, Appendix J, as required by 42 CFR 488.26 (5) (d).

CMS concurs with the actions taken by the State to ensure that certification surveys are performed and documented in accordance with Federal regulations.

This serves to clear and close finding and recommendation.

335930100 C

05-04. Intermediate Care Facility Sanctions. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure facilities are properly sanctioned for noncompliance with Federal health and safety requirements.

The Department has established procedures for instituting denial of payment sanctions, and established procedures to recoup funds paid to a facility in denial of payment status. CMS will verify that the state has implemented procedures to recoup funds paid to a facility in denial of payment status.

CMS Regional Office does not concur with the State Auditors that FFP of \$12,696 was paid to providers in denial of payment status. The State Auditors identified costs of four clients admitted to Fircrest Residential Habilitation Center "N" as questionable due to Fircrest N's denial of payment status. State records indicate that the facility in denial of payment status was Fircrest A, not Fircrest N, and the identified costs are allowable. There were no admissions to Fircrest A during its denial of payment status period.

This serves to clear and close finding and recommendation.

399913100 C

05-04. Intermediate Care Facility Sanctions. CMS concurs with OIG recommendation that procedures be developed and implemented to

ensure hearings are held for providers to appeal findings of noncompliance.

The Department established procedures to schedule and hold appeals hearings. CMS Survey and Certification concurs with the actions taken by the state to resolve this finding. CMS will verify that the State has implemented procedures to schedule and hold appeals hearings for providers found to be in noncompliance with Federal regulation.

This serves to clear and close finding and recommendation.

310901100 C

05-05, 05-06, 05-07, 04-12. Hospital Surveys. CMS partially concurs with OIG recommendation that procedures be strengthened to ensure hospital surveys are performed and documented in compliance with Federal regulations and the state plan.

05-05. The Department of Health (DOH) is not conducting hospital surveys according to the frequency stipulated by state law and the Medicaid State Plan. The 2005 Washington State Legislature changed statute to “inspection of hospitals on average at least every 18 months,” and modified the requirement for the JCAHO survey to allow those surveys to be deemed as meeting the 18 month survey requirement. These changes in statute became effective July 24, 2005 and as of December 31, 2005 all hospitals are now being surveyed according to the 18 month average. In addition, the State submitted State Plan Amendment 04-009 and received CMS approval for the change in survey time period. CMS concurs with the action taken by the State to ensure that hospital surveys are conducted according to frequency stipulated by state statute and the state plan.

05-06. The Department of Health and Department of Social and Health Services (DSHS) are not ensuring compliance with federal law regarding hospital surveys. The Department of Health revised the method of recording deficient findings during Medicare surveys. All reports now indicate that all Federal Medicare hospital certification regulations (Conditions of Participation) are reviewed for compliance during the on-site survey. All deficient findings are documented according to CMS Principles of Documentation. The State Medicaid Agency reviews the source documents and other information obtained during a survey, and determines if documentation is in accordance with Federal requirements. CMS concurs with the actions taken by the

Departments to ensure that hospital surveys are documented in accordance with Federal regulation.

05-07. The DOH and DSHS agreement covering hospitals' survey activities does not comply with federal regulations. CMS does not concur with the finding and recommendation of the State Auditor's Office. CMS Survey and Certification contracts with the DOH to perform surveys for non-long term care hospitals, and contracts with the DSHS to perform surveys for long term care hospitals. CMS Survey and Certification is responsible for enforcing the policies and developing procedures, including documentation requirements, for the surveys to be performed by each department. CMS Survey and Certification does not find that it is necessary for the State Departments to have an interagency survey agreement between them, as stated in 42 CFR 431.610(f), because both departments contract directly with CMS. The DOH performs surveys for CMS, not DSHS, as indicated in the State Auditor's finding.

This serves to clear and close findings and recommendations.

302908100 C

05-08, 04-05. Undocumented Aliens. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure non-emergency medical services provided to undocumented aliens are not charged to the Federal program. CMS does not agree with OIG recommendation to recover FFP of \$41,599,967.

The State Auditor's Office is in error when declaring that the State did not defer undocumented alien expenditures as instructed by CMS. The State deferred all undocumented alien costs for FY2005 and the first two quarters of FY2006. In March of FY2006, CMS partially released the deferral of costs for undocumented alien Labor & Delivery, Title XIX, and determined these costs were allowable in accordance with Social Security Act 1903(v)(3) which states..."For purposes of this subsection, the term "emergency medical condition" means a medical condition (including emergency labor and delivery)..." CMS also released the deferral of costs for undocumented alien prenatal costs which are allowable under Washington's State Plan for Title XXI. The State continues to defer expenditures for undocumented alien non-Labor & Delivery in accordance with request from CMS.

The OIG is currently performing an audit of FY2003 undocumented alien expenses. CMS will be performing a review of FY2005

undocumented alien expenditures, once the OIG has completed their audit. CMS will wait for the finalization of the current undocumented alien audit by the OIG, and make appropriate recoveries at that time.

This serves to clear and close finding and recommendation.

302908101 C 05-08, 04-05. Undocumented Aliens. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure unallowable costs are determined and returned. See Recommendation No. 302908100.

This serves to clear and close finding and recommendation.

399922100 C 05-09, 04-21. CMS-64 Report. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure allowable expenditures are properly reported. CMS does not concur with OIG recommendation to recover FFP of \$21,409,511. The State Auditor's Office is in error when finding that the State did not defer undocumented alien expenditures as instructed by CMS. The State deferred all undocumented alien costs for FY2005 and the first two quarters of FY2006. In March of FY2006, CMS partially released the deferral of costs for undocumented alien Labor & Delivery, Title XIX, and determined these costs were allowable in accordance with Social Security Act 1903(v)(3) which states..."For purposes of this subsection, the term "emergency medical condition" means a medical condition (including emergency labor and delivery)..." CMS also released the deferral of costs for undocumented alien prenatal costs which are allowable under Washington's State Plan for Title XXI. The State continues to defer expenditures for undocumented alien non-Labor & Delivery, in accordance with request from CMS. The OIG is currently performing an audit of FY2003 undocumented alien expenditures. CMS will be performing a review of FY2005 undocumented alien expense, once the OIG has completed their audit.

This serves to clear and close finding and recommendation.

306908100 N 05-10, 04-07. Basic Health Plus Program. CMS concurs with OIG recommendation that procedures be strengthened to ensure 1) eligibility determinations of Medicaid recipients are performed and documented in compliance with Federal regulations and 2) participant eligibility is accurately determined and periodically reviewed for any changes in status that would affect eligibility.

CMS will work to clarify the classification of the eligibility errors identified in this finding as either “systematic” errors inherent in the State’s policy, procedures, and systems, or errors that are under the purview of the MEQC Federal regulations at 42 CFR 431.800 – 431.865. A disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State’s MEQC program. CMS plans an on-site review of the State’s eligibility determination process and systems, and depending on the results of the review will recover costs as appropriate.

The State has taken steps to address the causes of the identified errors through additional staff training and cross-matching of social security numbers using systems interfaces. CMS concurs with the actions take by the state to address some of the issues of this finding. To close this finding, CMS will request a corrective action plan from the state to address any issues identified during the CMS on-site review.

This serves to clear this finding and recommendation.

302930100 N

05-11. Anabolic Steroids. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure expenditures charged to the Federal program are allowable and supported by adequate documentation.

The State has claims processing edits that stop all Point-of-Sale (POS) anabolic steroids expenditures for clinical review. Procedures to assure that anabolic steroid expenditures are allowable have been in place and operating effectively since the products came on the market.

The State has implemented its plan for managing the utilization of these medications and assuring that prescriptions written for medications classified as “anabolic steroids” are medically necessary through prior authorization. Procedures to direct all requests for these prescriptions to the Drug Utilization Review Team (DURT) for review and determination are implemented. Standards for required clinical information from the prescriber are in place, as well as criteria for making medical necessity determinations. In FY2005, DURT reviewed 171 requests of which 12 (7%) were denied for lack of medical necessity. The State is assessing the strength and consistency of its edits and prior authorization program. A request for data has been submitted to the contracted POS vendor to test the effectiveness of edits and to

determine if any of these medications has “slipped” through without prior authorization.

CMS concurs with the action taken by the State to resolve this finding. CMS will review the results of this assessment to ensure that the State’s corrective action plan is implemented and successful in ensuring that anabolic steroid prescriptions are medically necessary.

To close this finding, CMS will contact the State for claims information and recover costs as necessary.

This serves to clear finding and recommendation.

336901100 N

05-12. Reviewing Pharmaceutical Claims. CMS concurs with OIG recommendation that procedures be strengthened to ensure retrospective drug use reviews are performed and documented in compliance with Federal regulations.

The Pharmacy Point of Sale (POS) vendor has loaded DEA numbers from the national DEA database and the State has completed a change service request that will utilize this data to validate against the full DEA national database at the time of adjudication. This validation will eliminate the need to rely on a manual process for blocking invalid DEA numbers.

New Health Insurance Portability and Accountability Act (HIPAA) rules will require the use of a National Provider Identifier for medical providers. Upon implementation, this number will be used to identify prescribing providers in the POS, and the DEA number will be used solely for validation that a provider is registered to prescribe controlled substances.

The State is in the process of development and implementation of a new Medicaid Management Information System (MMIS) and Pharmacy POS. The new MMIS/POS is designed to support the NPI as described above.

The Department has a rigorous and extensive Drug Use Review Program and is in full compliance with Sec. 456.709. Post payment review of invalid DEA numbers has been added to the regular DSHS Payment Review Program (PRP) algorithm process. DSHS/PRP ran an algorithm that uses the federal DEA database to identify invalid DEA

numbers and issued overpayment notices totaling \$769,000 to 219 pharmacies state-wide in January 2006. The State will continue post-payment review of DEA numbers to identify inaccurate numbers and validate DEA numbers are used appropriately. This will continue until implementation of the change service request for validation of DEA at the time of adjudication.

CMS concurs with the actions taken by the State to ensure retrospective drug use reviews are performed and documented in compliance with Federal regulations.

To close this finding, CMS will request the documentation reviewed by the State to identify overpayment of pharmacy claims and ensure that the full amount of unallowable costs have been returned.

This serves to clear finding and recommendation.

335935100 C

05-13, 04-18. Reporting Adult Victims of Residential Abuse. CMS concurs with OIG recommendation that procedures be strengthened to ensure allegations of residential abuse are investigated and reported in a timely manner.

The Division of Alcohol and Substance Abuse (DASA), Mental Health Division Headquarters (HQ) and Eastern and Western State Hospitals now include procedures and policies to report allegations of abuse and neglect to the Medicaid Fraud Control Unit (MFCU) in accordance with federal regulation 42 CFR 1007.11. Mental Health's policy went into effect March, 2005 and DASA's policy went into effect June 30, 2005. With the policies and procedures now in place, Mental Health and Alcohol and Substance Abuse divisions are in compliance with federal requirements, therefore eliminating any liability to the state.

The MHD Compliance Officer currently reviews 100% of incident and daily reports submitted to the division from the hospitals. The DASA Certification Supervisor currently reviews 100% of incident reports of fraud or abuse. The DASA's Internal Auditor will monitor and review incident reports on a monthly basis and ensure the division is in compliance with all polices related to reporting requirements of Medicaid Fraud and Abuse of Medicaid Patients. The State will examine the adequacy of policies and procedures related to follow up on contacts made to the State by the Fraud Control Unit related to potential abuse.

CMS concurs with the action taken by the state to ensure that procedures are strengthened for reporting and investigation of allegations of residential abuse in a timely manner. CMS will review the policies and procedures of MHD and DASA to ensure that the corrective action plan of the State is implemented appropriately.

This serves to clear and close the finding and recommendation.

302901100 C

05-14, 04-14. Durable Medical Equipment Providers. CMS concurs with OIG recommendation that procedures be strengthened to ensure durable medical equipment claims are allowable.

The State's Provider Enrollment group has implemented new policies (the reverse directory) to verify a provider's address.

The State's current policy regarding providers with more than one license is: "When there is a business that has more than one business license (example; one state, one city, one county) the priority will be State, City, and then County. If one of the first two are obtained the others are not necessary." The current MMIS allows only one field for one license. Consequently, both business and professional licenses cannot be stored. The new Provider One system will allow both.

In January 2006, Provider Enrollment sent out "24 Month" letters asking providers who have not conducted any business with the State for the past 24 months to respond by Feb 15, 2006, if they wanted to remain on the State's active list. 820 providers were terminated as of Feb 18, 2006.

The current MMIS system is being replaced with the new "ProviderOne." Provider Enrollment staff are actively participating in design sessions for the new system. This includes requiring the system to identify expired business licenses.

The State has initiated a policy in which the Division of Auditing and Information Systems office (OPRA), visits DME providers ("drive-bys") to verify the address of the DME dealers in that area. This procedure is currently being performed and documented.

The State also has an agreement with the Division of Fraud and Investigations for their investigators to verify DME vendors' business locations when the DFI investigators are in the field.

CMS concurs with the action taken by the State to ensure durable medical claims are allowable. CMS will sample recently enrolled providers and review enrollment documentation to ensure that the State has implemented their new provider enrollment procedures.

This serves to clear and close recommendation and finding.

306901100 N

05-15, 04-02. Deceased Individuals. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure payments are only made on behalf of eligible living beneficiaries with valid social security numbers.

CMS will work to clarify the classification of the eligibility errors identified in this finding as either "systematic" errors inherent in the State's policy, procedures, and systems, or errors that are under the purview of the MEQC Federal regulations at 42 CFR 431.800 – 431.865. A disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's MEQC program. CMS plans an on-site review of the State's eligibility determination process and systems, and depending on the results of the review will recover costs as appropriate.

A review of the automated SSN verification at the time of ACES entry was completed on February 4, 2005. In addition, the State has enhanced procedures, including modification of the interface with the federal database to update nightly with income and Medicare eligibility updated daily.

DSHS will continue to provide instruction and written guidance to staff regarding the manner in which alerts are handled.

The State has initiated a cross-administration SSN Quality Improvement Workgroup and will continue to focus attention on increasing the accuracy of SSNs in ACES and MMIS. The State will continue to assess, prioritize, and resolve interface issues as they are identified.

The Design Phase of the new MMIS is underway and includes a complete assessment of the ACES/MMIS interface. Implementation of the new ProviderOne interface with ACES will be thoroughly tested prior to implementation to assure that data is being transferred accurately.

The Department is a stakeholder in a DOH initiative that will provide DSHS with real-time on-line access to DOH death data. Although currently being piloted in two counties; statewide implementation is not anticipated for several years. The Department receives quarterly death data from DOH.

DOH will remain dependent upon counties for receipt of death data, resulting in a lag in receipt of the information. Due to this lag, the Department will continue its successful post-pay review activities and the identification and recoupment of claims paid for deceased clients. The DSHS Payment Review Program follows up with quarterly post-payment review activities related to date of death with the identification of any potential provider fraud and appropriate referral to the Medicaid Fraud Control Unit.

CMS concurs with action taken by the State to ensure provider claims are valid. CMS has verified that the State is currently implementing corrective action plan, and will follow-up with on-site reviews.

This serves to clear finding and recommendation.

399923100 N

05-15, 04-02. Deceased Individuals. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure data is accurately entered into the State Online Query System.

The State Online Query (SOLQ) user interface is being modified to accommodate user's ability to perform multiple queries without exiting the system. Implementation was completed April 2006.

CMS concurs with actions taken by the State to ensure provider claims are valid. CMS has verified that State is currently implementing corrective action plan, and will follow-up with on-site reviews in 2007.

To close this finding, CMS will review the claim documentation that contains data entry error, and recover costs as appropriate.

This serves to clear finding and recommendation.

399908100 C 05-16. Surety Bond Requirement. CMS does not concur with OIG recommendation that procedures be developed and implemented to ensure surety bond requirements are met. The State Auditor's Office is in error when finding that the State did not comply with surety bond requirement.

CMS has stated through a State Medicaid Director's letter, dated February 26, 1998, that the State should not implement the surety bond requirements until further direction is given by Congress. No additional direction from Congress has been received at the time of this audit. CMS concurs with the State's response to this finding and does not require the State to take any action to resolve finding.

This serves to clear and close finding and recommendation.

399922101 C 05-16. Surety Bond Requirement. CMS does not concur with OIG recommendation that procedures be developed and implemented to ensure surety bond compliance is accurately reported. The State Auditor's Office is in error when finding that the State did not comply with surety bond requirement.

CMS has stated through a State Medicaid Director's letter, dated February 26, 1998, that the State should not implement the surety bond requirements until further direction is given by Congress. No additional direction from Congress has been received at the time of this audit. CMS concurs with the State's response to this finding and does not require the State to take any action to resolve finding.

This serves to clear and close finding and recommendation.

306905100 N 05-17. Home Health Agencies. CMS concurs with OIG recommendation that procedures be strengthened to ensure provider eligibility is properly determined and adequately documented.

Provider Enrollment has updated the Provider Enrollment manual to reflect all the required enrollment documents.

Provider Enrollment started a project in November 2005 to bring all Home Health providers up to date and ensure that files have all the needed documents. Project was completed in March 2006.

CMS concurs with the State's action to ensure provider eligibility is properly determined and adequately documented. CMS will sample recently enrolled providers and review enrollment documentation to ensure that the State has implemented their new provider enrollment procedures in 2007.

To close this finding, CMS will recover costs as appropriate.

This serves to clear finding and recommendation.

399905100 C

05-18. Background Checks. CMS does not concur with OIG recommendation that procedures be strengthened to ensure criminal background checks are properly performed and documented. The State Auditor's Office is in error when finding that the State is not retaining survey records in accordance with Federal regulations.

The goal of a Home Health Agency (HHA) survey is to determine if the entity is in compliance with conditions of participation as set forth in 42 CFR Part 482 and Part 484, and by inference all applicable state laws including the requirement that HHA perform criminal background checks.

If a surveyor determines that the subject HHA is in violation of the requirements to complete criminal background checks it is noted as such on the final report CMS form 2567. If violations involve specific employees a confidential list is also included.

If no violations have been found by the surveyor, the report is signed, filed and retained by the Department of Health. This fulfills the intent of 42 CFR 431.610(f) (3) to retain all information and reports, and is consistent with state law. The process and methodology for conducting the HHA survey, and reporting, conforms to CMS policies and procedures found in the State Operation Manual and Principles of Documentation Guide.

CMS concurs with the State and considers their method of documenting HHA surveys in compliance with Federal regulation. The intent of the review by the State Auditors is to determine if the Department of Health is in compliance with State regulation requiring Home Health Agencies to perform employee criminal background checks. It may not be reasonable for the State Auditors to expect the reports submitted by

Original [X]

Amended []

Page 24 of 34

Report Identification Number: A-10-06-85755Issue Date: 09/01/2006

DOH surveyors to CMS, to document compliance with specific state regulation. The survey reports are designed to fulfill Federal requirements, not state requirements.

This serves to clear and close finding and recommendation.

310920100 N

05-19. Home Health Care Providers. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure providers are properly certified unless specifically exempted in accordance with the terms of the waiver.

The State submitted and received CMS approval June 16, 2006, for SPA 06-008 (effective April 1, 2006) clarifying that home health agencies providing Private Duty nursing do not require Medicare certification. The state also submitted SPA 06-012 (to be effective June 1, 2006) to clarify that home health agencies providing only personal care services do not require Medicare certification. This SPA is not yet approved by CMS. The state submitted a COPES waiver amendment to clarify provider qualifications for skilled nursing services and home health aide services to be provided by licensed home health agencies, not Medicare certified agencies.

CMS concurs with the corrective action taken by the State to ensure providers are properly certified, unless specifically exempted in accordance with the terms of the waiver. The State identified FFP of \$3,463,384 associated with nursing services provided by non-Medicare Certified Home Health Agencies. CMS has determined it is not necessary to recover the FFP associated with nursing services, since these costs are for services provided to Medicaid beneficiaries and services are allowable under the State's Medicaid program. The State has taken the appropriate action to resolve the finding, and this problem should not occur in the future.

CMS has determined it is not necessary to recover the FFP of \$2,253,614 associated with non-nursing services provided by non-Medicare Certified Home Health Agencies, since these costs are for services provided to Medicaid beneficiaries and services are allowable under the State's Medicaid program. This determination is contingent upon CMS approval of SPA 06-12 submitted by the state to resolve this finding.

Original [X]

Amended []

Page 25 of 34

Report Identification Number: A-10-06-85755

Issue Date: 09/01/2006

FFP of \$7,805 is for non-Medicare Certified providers of the Children's Administration. To close this finding, CMS will recover costs as appropriate.

This serves to clear finding and recommendation.

306922100 N

05-20. Social Security Numbers. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure valid social security numbers are obtained and recorded in a timely manner.

CMS will work to clarify the classification of the eligibility errors identified in this finding as either “systematic” errors inherent in the State’s policy, procedures, and systems, or errors that are under the purview of the MEQC Federal regulations at 42 CFR 431.800 – 431.865. A disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's MEQC program. CMS plans an on-site review of the State’s eligibility determination process and systems, and depending on the results of the review will recover costs as appropriate.

The CMS regional office will conduct a file review to verify that quarterly post payment activities performed by the State successfully identifies claims paid for recipients after death and that funds are repaid to Federal Medicaid. CMS will also request results of review performed by the State for the SOLQ interface modification, and review State's process for reviewing monthly report for beneficiaries receiving two months of benefits without SSN.

This serves to clear finding and recommendation.

332922100 C

05-21, 04-20. Healthy Options Payment Rates. CMS concurs with OIG recommendation that procedures be strengthened to ensure payment rates are based on accurate information.

CMS has been working with the State to improve the data used for rate setting. CMS has completed a review of the Healthy Options Managed Care program and that report was issued December 12, 2006. However the contract and rates were approved August 14, 2003 with specific terms and conditions under 42 CFR 438.242(a) and (b) to strengthen the State's data for rate setting. The contract and rates were approved again on December 1, 2006, without the specific terms and conditions

mentioned above. CMS does a review of each managed care rate and ensures that the rates meet appropriate Federal regulations and are Actuarial sound in accordance with 42 CFR 438.6.

The State's new MMIS system "Provider One" will enhance the rate setting process by allowing encounter and other data to be tracked in one comprehensive system, thus significantly improving the data for rate setting.

CMS concurs with actions taken by the State to ensure payment rates are based on accurate information.

This serves to clear and close finding and recommendation.

302908102 C

05-22, 04-08. Proshare Payments to Public Hospital Districts. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure the Proshare payment method is in compliance with Federal regulations. CMS does not concur with OIG recommendation to recover FFP of \$20,577,000.

The State Auditor's Office is in error when finding that the State Proshare payment methodology was not approved by the Federal government or not included in the Washington State Medicaid Plan. In accordance with 42 CFR 447.272, CMS allowed the state to continue using their current State Plan supplemental payment methodology until June 30, 2005, at which time CMS requested the State to seek approval for a new supplemental payment methodology. CMS is currently reviewing the State Plan amendment 05-006 (Inpatient Hospital) CPE methodology proposed by the State. SPA 05-007 (Nursing Facility) CPE methodology has been approved as of October 18, 2006. CMS regional office is awaiting a decision from the National Institutional Reimbursement Team and CO on a decision to approve SPA 05-006.

CMS concurs with the action taken by the State to ensure the Proshare payment method is in compliance with Federal regulations.

This serves to clear and close finding and recommendation.

302901101 N

05-23, 04-13. Motorized Wheelchairs. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure motorized wheelchair expenditures are in compliance with program requirements.

CMS conducted a fiscal management review of DME in FY2006. The DME Wheelchair claims that have been first submitted to Medicare, and have a remaining balance due, are paid by the State's Medicaid program up to the allowable co-pay amount without prior authorization. If DME Wheelchair claim lines are denied by Medicare, the State Medicaid program pays claim lines based on medical necessity, but does not require prior authorization. This may not comply with state regulation.

The state has submitted new Washington Administrative Code (WAC) language, and to close this finding CMS will follow up to determine if new WAC will allow an exception to the prior authorization requirement for Medicare crossover claims. CMS concurs with the action taken by the State to develop and implement procedures to ensure wheelchair expenditures are in compliance with program requirements.

To close this finding, CMS will recover costs as appropriate.

This serves to clear finding and recommendation.

302935100 C

05-24. Final Settlement Amounts. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure provider overpayments are identified and returned in a timely manner.

The Division of Audit and Information Services is finalizing new policies and procedures that will direct proper reporting of provider overpayments identified during audits conducted by the Office of Payment Review and Audit. These policies prescribe guidance for determining the date of discovery for Hospital and Medical audits. The Office of Finance Recovery is establishing policy and procedures to ensure the State refunds the Federal share of overpayments within 60 days of the date of discovery, rather than 60 days of being established as a receivable.

CMS will ensure the corrective actions are in place and all overpayments identified are returned to CMS within 60 days of discovery.

Original [X]

Amended []

Page 28 of 34

Report Identification Number: A-10-06-85755

Issue Date: 09/01/2006

CMS has reviewed the new policies and procedures for the overpayment process and concurs with the actions taken by the State to ensure timely refund of Federal funds. CMS has recovered FFP of \$406,997 overpayments identified in this finding.

This serves to clear and close finding and recommendation.

305922100 C

05-25. Federal Financial Participation Rate. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure the Federal portion of uncashed and cancelled warrants is properly calculated and returned.

The Office of Accounting Services has implemented a process that ensures the correct federal/state allocation for Medicaid warrants is utilized, thus ensuring the warrant is cancelled at the correct federal percentage. The implementation of the process occurred in February 2006. CMS concurs with the action taken by the state to resolve this audit finding.

This serves to clear and close the finding and recommendation.

204901100 C

05-26, 04-17. Uncashed Warrants. CMS concurs with OIG recommendation that procedures be strengthened to ensure uncashed warrants are properly monitored and canceled in a timely manner.

The State's Office of Accounting Services believes it now has appropriate staff to address this function and has cross-trained a sufficient number of individuals to ensure adequate coverage for processing the Statute of Limitation (SOL) warrants. With the cross training of staff and the improvement of procedures, the refunding process has been current for the last three quarters of Federal Fiscal Year 2005. The office has improved its monitoring procedures that provide increased management oversight to ensure staff processes the transactions in a timely and accurate manner.

The Office will continue to develop effective monitoring procedures to identify and ensure SOL warrants are properly addressed so that refunds to federal programs will occur in a timely manner.

CMS concurs with the action taken by the state to resolve this finding, and will review the monitoring procedures implemented by the State to provide increased management oversight to ensure staff are processing the transactions in a timely and accurate manner.

This serves to clear and close finding and recommendation.

305908100 N

05-26, 04-17. Uncashed Warrants. CMS concurs with the OIG recommendation that the Federal share be returned.

CMS concurs with the action taken by the State to resolve this finding, will review the monitoring procedures implemented by the State to provide increased management oversight to ensure staff are processing the transactions in a timely and accurate manner. To close this finding, CMS will recover costs as appropriate.

This serves to clear finding and recommendation.

335901100 N

05-27, 04-09. Nursing Home Health and Safety Standards. CMS concurs with OIG recommendation that procedures be strengthened to ensure nursing homes receiving Federal funds are in compliance with program health and safety standards.

The State will continue to pursue more effective means of receiving timely notifications of denial-of-payment. The State has been routinely receiving e-mail notifications of denial of payment situations from CMS in lieu of relying on receipt of notifications through the regular mail system, and believe there has been some improvement since this practice was implemented. The State will pursue conversations with CMS to determine if denial of payment information can be obtained in a more reliable and timely manner.

CMS concurs with the actions taken by the State to strengthen the procedures to ensure nursing homes receiving Federal funds are in compliance with program health and safety standards. To close this finding, CMS will recover costs as appropriate.

This serves to clear finding and recommendation.

306901101 C

05-28, 04-03. Social Security Numbers for Deceased Individuals. CMS concurs with OIG recommendation that procedures be strengthened to

ensure payment is only made on behalf of living beneficiaries with valid social security numbers.

Washington Administrative Code (WAC) 388-476-0005 defines the Department's current Social Security number requirements for medical eligibility, and can be found in the Department's A-Z Manual at <http://www1.dshs.wa.gov/esa/EAZManual/Sections/SSN.htm>. Section 3 states "Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration (SSA). However, a person who does not comply with these requirements is not eligible for assistance".

Verification procedures are described under the section titled "Clarifying Information". SSN's are automatically verified through a cross-match with the SSA Numident file, once the data is entered into ACES. Section 3 under "Clarifying Information" states, "If a current and valid SSN is not available, the department is responsible to assist a client in making an application for a SSN." SSN discrepancies in Numident generate alerts to the workers as described in the ACES User Manual. Alert "253" describes alerts to workers when there is a SSN discrepancy in State Data Exchange (SDX), Beneficiary Data Exchange (BENDEX) or Numident.

When the Home and Community Services Quality Assurance Unit reviews client files to confirm financial eligibility, they check to see that the SSN recorded in the Social Services Payment System (SSPS) is the same as the SSN recorded in the ACES eligibility system. They report discrepancies, using ACES as the correct record of the SSN.

The limitations the State faces with the SSPS system will be corrected in the new "Provider One" system, when all payments made in SSPS will become part of the new Medicaid Management Information System payment system. This is scheduled to occur in 2008. At that time, all medical and social services payments will be made from the same system, and will use the same ACES SSN verification processes described above.

The State issued a Management Bulletin (MB) reminding staff of the importance of using the client's correct SSN from ACES, and instructions on how to obtain the ACES SSN.

The MB will stress the importance of using the accurate SSN when the new MMIS (Provider One) is implemented because using an incorrect SSN in Provider One will cause payments to suspend. Staff members were informed of RCW 9.35.020 via management bulletin this past year. It will be reiterated in the management bulletin referenced above.

The Department's Payment Review Program re-runs algorithms quarterly and findings are referred to the Office of Financial recovery or the Medicaid Fraud Control for recovery. No instances of identity theft were found as a result of last year's audit. Any instances of apparent identity theft will be referred appropriately.

The eligibility and verification procedures identified above meet U.S. Department of Health and Human Services requirements for Medicaid eligibility.

CMS concurs with the action taken by the state to resolve this finding. CMS will request Aging and Disability Services Administration to add an additional element to their corrective action plan (CAP). After the CAP has been implemented for a period of time, ADSA should perform a data analysis of SSN's in SSPS compared to listings of known correct SSN's from ACES (and/or other reliable SSN source) to verify that the error rate has decreased as a result of the CAP intervention. Such an analysis can be designed by the state as long as their methods are valid and representative of the population of data. The results should be shared with CMS and the State Auditor's Office.

CMS has reviewed the information provided by the State regarding questioned costs of \$2,232,201 FFP. The State was able to verify SSN's for all costs identified; with the exception of \$7,836 FFP associated with services provided to four beneficiaries who's SSN could not be verified. CMS will require the State to make the appropriate adjustment on the CMS-64 expenditure report.

This serves to clear and close finding and recommendation.

302906100 C

05-33. Duplicate Payments. CMS concurs with recommendation that procedures be developed and implemented to ensure duplicate payments are not made to providers and overpayments are recovered and returned.

The State's Payment Review Program has developed and uses algorithms to detect duplicate payments, and will continue to work closely with the State administrations to ensure duplicate payments are adequately addressed. The State has established overpayments on all duplicate payments that were identified in the audit process. The State will continue to provide staff training, supervisory overview and quality review of payment procedures used in the field.

CMS concurs with the corrective action taken by the State to ensure duplicate payments are not made to providers and overpayments are recovered and returned. CMS will verify that duplicate payments have been returned through the State's provider overpayment process.

This serves to clear and close finding and recommendation.

099009100 N

05-42. Medicaid Expenditures Transferred to SCHIP. CMS concurs with OIG recommendation that procedures be developed and implemented to ensure only allowable expenditures are transferred to the Federal program.

The State's current process to transfer expenditures from Medicaid to SCHIP involves a quarterly matching of Department of Health live births to claims data for the period of one day prior to birth and back 270 days. From this data, inpatient hospital claims for labor and delivery, abortion, and sterilization are excluded.

Additionally, The State has been advised by CMS that since Washington covers all services for pregnant women under the SCHIP unborn (prenatal) program, costs for such services as dental, vision and physical therapy are allowable expenditures of the SCHIP unborn program.

The State recognizes the possibility that unallowable costs such as postpartum and family planning services may not have been filtered from the claims data used to transfer Medicaid costs to SCHIP. The State is refining their current process to better isolate the ineligible costs based on diagnosis and/or procedure codes for exclusion. CMS concurs with the action taken by the State to resolve this finding.

To close this finding, CMS will request the State to review costs transferred and return funds to CMS as appropriate.

Original [X]

Amended []

Page 33 of 34

Report Identification Number: A-10-06-85755

Issue Date: 09/01/2006

This serves to clear finding and recommendation.

Sincerely,

Karen S. O'Connor
Associate Regional Administrator
Division of Medicaid and Children's Health

OIG CLEARANCE DOCUMENT DATE: (leave blank)
Monetary[X] and/or Non-monetary[X]

Original [X]

Amended []

Page 34 of 34

Report Identification Number: A-10-06-85755

Issue Date: 09/01/2006

bcc: (List any CMS Staff here)

Drafter: Treva Wornath (2/2/2007)

File Code: H:\ {type the path on the DMCH shared drive where you want the official copy of
the letter to be saved...Jo will save the final version to that location}

File name: letter_name.doc

Final: (leave blank)