

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**WASHINGTON STATE CLAIMED
UNALLOWABLE FEDERAL MEDICAID
REIMBURSEMENT FOR SOME
DENTAL SERVICES**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**James P. Edert
Acting Assistant Inspector General
for Audit Services**

**May 2016
A-09-13-02041**

Office of Inspector General

<http://oig.hhs.gov>

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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

Washington State claimed \$117,000 in unallowable Federal Medicaid reimbursement for dental services over a 3-year period.

WHY WE DID THIS REVIEW

Prior Office of Inspector General reviews of dental services provided under the Medicaid program identified unallowable payments due to documentation and billing errors, as well as concerns with the medical necessity of services provided. We selected Washington State for this review because its Medicaid dental expenditures increased by 49 percent between 2007 and 2012.

Our objective was to determine whether the Washington State Health Care Authority (State agency) claimed Federal Medicaid reimbursement for dental services that complied with certain Federal and State requirements.

BACKGROUND

Dental services are diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist. The Medicaid program pays for dental services provided to Medicaid-eligible children and in some States, dental services provided to eligible adults. Federal regulations state that for costs to be allowable under Federal awards, they must be necessary and reasonable, authorized or not prohibited under State laws or regulations, and adequately documented.

In Washington, State regulations identify coverage limitations and eligibility and documentation requirements for dental services. For certain dental services, a provider must submit a request for prior authorization to the State agency, which approves the request when it determines that a service is medically necessary.

Our audit covered approximately \$370.4 million (\$212.5 million Federal share) that the State agency claimed for dental services (excluding orthodontic services) from October 1, 2009, through September 30, 2012. We reviewed approximately 36,000 claim lines that contained potentially unallowable payments, totaling \$5.3 million.

WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for some dental services that did not comply with certain Federal and State requirements. We identified 2,251 claim lines that contained unallowable payments, consisting of (1) duplicate payments, (2) payments for services that were provided more frequently than State regulations allowed, and (3) payments for certain services that required prior authorization but for which the State agency did not have a record of providing authorization. The State agency made these unallowable payments because it did not have adequate internal controls within its claims processing system. As a result, the State agency claimed \$117,119 in unallowable Federal reimbursement.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund \$117,119 to the Federal Government and
- strengthen internal controls within its claims processing system to prevent payments for dental services that do not comply with Federal and State requirements.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency partially concurred with our first recommendation. The State agency agreed that all unallowable expenditures should be refunded and stated that it had recouped \$35,084 for some of the unallowable dental services. However, it disagreed that some services did not have or required a prior authorization and provided additional documentation for our consideration. The State agency concurred with our second recommendation and described the corrective action that it had taken to address our recommendation.

After reviewing the State agency's comments and additional documentation, we maintain that our findings and recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

Prior Office of Inspector General (OIG) reviews of dental services provided under the Medicaid program identified unallowable payments due to documentation and billing errors, as well as concerns with the medical necessity of services provided. We selected Washington State for this review because its Medicaid dental expenditures increased by 49 percent between 2007 and 2012. (Appendix A lists related OIG reports on Medicaid dental services.)

OBJECTIVE

Our objective was to determine whether the Washington State Health Care Authority (State agency) claimed Federal Medicaid reimbursement for dental services that complied with certain Federal and State requirements.

BACKGROUND

Medicaid Program

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.

The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. During our audit period (October 1, 2009, through September 30, 2012), the FMAP in Washington ranged from 50 to 62.94 percent.¹

Medicaid Coverage of Dental Services

Dental services are diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist. The Social Security Act (the Act) authorizes Federal reimbursement for dental services (§§ 1903(a)(1) and 1905(a)(10)). Medicaid pays for dental services provided to Medicaid-eligible children and, in some States, dental services provided to eligible adults:

- States must provide dental services through the early and periodic screening, diagnosis, and treatment (EPSDT) program to individuals under the age of 21 who are eligible under the State plan (the Act §§ 1905(a)(4)(B) and 1905(r)(3)). The EPSDT program requires States to provide dental services at intervals that meet reasonable standards of dental

¹ The American Recovery and Reinvestment Act of 2009 (P.L. No. 111-5) provided temporary increases in the FMAP rates from October 1, 2008, through June 30, 2011 (§ 5001).

practice and as medically necessary.² These services must, at a minimum, include relief of pain and infections, restoration of teeth, and maintenance of dental health, as well as any medically necessary dental services as determined by an EPSDT screening.³

- States have the flexibility to determine which dental services, if any, are provided to adult Medicaid beneficiaries (i.e., 21 years of age and older). There are no federally mandated minimum requirements for adult dental coverage.

For costs to be allowable under Federal awards, they must be necessary and reasonable for proper and efficient performance and administration of Federal awards, be authorized or not prohibited under State or local laws or regulations, and be adequately documented (2 CFR part 225, App. A, §§ C.1.a, C.1.c, and C.1.j, respectively).⁴ The Federal Government will reduce payment to the State by any overpayments made.

Medicaid Coverage of Dental Services in Washington

In Washington, the State agency administers the Medicaid program. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims for payment, including claims for dental services.

For Medicaid beneficiaries under the age of 21, the State agency provides comprehensive dental benefits, such as diagnostic, preventive, restorative, endodontic, prosthodontic, and oral and maxillofacial surgery services.⁵ The State agency also provides dental benefits to adult Medicaid beneficiaries (i.e., 21 years of age and older).⁶ The State agency pays for most dental services on a fee-for-service basis.

State Requirements for Dental Services

The Washington Administrative Code (WAC), chapter 182-535, contains the State agency's regulations for dental-related services, including coverage limitations, restrictions, beneficiary-age requirements for specific services, and documentation requirements.⁷ The State agency pays for dental-related services provided to an eligible beneficiary when the services meet the

² The Act § 1905(r)(3)(A) and the CMS *State Medicaid Manual* (the Manual) § 5110.

³ The Act § 1905(r)(3)(B); 42 CFR § 441.56(c)(2); and the Manual §§ 5110 and 5122.C.

⁴ Office of Management and Budget (OMB) Circular No. A-87, *Cost Principles for State, Local, and Tribal Governments*, was relocated to 2 CFR part 225. After our audit period, OMB consolidated and streamlined its guidance, which is now located at 2 CFR part 200.

⁵ Endodontic services include the diagnosis, prevention, and treatment of diseases and injuries of the pulp and associated conditions. Prosthodontics is the treatment of patients with missing or deficient teeth. Oral and maxillofacial surgery specializes in treating many diseases and injuries of the head, neck, face, mouth, and jaw.

⁶ The State agency's coverage of dental services for adults ended on January 1, 2011, and was restored on January 1, 2014.

⁷ During our audit period, Title 388 of the WAC was recodified as Title 182. For this report, we cited Title 182.

agency's prior authorization requirements (if any); are reasonable in amount and duration of care, treatment, or service; and are listed as covered in the agency's rules, published billing instructions, and fee schedules (WAC §§ 182-535-1079(1)(d), (e), (h), and (i)).

Prior Authorization for Dental Services

Certain dental services require providers to obtain prior authorization from the State agency for performing the service (WAC § 182-535-1079(1)(d)). In these cases, providers must submit to the State agency a request for prior authorization in writing, electronically, or by telephone, along with sufficient clinical information to establish medical necessity for the services requested, such as pertinent x-rays, patient records, or clinical findings and diagnosis. The State agency approves a request when it determines that the service is medically necessary (WAC §§ 182-535-1220(1), (2), and (5)). The provider is then eligible for payment from the State for the service.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$370,421,881 (\$212,542,620 Federal share) that the State agency claimed for dental services (excluding orthodontic services) from October 1, 2009, through September 30, 2012, representing 10,627,873 fee-for-service claim lines. We reviewed 35,814 claim lines that contained potentially unallowable payments, totaling \$5,291,452.

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 objectives.

Appendix B contains the details of our audit scope and methodology.

FINDINGS

The State agency claimed Federal Medicaid reimbursement for some dental services that did not comply with certain Federal and State requirements. We identified 2,251 claim lines that contained unallowable payments, consisting of (1) duplicate payments, (2) payments for services that were provided more frequently than State regulations allowed, and (3) payments for certain services that required prior authorization but for which the State agency did not have a record of providing authorization. The State agency made these unallowable payments because it did not have adequate internal controls within its claims processing system. As a result, the State agency claimed \$117,119 in unallowable Federal reimbursement.

THE STATE AGENCY CLAIMED FEDERAL MEDICAID REIMBURSEMENT FOR SOME DENTAL SERVICES THAT DID NOT COMPLY WITH CERTAIN FEDERAL AND STATE REQUIREMENTS

The State agency claimed Federal Medicaid reimbursement for some dental services that did not comply with certain Federal and State requirements. Specifically, we identified 2,251 claim lines that contained unallowable payments for services. In total, the State agency claimed \$117,119 in unallowable Federal reimbursement, as summarized in the table below.

Table: Unallowable Federal Reimbursement for Dental Services

Unallowable Dental Services	Applicable Federal or State Requirement	No. of Claim Lines	Unallowable Federal Reimbursement
Certain crowns provided more frequently than once every 3 years	WAC § 182-535-1084(6)(b)	410	\$40,836
Certain indirect crowns and endodontic retreatments provided without an approved prior authorization	WAC § 182-535-1084(5)(a) WAC § 182-535-1086(3)(e)	181	29,051
Services on a tooth (such as fillings, crowns, or other extractions) provided on the same date as or after an extraction of the same tooth	2 CFR part 225, App. A, § C.1.a	695	26,430
Duplicate payments for the same beneficiary, service, and date	2 CFR part 225, App. A, § C.1.a	653	12,148
More than one comprehensive oral exam provided per beneficiary per provider/clinic	WAC § 182-535-1080(1)(d) WAC § 388-535-1255(1)(d)	268	5,127
Multiple crowns provided on one tooth on a single date of service	2 CFR part 225, App. A, § C.1.a	44	3,527
Total		2,251	\$117,119

See Appendix C for details of the State requirements used to determine the unallowable services.

THE STATE AGENCY DID NOT HAVE ADEQUATE CONTROLS TO PREVENT UNALLOWABLE PAYMENTS FOR DENTAL SERVICES

The State agency made unallowable payments for dental services because it did not have adequate controls within its claims processing system. For example, the State agency did not have edits properly set up in its MMIS to prevent duplicate payments for services. Additionally, in at least one instance, State agency staff had overridden the prior authorization edit that the

State agency had implemented in the MMIS. During our audit, the State agency began the process of recouping the overpayments we identified.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$117,119 to the Federal Government and
- strengthen internal controls within its claims processing system to prevent payments for dental services that do not comply with Federal and State requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency partially concurred with our first recommendation. The State agency agreed that all unallowable expenditures should be refunded and stated that it had recouped \$35,084 for some of the unallowable dental services. However, it disagreed that some services did not have or required a prior authorization:

- The State agency provided additional documentation for claim lines for indirect crowns that it stated had prior authorizations that had not been captured in the claim payment data we reviewed.
- The State agency provided additional documentation for claim lines for endodontic retreatments and maintained that State agency rules allow retreatments by a provider who was not the original provider.

The State agency concurred with our second recommendation and described the corrective action that it had taken to address our recommendation. The State agency's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments and additional documentation, we maintain that our findings and recommendations are valid. The prior authorizations for indirect crowns that the State agency provided were either for claims after our audit period or for different procedure codes. Regarding the additional documentation that the State agency provided for endodontic retreatments, testimony from a State agency official during our audit concurred that a prior authorization was needed regardless of who provided the retreatment. We continue to recommend that the State agency refund \$117,119 to the Federal Government.

OTHER MATTER

THE STATE AGENCY MAY HAVE PAID FOR SERVICES THAT WERE NOT WITHIN ACCEPTED DENTAL PRACTICE STANDARDS

The State agency pays for dental-related services when the services are within accepted dental practice standards and when they are reasonable in amount and duration of care, treatment, or service (WAC §§ 182-535-1079(f) and (h)).

During our review, we identified payments for services that appeared unlikely to have been performed based on general dental practice standards for tooth development. For example, according to tooth development charts developed by the ADA, permanent second and third molars erupt around the ages of 11 and 17, respectively. We found instances where the State agency paid providers for services on these teeth for beneficiaries 6 years of age and younger. We discussed these specific instances with State agency officials to determine the likelihood that the services were actually performed. As a result, the State agency has requested provider records to review some of these services.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Most Children With Medicaid in Four States Are Not Receiving Required Dental Services</i>	<u>OEI-02-14-00490</u>	1/20/2016
<i>Questionable Billing for Medicaid Pediatric Dental Services in California</i>	<u>OEI-02-14-00480</u>	5/15/2015
<i>North Carolina Claimed Federal Medicaid Reimbursement for Dental Services That Did Not Always Comply With Federal and State Requirements</i>	<u>A-04-13-04014</u>	3/26/2015
<i>Questionable Billing for Medicaid Pediatric Dental Services in Indiana</i>	<u>OEI-02-14-00250</u>	11/4/2014
<i>Questionable Billing for Medicaid Pediatric Dental Services in Louisiana</i>	<u>OEI-02-14-00120</u>	8/19/2014
<i>Questionable Billing for Medicaid Pediatric Dental Services in New York</i>	<u>OEI-02-12-00330</u>	3/25/2014

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$370,421,881 (\$212,542,620 Federal share) that the State agency claimed for dental services (excluding orthodontic services) from October 1, 2009, through September 30, 2012, representing 10,627,873 fee-for-service claim lines. We reviewed 35,814 claim lines that contained potentially unallowable payments, totaling \$5,291,452.

We did not review the overall internal control structure of the State agency or the Medicaid program. We reviewed only those internal controls related to our objective. We limited our review to determining whether the State agency claimed Federal Medicaid reimbursement for dental expenditures in compliance with Federal and State requirements.

We performed our fieldwork at the State agency's office in Olympia, Washington.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance and the State plan;
- held discussions with CMS officials to gain an understanding of Washington's Medicaid dental program;
- held discussions with State agency officials to gain an understanding of the State agency's internal controls over claiming Federal reimbursement for dental services;
- obtained paid claim data for dental services from the State agency's MMIS for the audit period, representing 15,425,659 claim lines totaling \$633,514,079;
- removed 4,797,786 claim lines, totaling \$263,092,198, consisting of claim lines that (1) were not paid on a fee-for-service basis, (2) were paid entirely with State funds, (3) were paid to Federally Qualified Healthcare Centers, (4) were paid under the Children's Health Insurance Program, (5) had no dollars paid, or (6) were for orthodontic services;
- from the remaining 10,627,873 claim lines (totaling \$370,421,881), identified and reviewed 35,814 claim lines, totaling \$5,291,452, that contained potentially unallowable payments, such as duplicate payments, payments for services that were provided more frequently than State regulations allowed, and payments for services for which there was no evidence of a required prior authorization;
- determined the Federal share of unallowable costs by identifying the date that the State agency paid each claim and applying the corresponding FMAP rate to the amount paid; and

- discussed our findings with State agency officials.

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 objectives.

APPENDIX C: STATE REQUIREMENTS FOR DENTAL SERVICES

WAC § 182-535-1084(6)(b)

The State agency covers prefabricated stainless steel crowns with resin window, resin-based composite crowns, prefabricated esthetic coated stainless steel crowns, and fabricated resin crowns for primary anterior teeth once every 3 years only for beneficiaries 20 years of age and younger.

WAC § 182-535-1084(5)(a)⁸

The State agency covers the following indirect crowns once every 5 years, per tooth, for permanent anterior teeth for beneficiaries from 12 to 20 years of age when the crowns meet prior authorization criteria: (1) porcelain/ceramic crowns to include all porcelains, glasses, glass-ceramic, and porcelain fused to metal crowns and (2) resin crowns and resin metal crowns to include any resin-based composite, fiber, or ceramic-reinforced polymer compound.

WAC § 182-535-1086(3)(e)⁹

The State agency covers endodontic retreatment for beneficiaries 20 years of age and younger when the provider has obtained a prior authorization for the service.

WAC §§ 182-535-1080(1)(d) and 388-535-1255(1)(d)¹⁰

The State agency covers comprehensive oral evaluations once per beneficiary, per provider or clinic, as an initial examination.

⁸ Also located in WAC § 388-535-1084(8)(a).

⁹ After our audit period, this requirement was moved to WAC § 182-535-1086(5)(a).

¹⁰ WAC § 388-535-1255(1)(d) applied to adult dental beneficiaries until coverage of adult comprehensive services ended on January 1, 2011.

APPENDIX D: STATE AGENCY COMMENTS



STATE OF WASHINGTON HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

March 21, 2016

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region X
Office of Inspector General
Department of Health and Human Services
90 7th Street, Suite 3-650
San Francisco, CA 94103

Dear Ms. Ahlstrand:

SUBJECT: Report Number: A-09-13-02041

The Washington State Health Care Authority (HCA) welcomes the opportunity to provide comments on the recommendations contained in the draft report entitled *Washington State Claimed Unallowable Federal Medicaid Reimbursement for Some Dental Services*.

As requested in your letter dated January 19, 2016, HCA is providing a statement of concurrence or non-concurrence for each of the recommendations contained in the draft report.

Recommendation 1: *Refund \$117,119 to the Federal Government.*

HCA partially concurs with this recommendation. HCA agrees that all unallowable expenditures should be refunded to the Federal Government and has already recouped \$35,084 of the identified unallowable expenditures.

The Office of the Inspector General (OIG) questions \$29,051 as unallowable because HCA did not have documentation of prior authorization for certain indirect crowns and endodontic retreatments. HCA believes approximately \$21,848 of those costs are allowable, as explained below:

- HCA has provided additional documentation to OIG that 39 of the questioned claim lines for crowns did have a prior authorization. Unfortunately, these prior authorizations were not captured in the claims payment data reviewed by OIG. The federal share of these costs total approximately \$13,000.

Lori A. Ahlstrand
Regional Inspector General for Audit Services
March 21, 2016
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- HCA has also provided additional documentation to the OIG that certain questioned endodontic retreatments were treatments by a provider who was not the original provider. HCA rules allow retreatments provided by a different provider. The federal share of these treatments total \$8,848.

Recommendation 2: *Strengthen internal controls within its claims processing system to prevent payments for dental services that do not comply with federal and state requirements.*

HCA concurs with this recommendation and has developed algorithms to identify the types of exceptions noted by OIG in this report.

Should you have any questions or concerns, please contact Kathy E. Smith, Audit and Accountability Manager, by telephone at 360-725-0937 or via email at kathy.smith2@hca.wa.gov.

Sincerely,

Dorothy F. Teeter

MaryAnne Lindeblad

Dorothy F. Teeter, MHA
Director

MaryAnne Lindeblad, BSN, MPH
Medicaid Director

By certified mail
By email

cc: Kathy E. Smith, Audit and Accountability Manager, EXO, HCA
Dianne Baum, Medical Assistance Program Specialist 3, CQCT, HCA