



February 24, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /George M. Reeb/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Family Planning Services Claimed by Washington State During the
Period October 1, 2005, Through September 30, 2008 (A-09-09-00049)

Attached, for your information, is an advance copy of our final report on family planning services claimed by Washington State. We will issue this report to the Washington State Department of Social and Health Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to contact me at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360 or through email at Lori.Ahlstrand@oig.hhs.gov. Please refer to report number A-09-09-00049.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

February 28, 2011

Report Number: A-09-09-00049

Mr. Doug Porter
Medicaid Director
Administrator, Health Care Authority
Department of Social and Health Services
676 Woodland Square Loop, SE
P.O. Box 42700
Olympia, WA 98504-2700

Dear Mr. Porter:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Family Planning Services Claimed by Washington State During the Period October 1, 2005, Through September 30, 2008*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Janet Tursich, Audit Manager, at (206) 615-2063 or through email at Janet.Tursich@oig.hhs.gov. Please refer to report number A-09-09-00049 in all correspondence.

Sincerely,

/Lori A. Ahlstrand/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
FAMILY PLANNING SERVICES
CLAIMED BY WASHINGTON STATE
DURING THE PERIOD
OCTOBER 1, 2005, THROUGH
SEPTEMBER 30, 2008**



Daniel R. Levinson
Inspector General

February 2011
A-09-09-00049

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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THIS REPORT IS AVAILABLE TO THE PUBLIC
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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. Section 1115 of the Act authorizes demonstration projects to assist in promoting the objectives of the Medicaid program.

Pursuant to section 1905(a)(4)(C) of the Act, States are required to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and desire such services and supplies. Section 1903(a)(5) of the Act and Federal regulations (42 CFR § 433.10(c)(1)) authorize Federal reimbursement for family planning services and supplies at the enhanced Federal medical assistance percentage (FMAP) of 90 percent (90-percent rate). Family planning services prevent or delay pregnancy or otherwise control family size.

In Washington State, the Department of Social and Health Services (the State agency) administers the Medicaid program. The State agency provides family planning services and supplies under Medicaid and a family planning demonstration project (Take Charge). Within Medicaid, family planning services are provided under the Reproductive Health Services and Family Planning Only programs.

Pursuant to the Washington Administrative Code, for the Family Planning Only and Take Charge programs, a family planning service must have a primary focus and diagnosis of family planning. State agency guidance limits reimbursement to those services that are identified with one of the approved primary diagnosis codes for family planning. Also, for family planning prescription drugs (including supplies), State agency guidance requires that the claim contain one of the approved therapeutic classification codes. Under the Reproductive Health Services program, family planning services are defined as medically safe and effective medical care, educational services, and/or contraceptives that enable individuals to plan and space the number of children and avoid unintended pregnancies.

The State agency claimed approximately \$110 million (\$99 million Federal share) for family planning services and supplies provided to Medicaid beneficiaries during the period October 1, 2005, through September 30, 2008. We reviewed \$19 million (Federal share) of claims for family planning services and supplies that did not contain approved diagnosis codes or approved therapeutic classification codes.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal reimbursement at the 90-percent rate for family planning services and supplies in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency did not always claim Federal reimbursement at the 90-percent rate for family planning services and supplies in accordance with Federal and State requirements. Specifically, the State agency claimed \$18,727,441 (Federal share) of medical services and supplies that were not related to family planning. Contrary to State requirements, the claims for services did not contain approved primary diagnosis codes, and the claims for supplies did not contain approved therapeutic classification codes. By calculating the difference between what the State agency claimed and what it should have claimed, we determined that the State agency was overpaid \$8,458,169 (Federal share).

This overpayment occurred because the State agency's Medicaid Management Information System (MMIS) controls did not properly distinguish claims eligible for reimbursement at the 90-percent rate from claims eligible for reimbursement at the regular FMAP rate. In July 2007, the State agency changed the MMIS controls to properly identify these claims.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$8,458,169 to the Federal Government and
- identify and refund any overpayments for family planning claims before October 1, 2005, that did not contain approved primary diagnosis or therapeutic classification codes identifying the claims as eligible for reimbursement at the 90-percent rate.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, the State agency concurred with our findings and our first recommendation. Regarding our second recommendation, the State agency said that because it had implemented a new MMIS in May 2010, it was unable to review medical claims submitted before December 2005 or pharmacy claims submitted before April 2006. The State agency's comments are included in their entirety as Appendix B.

The State agency should work with CMS to resolve the issue of overpayments for medical claims submitted before December 2005 and pharmacy claims submitted before April 2006. Even though the detailed information is no longer available, CMS may want to use alternative methods, such as estimations, to determine the amount that the State agency should refund.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. Section 1115 of the Act authorizes demonstration projects to assist in promoting the objectives of the Medicaid program.

Medicaid Coverage of Family Planning Services

Pursuant to section 1905(a)(4)(C) of the Act, States are required to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and desire such services and supplies. Section 1903(a)(5) of the Act and Federal regulations (42 CFR § 433.10(c)(1)) authorize Federal reimbursement for family planning services and supplies at the enhanced Federal medical assistance percentage (FMAP) of 90 percent (90-percent rate).

Section 4270 of the CMS *State Medicaid Manual* (the Manual) states that family planning services include those that prevent or delay pregnancy or otherwise control family size and may also include infertility treatments. The Manual indicates that States are free to determine which services and supplies will be covered as long as those services and supplies are sufficient in amount, duration, and scope to reasonably achieve their purpose. However, only supplies and services clearly furnished for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate.

Washington State's Medicaid Program

In Washington State, the Department of Social and Health Services (the State agency) administers the Medicaid program. Within the State agency, the Health and Recovery Services Administration administers the family planning programs.

The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims for payment by the Agency Financial Reporting System. The expenditures related to the claims are reported on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, for Federal reimbursement.

The Federal share of the Medicaid program is determined by the FMAP. During our audit period, the FMAP in Washington State was 50 percent (October 1, 2005, through

September 30, 2006), 50.12 percent (October 1, 2006, through September 30, 2007), and 51.52 percent (October 1, 2007, through September 30, 2008).

Washington State's Medicaid Family Planning Programs

The State agency provides family planning services and supplies under Medicaid and a family planning demonstration project (Take Charge).

Medicaid: Reproductive Health Services and Family Planning Only Programs

Within Medicaid, the State agency offers family planning services through the Reproductive Health Services and Family Planning Only programs. Pursuant to WAC § 388-532-001, the purpose of the Reproductive Health Services program is to provide services that assist clients to avoid illness, disease, and disability related to reproductive health; provide related and appropriate medically necessary care when needed; and assist clients to make informed decisions about using medically safe and effective methods of family planning. Pursuant to WAC § 388-532-050, family planning services under the Reproductive Health Services program are defined as medically safe and effective medical care, educational services, and/or contraceptives that enable individuals to plan and space the number of children and avoid unintended pregnancies. Pursuant to WAC § 388-532-500, the purpose of the Family Planning Only program is to provide family planning services at the end of pregnancy to women who received medical assistance benefits during pregnancy. The primary goal of the Family Planning Only program is to prevent an unintended subsequent pregnancy.

Take Charge Program

Pursuant to CMS's award letter to the State agency for its section 1115 Family Planning Demonstration waiver and WAC § 388-532-720, individuals eligible for the Take Charge program are not otherwise eligible for Medicaid. Under the special terms and conditions of the Take Charge demonstration project, family planning services and supplies whose primary purpose is family planning are eligible for reimbursement at the 90-percent rate. These special terms and conditions also state that the 90-percent rate is not available for any services whose primary purpose is not family planning even if family planning clinics or providers furnish those services. Pursuant to WAC § 388-532-710, the Take Charge program is defined as the State's demonstration and research program approved by the Federal Government under a Medicaid program waiver to provide family planning services.

State Requirements for Family Planning Programs

For the Reproductive Health Services program, WAC § 388-532-120 allows an annual comprehensive family planning preventive medical visit billable only by a Take Charge provider. Other allowable family planning services include sterilization and prescription drugs. State agency guidance has specific requirements for these services.

For the Family Planning Only and Take Charge programs, the State agency will not cover medical services unless the services are performed in relation to a primary focus and diagnosis of

family planning (WAC §§ 388-532-540 and 388-532-750, respectively). Pursuant to WAC § 388-502-0100, to receive payment, the provider must bill according to department rules and billing instructions.¹ State billing instructions limit reimbursement to those services that are identified with one of the approved primary diagnosis codes for family planning.² These diagnosis codes must be within the V25 diagnosis code series. The *International Classification of Diseases*³ defines the V25 diagnosis code series as contraceptive management. For family planning prescription drugs (including supplies), State agency guidance requires that the claim contain one of the approved therapeutic classification codes.

For the Reproductive Health Services program, State agency officials informed us that the requirement to identify family planning services with a V25 diagnosis code or therapeutic classification code also applies.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed Federal reimbursement at the 90-percent rate for family planning services and supplies in accordance with Federal and State requirements.

Scope

The State agency claimed \$110,180,570 (\$99,162,513 Federal share) for family planning services and prescription drugs (including supplies) provided to Medicaid beneficiaries during our audit period (October 1, 2005, through September 30, 2008). These claims consisted of family planning services totaling \$95,115,180 (Federal share) and prescription drugs and supplies totaling \$4,047,333 (Federal share).

We reviewed \$19,403,313 (Federal share) of claims for family planning services and supplies that did not contain approved primary diagnosis codes within the V25 series or approved therapeutic classification codes.⁴ We did not review the remaining \$79,759,200 (Federal share) because these claims contained the appropriate diagnosis codes or therapeutic classification codes.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

¹ Family Planning Only and Take Charge providers are required to comply with WAC § 388-502-0100. See WAC § 388-532-520 and WAC §§ 388-532-730, 050, and 110.

² Health and Recovery Services Administration, *Family Planning Provider Billing Instructions*, pages B.6 and C.29.

³ *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)*.

⁴ This amount did not include any claims for prescription drugs.

We performed our fieldwork at the Health and Recovery Services Administration's office in Olympia, Washington.

Methodology

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and guidance and the approved State plan and Take Charge demonstration project requirements;
- held discussions with CMS officials and gained an understanding of CMS guidance furnished to State agency officials concerning Medicaid family planning claims;
- held discussions with State agency officials to gain an understanding of State policies and procedures for claiming Federal reimbursement for family planning services and supplies;
- obtained family planning claim data from the State agency's MMIS;
- reconciled family planning claim data to Form CMS-64;
- identified claims for services that did not have approved primary diagnosis codes in the V25 series;
- identified supplies that did not have approved therapeutic classification codes; and
- calculated the unallowable Federal reimbursement claimed by the State agency.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not always claim Federal reimbursement at the 90-percent rate for family planning services and supplies in accordance with Federal and State requirements. Specifically, the State agency claimed \$18,727,441 (Federal share) of medical services and supplies that were not related to family planning. Contrary to State requirements, the claims for services did not contain approved primary diagnosis codes, and the claims for supplies did not contain approved therapeutic classification codes. By calculating the difference between what the State agency claimed and what it should have claimed, we determined that the State agency was overpaid \$8,458,169 (Federal share).

This overpayment occurred because the State agency's MMIS controls did not properly distinguish claims eligible for reimbursement at the 90-percent rate from claims eligible for reimbursement at the regular FMAP rate. In July 2007, the State agency changed the MMIS controls to properly identify these claims.

FEDERAL REQUIREMENTS

Pursuant to section 4270.B of the Manual, States are free to determine which family planning services and supplies will be covered as long as they are sufficient in amount, duration, and scope to reasonably achieve their purpose. However, the Manual states that only supplies and services clearly furnished for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate.

STATE REQUIREMENTS

The State plan provides for family planning services and supplies for Medicaid-eligible individuals of childbearing age without limitations.

For the Reproductive Health Services program, WAC § 388-532-120(1)(ii) states that for covered services for women, the State agency covers per client per year "[o]ne comprehensive family planning preventative medicine visit, billable by a Take Charge provider only." Pursuant to WAC § 388-532-120(2)(a), covered services for men include "[o]ffice visits where the primary focus and diagnosis is contraceptive management and/or there is a medical concern." Covered services for both men and women also include over-the-counter contraceptives, drugs, and supplies and sterilization procedures that meet the requirements of the WAC.

For the Family Planning Only and Take Charge programs, WAC §§ 388-532-550(1) and 388-532-780(1) follow Federal requirements and limit reimbursement to services that have a primary focus and diagnosis of family planning and are medically necessary for beneficiaries to safely, effectively, and successfully use chosen contraceptive methods. The State agency's *Family Planning Provider Billing Instructions* (pages B.2, B.5, C.27, and C.28) specifies that the diagnosis codes must be within the V25 code series and provides a list of authorized contraceptive management drugs. The ICD-9-CM defines the V25 diagnosis code series as contraceptive management.

For the Reproductive Health Services program, State agency officials informed us that the requirement to identify family planning services with a V25 diagnosis code or therapeutic classification code also applies.

SERVICES AND SUPPLIES NOT RELATED TO FAMILY PLANNING

The State agency claimed \$18,727,441 (Federal share) of medical services and supplies that were not related to family planning. We identified claims that were billed with primary diagnosis

codes or therapeutic classification codes that were not approved by the State agency as family planning services and supplies.⁵ The table below summarizes the improper claims.

Summary of Improper Claims

Claim Category	Amount Claimed (Federal Share)	Amount Overpaid (Federal Share)
Medical services	\$17,992,506	\$8,132,237
Supplies	734,935	325,932
Total	\$18,727,441	\$8,458,169

Primary Diagnosis Codes Not Eligible for Reimbursement at the 90-Percent Rate

The State agency claimed \$17,992,506 (Federal share) at the 90-percent rate for medical services that were not related to family planning. We reviewed the claim data and identified claims with primary diagnosis codes that were not in the V25 series and thus not eligible for reimbursement at the 90-percent rate. Examples of these diagnosis codes were V20.1, health supervision of infant or child; 250.00, diabetes mellitus; 724.2, lumbago; and 401.9, essential hypertension—unspecified.

These claims were for both the Medicaid and Take Charge programs. The claims for Medicaid beneficiaries were eligible for reimbursement at Washington State’s regular FMAP for the years in which the claims were paid. We calculated that the State agency was overpaid \$7,875,120 for these claims. The claims for Take Charge beneficiaries were not eligible for Federal reimbursement because Take Charge beneficiaries are eligible only for family planning services. Therefore, we disallowed the entire Federal reimbursement for these claims. The State agency was overpaid \$257,117. In total, we calculated that the State agency was overpaid \$8,132,237 for medical services not related to family planning.

Therapeutic Classification Codes Not Eligible for Reimbursement at the 90-Percent Rate

The State agency claimed \$734,935 (Federal share) at the 90-percent rate for supplies that were not related to family planning services. We reviewed the claims for supplies and identified claims with therapeutic classification codes that were not on the State agency’s list of authorized contraceptives and thus not eligible for reimbursement at the 90-percent rate. Specifically, the claims included two unapproved codes: X2A (needles and needleless devices) and X2B (syringes and accessories).

The claims for supplies were eligible for reimbursement at Washington State’s regular FMAP for the years in which the claims were paid. We calculated that the State agency was overpaid \$325,932 for these claims.

⁵ Appendix A contains examples of primary diagnosis and therapeutic classification codes claimed that were not related to family planning services and supplies.

CAUSE OF THE OVERPAYMENTS

The overpayments for services and supplies not related to family planning occurred because the State agency's MMIS controls did not properly distinguish claims eligible for reimbursement at the 90-percent rate from claims eligible for reimbursement at the regular FMAP rate. For example, the MMIS allowed a claim with an unapproved family planning diagnosis code, such as 724.2 for diabetes, to be reimbursed at the 90-percent rate if the claim had an approved family planning procedure code (such as 99201 for an office visit). Additionally, the MMIS did not properly limit reimbursement for supply claims to those with approved therapeutic classification codes.

In July 2007, the State agency found that the MMIS edits did not deny reimbursement at the 90-percent rate for claims that did not qualify as family planning services and supplies. The State agency corrected the MMIS edits, and we verified that they were working. However, the State agency did not review claims reimbursed before July 2007.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$8,458,169 to the Federal Government and
- identify and refund any overpayments for family planning claims before October 1, 2005, that did not contain approved primary diagnosis or therapeutic classification codes identifying the claims as eligible for reimbursement at the 90-percent rate.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, the State agency concurred with our findings and our first recommendation. Regarding our second recommendation, the State agency said that because it had implemented a new MMIS in May 2010, it was unable to review medical claims submitted before December 2005 or pharmacy claims submitted before April 2006. The State agency's comments are included in their entirety as Appendix B.

The State agency should work with CMS to resolve the issue of overpayments for medical claims submitted before December 2005 and pharmacy claims submitted before April 2006. Even though the detailed information is no longer available, CMS may want to use alternative methods, such as estimations, to determine the amount that the State agency should refund.

APPENDIXES

**APPENDIX A: EXAMPLES OF UNAPPROVED PRIMARY
DIAGNOSIS AND THERAPEUTIC CLASSIFICATION CODES**

Unapproved Primary Diagnosis Codes

V20.1	Health Supervision of Infant or Child
250.00	Diabetes Mellitus
724.2	Lumbago
465.9	Acute Upper Respiratory Infections
635.92	Legally Induced Abortion Without Mention of Complication
401.1	Essential Hypertension—Benign
382.10	Unspecified Otitis Media—Ear Infection
401.9	Essential Hypertension—Unspecified
V58.3	Attention to Surgical Dressings
042	Human Immunodeficiency Virus (HIV) Diseases
625.9	Unspecified Symptom Associated With Female Genital Organs
801.75	Open Fracture at Base of Skull

Unapproved Therapeutic Classification Codes

X2A	Needles and Needleless Devices
X2B	Syringes and Accessories

APPENDIX B: DEPARTMENT OF SOCIAL AND HEALTH SERVICES COMMENTS



STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Medication Purchasing Administration
626 8th Avenue, S.E. • P.O. Box 45502
Olympia, Washington 98504-5502

December 6, 2010

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, California 94103

Dear Ms. Ahlstrand:

We are in receipt of your draft report entitled *Review of Family Planning Services Claimed by Washington State during the Period October 1, 2005 through September 30, 2008*.

We concur with the findings and will make the necessary adjustments to the CMS 64 Report for the Quarter January 1, 2011 through March 31, 2011. We will return \$8,458,169 to the Federal Government.

The report also requests that we "...identify and refund any overpayments for family planning claims before October 1, 2005 that did not contain approved family planning diagnosis or therapeutic classification codes identifying the claims as eligible for reimbursement for the 90 percent rate." You may be aware that we implemented a new MMIS system, ProviderOne, on May 9, 2010. Consequently, we are unable to review medical claims submitted prior to December 2005 or pharmacy claims prior to April 2006, as that information is no longer available. We can assure you that our new ProviderOne system is now paying family planning claims correctly.

While it was distressing for us to discover via the audit process that our old system was not paying correctly, we appreciate the professional manner in which the audit was conducted. The family planning staff spoke very highly of both of the auditors, Teri Kirkpatrick and Virginia Liley, who conducted the review.

Sincerely,

Doug Porter
Administrator
Medicaid Director
Health Care Authority

cc: Preston Cody, Director, DHS and BH, HCA/MPA
Mo Considine, Program Manager, DHS, HCA/MPA
Thuy Hua-ly, Director, DRF, HCA/MPA
Cathie Ott, Assistant Director, DSM, HCA/MPA
Manning Pellanda, Director, DESD, HCA/MPA
Todd Slettvet, Office Chief, DHS, HCA/MPA
Mary Wood, Office Chief, DESD, HCA/MPA