Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2005

Summary of Auditor's Results

FINANCIAL STATEMENTS

- We issued an unqualified opinion on the state's financial statements.
- We found no significant deficiencies in the design or operation of internal control over financial reporting that we consider a reportable condition.
- We noted no instances of noncompliance that were material to the financial statements of the state.

FEDERAL AWARDS

- Except for the Medicaid program, we issued an unqualified opinion on the state's compliance with requirements applicable to each of its major federal programs.
- We noted deficiencies in the design or operation of internal control over major federal programs that we consider to be reportable conditions. The following reportable conditions noted in this schedule are considered material weaknesses: 05-01 to 05-04, 05-06, 05-08 to 05-12, 05-15 to 05-16, 05-23 to 05-26, 05-28 to 05-30, 05-35 and 05-53.
- We reported findings that are required to be disclosed under OMB Circular A-133, Section 510(a).
- The dollar threshold used to distinguish between Type A and Type B programs, as prescribed by OMB Circular A-133, Section 520(b), was $28,759,600.
- The state did not qualify as a low risk auditee under OMB Circular A-133, Section 530.
- The following were major programs, determined in accordance with OMB Circular A-133, Section 520:

CFDA	PROGRAM
	Food Stamp Cluster
10.551	Food Stamps
10.561	State Administrative Matching Grants for Food Stamp Program
10.557	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
12.401	National Guard Military Operations & Maintenance (O&M) Projects

Summary of Auditor's Results- continued

CFDA	PROGRAM
17.225	Unemployment Insurance (UI)
17.245	Trade Adjustment Assistance--Workers
 17.258 17.259 17.260	WIA Cluster WIA Adult Program WIA Youth Activities WIA Dislocated Workers
20.205	Highway Planning & Construction
64.005	Grants to States for Construction of State Home Facilities
66.458	Capitalization Grants for Clean Water State Revolving Funds
84.010	Title I Grants to Local Educational Agencies (LEAs)
84.126	Rehabilitation Services—Vocational Rehabilitation Grants to States
93.268	Immunization Grants
93.283	Center for Disease Control and Prevention Investigations and Technical Assistance
93.389	National Center for Research Resources/Research Infrastructure
93.556	Promoting Safe and Stable Families
93.558	Temporary Assistance to Needy Families (TANF)

Summary of Auditor's Results- continued

CFDA	PROGRAM
93.568	Low-Income Home Energy Assistance
	CCDF Cluster
93.575	Child Care and Development Block Grant
93.596	Child Care Mandatory and Matching Funds for the Child Care and Development Fund
93.658	Foster Care—Title IV-E
93.659	Adoption Assistance
93.767	State Children's Health Insurance Program (SCHIP)
	Medicaid Cluster
93.775	State Medicaid Fraud Control Units
93.777	State Survey and Certification of Health Care Providers and Suppliers
93.778	Medical Assistance Program (Medicaid: Title XIX)
93.959	Block Grant for Prevention and Treatment of Substance Abuse
	Disability Insurance/SSI Cluster
96.001	Social Security—Disability Insurance (DI)
96.006	Supplemental Security Income (SSI)
	Student Financial Assistance Programs
84.007	Federal Supplemental Educational Opportunity Grants
84.032	Federal Family Education Loans
84.033	Federal Work-Study Program
84.038	Federal Perkins Loan Program Federal Capital Contributions
84.063	Federal Pell Grant Program
84.268	Federal Direct Student Loans
84.364	Literacy Through School Libraries
Various	Research and Development Cluster

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2005

Financial Statement Findings

None reported. However, we do report instances of noncompliance with state laws and regulations that are not material to the state's basic financial statements in separate agency accountability reports. These reports are available on our internet site at **www.sao.wa.gov/.**

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2005

Summary of Federal Findings

Finding Number	Finding
05-01	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not have procedures to identify treatments and services that may not be allowable for reimbursement under the State Medicaid Plan.
05-02	The Department of Social and Health Services, Aging and Disability Services Administration, does not have adequate controls to ensure that all alleged violations and complaints of abuse and neglect are investigated in accordance with federal law.
05-03	The Department of Social and Health Services, Aging and Disability Services Administration, does not perform certification surveys of Intermediate Care Facilities for the developmentally disabled according to federal law.
05-04	The Department of Social and Health Services, Aging and Disability Services Administration does not have a process to impose sanctions, recover funds, schedule or hold hearings for Intermediate Care Facilities for the Developmentally Disabled that are not in substantial compliance with federal health and safety standards.
05-05	The Department of Health is not conducting hospital surveys according to the frequency stipulated by state law and the Medicaid State Plan.
05-06	The Department of Health and the Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), are not ensuring compliance with federal law regarding hospital surveys.
05-07	The Department of Health and the Department of Social and Health Services, Health and Recovery Services Administration, agreement covering hospitals' survey activities does not comply with federal requirements.
05-08	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), received federal Medicaid funds for unallowable services provided to undocumented aliens.
05-09	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), is not complying with federal requirements to defer Medicaid expenditures related to undocumented aliens.
05-10	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), has not established sufficient internal controls to support its decisions on eligibility of clients enrolled in Medicaid's Basic Health Plus Program.

Finding Number	Finding
05-11	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not have procedures to determine whether expenditures for anabolic steroids are allowable under the Medicaid program.
05-12	The Department of Social and Health Services is not adequately reviewing pharmaceutical claims to identify patterns of fraud and abuse.
05-13	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), is not in compliance with the federal Medicaid requirements for reporting adult victims of residential abuse to the Medicaid Fraud Control Unit.
05-14	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not perform adequate reviews of providers of durable medical equipment to ensure the providers exist, are properly licensed and have submitted accurate information.
05-15	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), has not established sufficient internal controls to prevent Medicaid payments for services provided after a client's death or to prevent payments for services provided to individuals using the Social Security number of a deceased person.
05-16	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), did not ensure that home health agencies providing services under the Medicaid program complied with federal surety bond requirements.
05-17	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not have adequate reviews of home health agencies to ensure providers are licensed, Medicare certified and have signed a Core Provider Agreement as required by law.
05-18	The Department of Health does not retain documentation that would provide evidence to ensure all home health agency providers performed criminal background checks and obtained disclosures on employees having unsupervised access to vulnerable adults, as the law requires.
05-19	The Department of Social and Health Services, Aging and Disability Services Administration, does not ensure providers of home health care services are Medicare-certified as required by the Medicaid State Plan.
05-20	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), is not complying with federal regulations that require people receiving Medicaid benefits to have valid Social Security numbers.

Finding Number	Finding
05-21	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), has not established internal controls sufficient to ensure payment rates to its Healthy Options managed care providers are based on accurate data.
05-22	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), made supplemental Medicaid payments to public hospital districts totaling $41,154,000 without a federally approved payment methodology.
05-23	The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not ensure that providers of motorized wheelchairs have the documentation required to substantiate claims for payment.
05-24	The Department of Social and Health Services, Office of Financial Recovery and Health and Recovery Services Administration (formerly Medical Assistance Administration), does not have adequate internal controls to ensure that final settlement amounts are refunded to the federal government and in a timely manner.
05-25	The Department of Social and Health Services' Office of Accounting Services does not have adequate internal controls to ensure the federal portion of uncashed and cancelled warrants is refunded at the appropriate rate to the federal Medicaid Program.
05-26	The Department of Social and Health Services' Office of Accounting Services does not have sufficient controls to ensure that the federal portion of uncashed warrants is refunded to the Medicaid Program in a timely manner.
05-27	The Department of Social and Health Services, Aging and Disability Services Administration and Health and Recovery Services Administration (formerly Medical Assistance Administration), has not set up an effective system to ensure Medicaid payments are not being made to nursing homes that are not in compliance with federally mandated health and safety standards.
05-28	The Department of Social and Health Services paid providers with Medicaid funds through the Social Services Payment System for services to clients using Social Security numbers belonging to deceased persons.
05-29	The Department of Social and Health Services does not have adequate internal controls over the processing of expenditures through the Agency Financial Reporting System.
05-30	The Department of Social and Health Services, Division of Child Care and Early Learning, does not have adequate internal controls over support for payments to child care providers.
05-31	The Department of Social and Health Services, Division of Child Care and Early Learning and Children's Administration, did not perform adequate background checks.

Finding Number	Finding
05-32	The Department of Social and Health Services, Economic Services Administration, reimbursed contractors for services that were not adequately supported.
05-33	The Department of Social and Health Services made unallowable duplicate payments through the Social Services Payment System.
05-34	The Department of Social and Health Services does not ensure that all recovered overpayments are credited to the appropriate funding source.
05-35	The Department of Social and Health Services does not have adequate internal controls over the Social Service Payment System.
05-36	The Department of Social and Health Services, Economic Services Administration, should improve compliance with eligibility requirements for the Temporary Assistance for Needy Families Program.
05-37	The Department of Social and Health Services, Economic Services Administration, does not adequately monitor other state agencies to which it provides funds from the federal Temporary Assistance to Needy Families Program.
05-38	The Department of Social and Health Services, Economic Services Administration, did not comply with state and federal regulations requiring a monthly inventory of electronic benefit transfer cards used by the Food Stamp Program.
05-39	The Department of Social and Health Services, Division of Disability Determination Services, did not comply with state and federal regulations when contracting for services paid with Social Security Disability Insurance Program funds.
05-40	The Department of Social and Health Services, Division of Disability Determination Services, reported incorrect expenditures for the Social Security Disability Insurance Program on several reports, including the Schedule of Expenditures of Federal Awards.
05-41	The Department of Social and Health Services, Division of Disability Determination Services, received reimbursement for unallowable costs for the Social Security Disability Insurance Program.
05-42	The Department of Social and Health Services, Health and Recovery Services Administration, claimed costs for unallowable activities under the State Children's Health Insurance Program.
05-43	The Department of Social and Health Services, Mental Health Division, did not comply with state laws or the Department's policies and procedures for recovering a Community Mental Health Services Block Grant overpayment reported in the previous audit.

Finding Number	Finding
05-44	The Department of Social and Health Services, Mental Health Division, did not comply with state and federal regulations when contracting for services paid with federal Community Mental Health Services Block Grant funds.
05-45	The Department of Social and Health Services, Mental Health Division, did not comply with federal requirements for independent peer reviews of the Community Mental Health Services Block Grant.
05-46	The Department of Social and Health Services, Mental Health Division, is not complying with subrecipient monitoring requirements for the Community Mental Health Services Block Grant.
05-47	The Department of Community, Trade, and Economic Development did not comply with state and federal regulations when contracting for services paid with federal Low Income Home Energy Assistance Program funds.
05-48	The Department of Community, Trade, and Economic Development, Energy Assistance Section, is not complying with subrecipient monitoring requirements for the Low Income Home Energy Assistance Program.
05-49	The Department of Community, Trade, and Economic Development did not comply with earmarking requirements for the Low Income Home Energy Assistance Program.
05-50	Certain University of Washington departments' controls are not working effectively to ensure Time And Effort Certification forms are completed in a timely manner and to ensure monthly certification of salaries and wages paid for federal programs are completed as required.
05-51	The University of Washington did not submit financial status reports in a timely manner.
05-52	The Department of Community, Trade, and Economic Development did not comply with federal requirements for suspension and debarment for the Home Investment Partnership Program.
05-53	The Department of Employment Security has inadequate internal controls over payments to claimants for unemployment insurance benefits.
05-54	The Employment Security Department did not comply with federal requirements for suspension and debarment for the Workforce Investment Act and Unemployment Insurance programs.

Finding Number	Finding
05-55	The Military Department is not properly accounting for and safeguarding assets purchased by the National Guard Military Operations and Maintenance Projects Program.
05-56	The Military Department is not in compliance with subrecipient monitoring requirements for the State Domestic Preparedness Equipment Support Program.
05-57	The Military Department was reimbursed for unallowable charges for the National Guard Military Operations and Maintenance Projects Program.
05-58	The Department of Ecology is not complying with subrecipient monitoring requirements for the Clean Water State Revolving Funds Program.
05-59	The State of Washington is not complying with federal requirements for time and effort reporting for some of the programs it administers.

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2005

Summary of Questioned Costs

Federal Grantor	State Agency	CFDA No.	Federal Program	Questioned Costs	Finding No.
U.S. Department of Health and Human Services	Department of Social and Health Services	93.778	Medicaid	$80,363,063	05-01 to 05-28
U.S. Department of Health and Human Services	Department of Social and Health Services	93.575 93.596 93.558 93.667	Childcare Cluster Child Care and Development Fund Temporary Assistance for Needy Families Social Services Block Grant	$800,000	05-30
U.S. Department of Agriculture	Department of Social and Health Services	10.561	State Administrative Matching Grants for the Food Stamp Program	$136,891	05-32
U.S. Department of Health and Human Services	Department of Social and Health Services	93.658 93.659 93.778	Foster Care Title IV-E Adoption Support Medicaid	$ 6,480 $ 3,000 $35,398	05-33
U.S. Department of Health and Human Services	Department of Social and Health Services	93.558	Temporary Assistance for Needy Families	$7,516,082	05-37
U.S. Department of Health and Human Services	Department of Social and Health Services	96.001	Social Security—Disability Insurance (DI)	$7,740,327 $76,021	05-39 05-41
U.S. Department of Health and Human Services	Department of Social and Health Services	93.767	State Children's Insurance Program	$1,573,409	05-42
U.S. Department of Health and Human Services	Department of Community, Trade and Economic Development	93.568	Low-Income Home Energy Assistance	$60,000 $476,609	05-47 05-49
U.S. Department of Labor	Employment Security Department	17.225 (**Note 1**)	Unemployment Insurance	$54,523	05-53
U.S. Department of Defense	Military Department	12.401	National Guard Military Operations and Maintenance Projects Program	$1,486,473 $24,939	05-56 05-57

Summary of Questioned Costs - continued

Federal Grantor	State Agency	CFDA No.	Federal Program	Questioned Costs	Finding No.
U.S. Department of Justice	Department of Social and Health Services	16.523	Juvenile Accountability Incentive Block Grant	$24,849	05-59
U.S. Department of Education		84.126	Rehabilitation Services Vocational Rehabilitation Grants to States	$101,618	
U.S. Department of Health and Human Services and the	Department of Community, Trade and Economic Development	93.568	Low Income Home Energy Assistance Program	$16,843	
U.S. Department of Defense	Military Department	12.401	National Guard Military Operations and Maintenance Projects Program	$217,630	
Department of Justice Department of Homeland Security		16.007 & 97.004 **(Note 2)**	State Domestic Preparedness Equipment Support Program	$353,000	
			TOTAL	**$101,067,155**	

Note 1 – The costs listed in finding 05-53 relate to unemployment benefits paid from state unemployment tax revenues that are deposited into Unemployment Trust Fund. Although these payments are not costs charged to a federal award, they are subject to audit under OMB Circular A-133 and reported in a manner similar to federal questioned costs.

Note 2 – This finding 05-59 relates to federal funding that was initially funded by the U.S. Department of Justice but the program was transferred to the U.S. Department of Homeland Security.

Federal Findings and Questioned Costs

05-01 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not have procedures to identify treatments and services that may not be allowable for reimbursement under the State Medicaid Plan.

Background

In our audit of 2004, we found charges for treatments and services that did not appear to comply with the State Medicaid Plan's descriptions of allowable services. Specifically, we found clients who appeared to have received elective surgical procedures for purposes other than remedying health conditions. Diagnostic and procedure codes on providers' claims for reimbursement indicated these procedures included cosmetic and other elective surgeries that might not be allowable with Medicaid funds or that would require pre-authorization. We performed our review with the information that was available to us. However, we encountered difficulties in obtaining information as follows:

- We were not provided access to line staff at the Administration's Division of Medical Management and were unable to obtain information from consultants to help us determine what controls were in place and whether the procedures were pre-authorized.

- We did not receive requested documentation in a timely manner. We were given the information after our audit ended.

Description of Condition

In our current audit, we performed computer analysis of 22 of the diagnosis and procedure codes identified in our previous audit that appeared to be unallowable, cosmetic or requiring pre-authorization. We found 1,582 transactions totaling $325,784 for these procedures. From these transactions, we selected three diagnostic areas to review further. Our selection was based on the amount of claims paid by the Administration for these procedures and the risk that these expenditures may not be considered medically necessary under the Medicaid program. We selected:

- Clients that received breast enlargements.

- Clients that received breast reductions.

- Clients that received surgeries for trans-sexualism, or pre- or post-surgery hormone treatment, or other related treatment.

From these groupings, we selected 28 clients. Nineteen were from the first two groups and nine from the last group. We obtained medical records pertaining to treatment of these clients directly from the providers, when we were able, and reviewed each for medical necessity and pre-authorization by the Division of Medical Management.

For the 19 clients receiving surgeries of the breast we found three (16 percent) were not required for reconstruction due to cancer or to alleviate pain. Costs related to these clients totaled $4,795.
From the last category:

- We found one client who received the surgery. The expenditures paid under the diagnosis code for trans-sexualism totaled $70,998 with $56,257 paid in 2002, $11,487 in 2003 and $3,253 in 2004. We have evidence showing the Department initially considered these procedures "non-covered service". We also have evidence that this care was pre-authorized pursuant to a settlement agreement. The agreement

authorized the Department to pay for some of the procedures, but would not pay for surgeries related to cosmetic procedures. We did see evidence that one of the procedures was cosmetic. In addition, the Department's records indicated that it paid, at least in part, for transportation to the distant state where procedures were performed.

- One client apparently paid for some of the surgery. We have evidence that pre-authorization was requested by both client and physician for other surgical procedures related to the transition but was denied by the Department. However, we found authorization for some procedures. It was not clear from the documentation provided by the Department why some procedures were considered medically necessary and others were not. The expenditures paid on behalf of this client under the trans-sexual diagnostic code were $1,440.

- The other seven clients had expenditures coded under the diagnostic code for trans-sexualism, but for procedures that did not include the surgery. Some of these procedures included skin grafts, office visits and therapeutic, prophylactic or diagnostic injections. The Department reports no authorization was given for payments under the diagnostic code for trans-sexualism on behalf of these clients but provided no evidence that would support these representations. We do not know if these clients requested care and were denied or if the payments were paid without going through the pre-authorization process. Expenditures for these seven clients totaled $18,707.

Due to the highly sensitive nature of these medical procedures and the fact that "medical necessity" as defined in the Medicaid State Plan and Washington Administrative Code is broad enough to cover almost any interpretation, we consulted with the U.S. Department of Health and Human Services, Office of the Inspector General for additional guidance. Our discussions with the federal government indicated such procedures generally would not be considered allowable expenditures for federal Medicaid dollars.

The purpose of our review was not to identify all trans-sexual clients. The code identifying trans-sexual surgeries was found in our previous audit while performing other audit procedures and we followed up as required by federal audit standards. We do not know if other clients received treatments for trans-sexual surgeries. Transition procedures may have been paid under codes other than those designated for trans-sexualism.

Cause of Condition

The Administration has no procedures for documenting its approval or denial of requests for authorization.

Effect of Condition

We found charges for treatments and procedures which the federal government indicated would generally not be considered allowable for federal Medicaid dollars. However, our testing showed that the Department was unable to provide support for their decisions of medical necessity for certain procedures. This was often due to no supporting documentation. In cases that were preauthorized we could not determine why some procedures were considered allowable while others were not. We also found clients who appeared to have received elective surgical procedures for purposes other than remedying health conditions. The total questioned costs of these procedures were $95,940. Of this amount $47,970 was paid with federal funds.

Because the costs related to trans-sexual surgeries occur over a period of time and are likely to continue over the individual's lifetime, the total cost of care for clients receiving these procedures is unknown. Additionally, we do not know if any other services, unrelated to physical treatments such as psychosexual counseling, were paid on behalf of these clients and charged to the Medicaid program.

Recommendation

We recommend the Department:

- Ensure procedures that are not medically necessary or are for purposes other than remedying health conditions are not paid for with federal Medicaid funds.

- Consider amending its rule to better define "medically necessary".

- Provide consistent treatment of all clients requesting services that may not be covered and be sure such decisions are adequately documented.

- Work with U.S. Department of Health and Human Services to determine if any costs charged to Medicaid federal funds must be reimbursed as a result of this noncompliance.

Department's Response

The Department partially agrees with the finding.

Breast Enlargement and Reduction Surgeries

With respect to breast enlargement and reduction surgeries, the Department currently manages breast reduction and enlargement under the expedited prior authorization (EPA) program. This program is intended to manage services that are often provided under the appropriate medical circumstances, but which do require some review. This program allows authorization staff to focus on reviewing those services that do not meet an established threshold. The criteria establishing the medical necessity of services in the EPA program is published in the Department's billing instructions and providers are required to certify the criteria were met at the time a service is performed. All providers, physicians and the hospital, which bill for services associated with performing the service, are asked to prepare the claim form using the authorization code designated for that service.

To assure funds were not disbursed for treatment that was not medically necessary, a review was conducted on the four clients whose names were provided to the Health and Recovery Services Administration (HRSA) as having received breast reduction mammoplasties without documented justification. This review confirmed the physicians for each of these clients certified the medical necessity of the surgery using the EPA process as described above. To validate the appropriateness of the physician's certification, the diagnosis history established from the all professional claims were reviewed for each patient. Each of the clients had been receiving medical care to treat pain, disc disease and radiculitis of the neck and back. It was also documented one client suffered from osteoporosis of the spine. These diagnoses were established at least six months prior to the surgical dates for each of the clients. It was also noted one patient had a lump removed for pathological evaluation from her breast on the same day of the mammoplasty. The Department will conduct a review of the medical record from the treating physician's office to verify these diagnoses were indeed present and a factor in the decision to perform the surgeries. It will also be determined if there were any other symptoms or conditions being treated to justify this intervention. This review will be completed by June 30, 2006. If indicated, monies will be recovered.

In addition, by April of 2006, the Division of Medical Management will hire a registered nurse to conduct analytical reviews of provider compliance and success of the EPA program. This staff member will evaluate the utilization and cost of every service managed via EPA to determine whether this type of authorization is effective at maintaining an acceptable rate of utilization and cost for that service. If a service is not able to be managed under this program it will be placed on a list of services requiring prior authorization.

Gender Reassignment Surgery:

A review of Department records shows that two clients have received gender reassignment surgery since 2000, one of which was preauthorized as a result of the settlement agreement referenced above. A third client received corrective surgery for a gender reassignment performed out of the country and not paid for by Medicaid. Total costs paid to date for these three instances totals $96,894: $84,237 for the procedures authorized under the settlement agreement, $28,592 for the second reassignment surgery, and $12,657 for the corrective surgery for a gender reassignment.

At this time, three additional clients have appealed the Department's denial of their requests for gender reassignment surgery to Office of Administrative Hearings. In one case the Administrative Law Judge has entered a decision overruling the department's denial and requiring the department to perform the surgery. The Department

is appealing this decision. A second appeal was heard in January 2006, and we are waiting for the decision to be issued. A third appeal is scheduled for a hearing in April, 2006. If the Department does not prevail in these appeal proceedings we will be required to cover these surgical procedures.

The Department is pursuing a change to its policy with respect to gender reassignment surgery to make the procedure a non-covered service. We anticipate that the rule making process will be completed and the revised policy will be in place by December 31, 2006. However, even with this revised policy, clients still have access to the Medicaid program appeal process. If the client successfully appeals, the Department will be obliged to pay for these services. In those cases, we will claim federal matching funds and historically CMS has not challenged those claims.

HRSA received many claims for the clients noted in the audit finding that were denied because of not having prior authorization. However, claims were paid for the above clients for one or more of the following reasons:

- *Prior authorization was obtained and medically necessary services were authorized or allowed on the order of an Administrative Law Judge.*
- *The clients were dual eligible and their associated medical claims represent "crossover" claims consistent with Medicare medical necessity.*
- *The gender diagnosis was listed as a secondary diagnosis, and the claim was paid for a procedure that did not require prior authorization.*

Auditor's Concluding Remarks

The Department states that the criteria establishing the medical necessity of services in the Expedited Prior Authorization program is published in the Department's billing instructions and providers are required to certify that criteria were met at the time a service is performed. The State Auditor's Office holds that, since the provider stands to materially gain, this individual should not be the Department's internal control in determining or certifying the medical necessity of services for the Medicaid program. It is our position that the Department, upon reviewing the documentation sent by the provider, would be in the best position to objectively determine medical necessity.

We were not provided with any evidence to support the Department's claims that the exceptions we took were medically necessary. Documentation that we obtained directly from the provider does not indicate these procedures conformed to the definition of medically necessary as stipulated in the Medicaid State Plan or the Washington Administrative Code.

With regard to the gender reassignment surgery, the Department's response includes information that we were not given the opportunity to review or makes representations that contradict what we found during our testing.

With respect to the Department's justifications for paying claims for which there was no evidence of prior authorization:

- After our testing was concluded, we were provided with one settlement agreement entered in an appeal before an Administrative Law Judge. We have evidence that this was a negotiated settlement between the Department and the client but we do not know if there was an administrative order to accompany it. Additionally, the Department did not provide us with any evidence nor did the settlement agreement indicate that the Department required all of the multidisciplinary evaluations specified in the Washington Administrative Code for gender dysphoria. Moreover, other than a statement in the agreement that the Department indicated gender reassignment surgery appeared to be medically necessary, we do not know what this determination was based on. The settlement agreement also states that the preoperative assessment was not yet complete.

- The settlement agreement did not state how it complied with all of the evaluations required by the Washington Administrative Code rule for gender dysphoria nor were we provided with other evidence that demonstrated such compliance. Although federal matching funds are available to carry out hearing decisions, the federal regulation specifies that hearing decisions identify the regulations and evidence that

support the decision. The settlement agreement does not have these elements and does not conform to 42CFR431.244(d) or (e).

- We were not provided with any evidence to support the Department's claim that the "crossover" claims were considered medically necessary under the Medicare program. Our audit tested compliance for the Medicaid program and thus we would have no reason to review the requirements of any other program.

- Some of the expenditures listed in the Department's records did not indicate the medical procedure that was performed to justify the expenditure. Thus, for some expenditures we do not know what the Department actually paid for. We found this condition to be present in other tests we performed during this audit. The Department has not provided any evidence that any claim we questioned was paid for was a procedure that did not require prior authorization.

We reaffirm our finding and our recommendations.

Applicable Laws and Regulations

The Department acknowledges the authority of the Medicaid State Plan and states its commitment to abide by it. Section 1.1 of the State Plan states:

> As a condition for receipt of Federal funds under title XIX of the Social Security Act, the Department of Social and Health Services submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

The State Plan, Attachment 3.1-B, Section 5.a. describes limitations on physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. Subsection (1) includes as one of the limitations:

> Exceptions for noncovered services and service limitations are allowed when medically necessary and prior authorized by the department.

Medicaid State Plan and Washington Administrative Code 388-500-0005, state in part:

> Medical necessity or medically necessary - a term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in the recipient that endanger life or cause suffering or pain or result in illness or infirmity or threaten to cause or aggravate a handicap or cause a physical deformity or malfunction, and there is no other equally effective, or more conservative or substantially less costly course of treatment available or suitable for the person requesting services . . . .

Washington Administrative Code 388-531-0100, states in part:

> (5) MAA covers the following physician-related services
>
> > (g) Gender dysphoria surgery and related procedures, treatment, prosthetics, or supplies when recommended after a multidisciplinary evaluation including at least urology, endocrinology and psychiatry . . . .

WAC 388-86-200 (2) (g), which existed contemporaneously at the time of the settlement agreement, states in part:

> 2) . . . MAA shall specifically exclude from the scope of covered services:

(g) Procedures, treatment, prosthetics or supplies related to gender dysphoria surgery except when recommended after a multidisciplinary evaluation including but no limited to urology, endocrinology and psychiatry . . . .

42CFR431.244 (d) and (e) requires that:

(d) In any evidentiary hearing, the decision must be a written one that—
(1) Summarizes the facts; and
(2) Identifies the regulations supporting the decision.

(e) In a de novo hearing, the decision must—
(1) Specify the reasons for the decision; and
(2) Identify the supporting evidence and regulations . . . .

05-02 The Department of Social and Health Services, Aging and Disability Services Administration, does not have adequate controls to ensure that all alleged violations and complaints of abuse and neglect are investigated in accordance with federal law.

Background

Intermediate care facilities for the developmentally disabled were created to care for individuals who are mentally disabled, which is determined based on specific criteria. Additionally, many of these individuals are non-ambulatory, have seizure disorders, behavioral problems, mental illness and/or visual or hearing impairments. Many developmentally disabled individuals receive treatment under the Medicaid program with much of this care provided in an institutional setting. Intermediate care facilities for the developmentally disabled provide active treatment programs in a protected residential setting that includes 24-hour supervision.

Facilities that seek to care for the developmentally disabled under the Medicaid program must be certified. Federal law requires these facilities be surveyed each year to determine whether they are in substantial compliance with specific health and safety standards known as conditions of participation. The eight conditions of participation include 400 standards that are intended to regulate these facilities. In order for a provider to participate in the Medicaid program and for the state to receive federal matching funds, federal law requires the facility comply with all the conditions of participation and the standards. Additionally, the state must make provisions and have a system for reporting and investigating allegations of provider fraud and client abuse, mistreatment and neglect.

Description of Condition

In another part of our audit we found that the Aging and Disability Services Administration does not inspect the facilities according to federal standards. However, the Administration believes that the facilities are well-monitored because it performs frequent investigations of complaints received throughout the year. The Administration reported it received approximately 25,000 complaints concerning residential care during 2004, the majority of which it stated were inconsequential.

In view of the number of complaints the Administration reported it receives and the noncompliance with federal survey requirements that we found in our other audit work this year, we attempted to review investigations of individual complaints to determine if controls were in place to ensure the complaint and investigation process for allegations of abuse and neglect are consistent with federal law.

We requested a list of all complaints from period January 1, 2003 through August 31, 2005. We were given a log that included a case number, a brief intake description relating the nature of the complaint and the priority the Administration assigned to it.

We found the type of information provided in the intake descriptions was not consistent and varied with respect to the amount of information provided. When we attempted to obtain additional information we were given a box of paperwork that was poorly organized and not cross-referenced. Additionally, these records were not available to us electronically. As a result, looking for potential patterns of abuse for certain clients and/or at specific facilities was not possible. At times we received information that conflicted with management's prior representations. Additionally, documentation that appeared to be available at one time could not be obtained at later dates.

In view of the large numbers of complaints, the allegations of abuse and neglect that we saw in the complaint intake descriptions and the lack of information from the Department for many of these cases, we reviewed this area for compliance with federal Medicaid regulations regarding investigating allegations of mistreatment, neglect or abuse. We selected 57 complaints for our review and found no detail documentation for 29 cases. And for 27 cases where we were able to find investigation reports, the information that we found in these reports gave us no reasonable assurance that the investigations were performed according to federal requirements.

For the reports that we could locate, our examination indicated the Department's investigations were only a review of documentation prepared by the facility during its own internal investigation and interviews with facility administrators and staff. Our review of the reports also indicated the Department's concerns centered mostly on whether the investigation was performed within the requisite five days.

Cause of Condition

The Administration does not have an adequate process in place for ensuring complaints are investigated in accordance with federal law.

Effect of Condition

By not following federal regulations for surveys and investigations, vulnerable clients may be abused or susceptible to abuse and neglect. If the state has reason to know such conditions are present at an intermediate care facility for the developmentally disabled and does not take appropriate action, federal and state governments are susceptible to substantial liability, placing tax dollars at risk.

The state is not eligible to receive federal matching funds for disbursements made to facilities whose health and safety standards are not in substantial compliance with federal law.

Recommendation

We recommend the Department conduct complaint investigations according to federal law to ensure abuse and neglect of developmentally disabled individuals residing in intermediate care facilities is prevented and/or detected.

Department's Response

The Department agrees that allegations of abuse, neglect and mistreatment need to be investigated by the certified facility in accordance with federal law. There were statements written in the State Auditor's report with which the Department disagrees. The Department would like to clarify that the Department:

- *Is not the primary investigative body for allegations of abuse in facilities;*
- *Is not the primary investigator of provider fraud;*
- *Does not believe that complaint surveys substitute for full surveys;*
- *Does not believe that the majority of complaints it receives are "inconsequential"; and*
- *Does not believe that complaint reports do not have to be complete.*

The Department also disagrees with the report's apparent assumption that allegations it receives should always result in findings of deficient practice. Further, the Department does not agree that its processes related to allegations of abuse, neglect, and misappropriation are inconsistent with federal law.

All complaint reports contain allegations. These allegations require further investigation to gather evidence to support or refute compliance with the regulations. The Department follows deta*iled processes to evaluate allegations and their possible connection to other allegations that have already been reported.*

The Code of Federal Regulations (CFR), 42 CFR 483 Subpart I, describes standards that must be followed by Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) in order to protect individuals from abuse, neglect and mistreatment. According to the federal regulations at 42 CFR § 483.420(d), it is the responsibility of the ICF/MR to protect the residents, investigate allegations of abuse, neglect or mistreatment and fix any problem it uncovers. In contrast, the role of the Department is to:

- *Evaluate the quality of investigations conducted by the ICF/MR; and*
- *Focus on whether or not the ICF/MR's investigations meet the federal regulations.*

If the Department determines that the facility has not done a thorough investigation, it may be required to redo it or the Department may conduct the investigation.

The Department agrees that provider fraud and abuse need to be investigated according to federal law. The Department has a long-standing Memorandum of Understanding (MOU) with the Medicaid Fraud Control Unit (MFCU), in the Office of the Attorney General, which specifies how the process works. In compliance with the terms of the MOU, we refer complaint intake allegations to the MCFU that name a perpetrator, and where it appears that criminal activity has occurred in a Medicaid certified long-term care facility, including ICFs/MR.

We believe that there may have been some miscommunication during the course of the audit so we offer the following clarifications. The Department knows that complaint surveys do not take the place of certification surveys, and they are not used in that way. They provide additional opportunities to review facility practice, and enable a focused review of facility practice. Complaint surveys and certification surveys are complementary processes; they are not substitutions, additions or fill-ins for one another.

The report stated that the Department received approximately 25,000 complaints and that the majority of them were "inconsequential." The Department strongly disagrees with this statement. The Department takes all complaints seriously, and none is considered inconsequential. Each complaint reflects a real problem or concern that may, upon review, warrant further action.

The report also identified the possible incompleteness of reports in a database. The Complaint Resolution Unit (CRU) system is our official complaint tracking system and it is complete.

The Department agrees that all of its on-site investigations should be documented, however it disagrees that it does not do so. Many of the complaints reflected multiple calls about one incident. The state auditor's report lists 29 allegations called into the CRU and states there was "no documentation for 29 cases." Several of the allegations were called in multiple times so there were only 20 different incidents. Thirteen of these 20 incidents were investigated. Each of the 13 investigated incidents has a documented report. Four of these investigations led to citations against the ICF/MR.

The state auditor's report indicated that 27 "cases" had investigation reports but that there was no indication the investigations followed federal requirements. The Department believes these 27 cases reflect 20 different incidents. In 17 of these cases the Department, following the Centers for Medicare and Medicaid Services (CMS) investigation processes, found there was no failed practice by the ICF/MR. In two cases, the Department found failed practice and citations were issued to the facility. In the remaining report the Department referred to failed facility practice that had been cited under a different investigation. We reviewed the complaint intakes, narratives and working papers and found that we did follow the process and did address the issues on the intake form.

The CMS has oversight authority over the Department's regulation of ICFs/MR. During the audit period CMS conducted six oversight reviews. Verbal feedback received from CMS regional office staff stated that the Department is following the federal inspection standards and should continue to follow the processes it is using.

Auditor's Concluding Remarks

Residents of intermediate care facilities for the developmentally disabled are among our most vulnerable citizens. Many of these individuals are unable to communicate in an effective manner and others have little contact with family or those outside the facility. This leaves these individuals with little advocacy or recourse if they should suffer abuse or neglect. Congress passed detailed legislation to regulate facilities and caregivers in an attempt to guarantee adequate protections were incorporated into the system. In another finding, we addressed the Department's noncompliance with federal regulations requiring adequate facility surveys. In an attempt to reassure us that residents' care did not suffer from the reduced survey scope, the Department stated that it maintained a constant surveillance of facilities because of their numerous visits to review complaints. They reported that 25,000 complaints were reported in 2004. We questioned this approach and maintained that guaranteeing compliance with all conditions and standards would reduce the risk of jeopardy to residents and thus reduce reported complaints.

We view the Department's response as an attempt to relieve itself of the responsibility for facility oversight. Conditions of participation outline the requirements of care that facilities must provide; however, it is the Department's responsibility as the administrative agency for Medicaid in the state of Washington to ensure that facilities comply with all conditions and standards. If the Department does not annually certify facilities are in compliance with all standards of care, but then relies on these same facilities to conduct abuse and neglect investigations, it fails in its mission to protect these individuals.

The Department states it is not the primary investigative body for abuse and neglect. Facilities are required, as a condition of participation, to conduct investigations of complaints of abuse, neglect and fraud. However, the Department is required by 42CFR455.14 and 42CFR455.15 to conduct investigations of all complaints of provider abuse and fraud received. One investigation is not a substitute for another. Providers with allegations of perpetuating abuse should not be entrusted to be the sole investigative agency for these allegations.

In another section in this report we found that the Department of Social and Health Services, Health and Rehabilitative Services Administration, is not in compliance with the federal Medicaid requirements for reporting adult victims of residential abuse to the Medicaid Fraud Control Unit. We questioned the Department about the complaint review process, attempting to locate a repository that would include complete information for all allegations received and related documentation assembled during investigation and resolution. We were informed that such a composite record existed; however, when we attempted to locate specific complaints, we often found incomplete records or that records could not be located.

We reaffirm our finding that the Department of Social and Health Services, Aging and Disability Services Administration, does not have controls to ensure that all alleged violations and complaints of abuse and neglect are thoroughly investigated as federal law requires.

Applicable Laws and Regulations

42CFR483.420 pertains to IMC/MR facilities and states in part:

> (d) Standard: Staff treatment of clients.
>
> > (1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.
> >
> > > (i) Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment.
> > > (ii) Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.
> > > (iii) The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.
> >
> > (2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.
> >
> > (3) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress.
> >
> > (4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and, if the alleged violation is verified, appropriate corrective action must be taken.

42CFR455.2, states in part:

> Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

42CFR455.14 Preliminary investigation, states:

> If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

42CFR455.15 Full investigation states in part:

> If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must take the following action, as appropriate:
>
> > (a) If a provider is suspected of fraud or abuse, the agency must—
> >
> > > (1) In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit under the terms of its agreement with the unit entered into under Sec.
> > > 1002.309 of this title; or
> > >
> > > (2) In States with no certified Medicaid fraud control unit, or in cases where no referral to the State Medicaid fraud control unit is required under paragraph (a)(1) of this section, conduct a full investigation or refer the case to the appropriate law enforcement agency.
> >
> > (b) If there is reason to believe that a recipient has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.
> >
> > (c) If there is reason to believe that a recipient has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

42CFR455.16 Resolution of full investigation, states in part:

> A full investigation must continue until—
>
> > (a) Appropriate legal action is initiated;
> >
> > (b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or
> >
> > (c) The matter is resolved between the agency and the provider or recipient. This resolution may include but is not limited to—
> >
> > > (1) Sending a warning letter to the provider or recipient, giving notice that continuation of the activity in question will result in further action;
> > >
> > > (2) Suspending or terminating the provider from participation in the
> > > Medicaid program;

(3) Seeking recovery of payments made to the provider; or

(4) Imposing other sanctions provided under the State plan.

42CFR483.420 requires client protections and states:

(a) Standard: Protection of clients' rights. The facility must ensure the rights of all clients. Therefore, the facility must—

(1) Inform each client, parent (if the client is a minor), or legal guardian, of the client's rights and the rules of the facility;

(2) Inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment;

(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process;

(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities;

(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment;

(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;

(7) Provide each client with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs;

(8) Ensure that clients are not compelled to perform services for the facility and ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities;
(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail;

(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans;

(11) Ensure clients the opportunity to participate in social, religious, and community group activities;

(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and ensure that each client is dressed in his or her own clothing each day; and

(13) Permit a husband and wife who both reside in the facility to share a room.

(b) Standard: Client finances.

(1) The facility must establish and maintain a system that--

(i) Assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients; and

(ii) Precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client's financial record must be available on request to the client, parents (if the client is a minor) or legal guardian.

(c) Standard: Communication with clients, parents and guardians. The facility must—

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate;

(2) Answer communications from clients' families and friends promptly and appropriately;

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate;

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy;

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations; and

(6) Notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse or unauthorized absence.

(d) Standard: Staff treatment of clients.

(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

(i) Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment.

(ii) Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

(iii) The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

(3) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and, if the alleged violation is verified, appropriate corrective action must be taken.

05-03 The Department of Social and Health Services, Aging and Disability Services Administration, does not perform certification surveys of Intermediate Care Facilities for the developmentally disabled according to federal law.

Background

Intermediate care facilities for the developmentally disabled were funded by state or local government funds until 1971. In that year, Congress enacted legislation that allowed states to include services to the developmentally disabled as an optional Medicaid benefit. Under the Medicaid program states choosing to provide this optional benefit would be eligible to receive federal matching funds if the provision for such services was included in the Medicaid State Plan and if the state ensured that its providers met federal health and safety requirements. Providers must qualify to render services to Medicaid clients. These qualifications include certification and compliance with a national minimum set of standards created to protect the care and rights of their clients. This set of standards is federally mandated and consist of eight conditions of participation, which detail 400 standards. Certification surveys are required each year to assure that participating facilities are in substantial compliance with these conditions of participation.

Description of Condition

During our audit for state fiscal year 2005, we found that the Department does not perform its certification surveys of intermediate care facilities for the developmentally disabled according to federal law. Although surveys are conducted with the appropriate frequency, facilities are inspected according to the guidelines of the State Operations Manual. This manual was developed by the Centers for Medicare and Medicaid Services (CMS) in an effort to make the survey process less resource intensive for providers that consistently demonstrate compliance with the regulations.

The Department reported that survey activities are now focused on the outcome for the individual and not on specific, itemized regulations. We found that the manual does not require all standards and conditions of participation be reviewed. Instead, it allows surveyors to review only four of the eight conditions of participation and only 57 of the 400 standards. Under guidance of the manual, if the facility appears to be in compliance with those requirements, the facility is assumed to be compliant with all the standards and conditions of participation and no further survey activity is performed.

The federal regulation setting forth the outcome-oriented survey process states that this survey process is not to be used for intermediate care facilities for the developmentally disabled. We could find no federal regulation that approves limiting the scope of surveys for intermediate care facilities for the developmentally disabled. Additionally, neither the Department nor CMS could give us any evidence that would allow the state to deviate from the survey protocol cited in the Code of Federal Regulations.

During our audit, we reviewed records for 14 out of 14 facilities. We found that no intermediate care facility for the developmentally disabled was surveyed according to federal regulation for state fiscal year 2005. Furthermore, the Department could not tell us the last time any of these facilities received a full survey, or was surveyed according to requirements set forth in federal law as it pertains to content of survey.

Cause of Condition

The Department reported it is conducting surveys according to protocol established by CMS as outlined in the State Operation Manual Appendix J.

Effect of Condition

The state is making significant payments to intermediate care facilities for the developmentally disabled, for services to Medicaid clients, with no reasonable assurance that the services provided are meeting federal health and safety standards. This could expose vulnerable adults to exploitation, abuse and neglect. Payments to these facilities during 2004 were at least $129,814,871 of which, $65,434,803 was paid with federal funds and the remainder with state funds.

Recommendation

We recommend:

- CMS provide states with instructions that are consistent with federal Medicaid laws regarding surveys of intermediate care facilities for the developmentally disabled that receive Medicaid funds.

- The Department of Social and Health Services conducts certification surveys to include all eight conditions of participation and 400 standards, as required by federal law.

Department's Response

The Department agrees that CMS should provide consistent instructions for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) surveys in accordance with federal law. The Department disagrees that CMS does not do so.

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

- *ICF/MR providers 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."*

During an initial certification survey the Department reviews all of the eight Medicaid conditions of participation, including the associated four hundred eighty-nine standards. During the audit period there were no initial certification surveys because no applications for ICF/MR certification were submitted.

For a recertification survey, CMS has adopted specific procedures, Appendix J: "Survey Protocol & Guidelines" of the Centers for Medicare & Medicaid Services' (CMS) State Operations Manual (SOM); Transmittal No. 278 "Survey Procedures for Intermediate Care Facilities For Persons with Mental Retardation"; PART 1, III. "Survey Process," (pages J-3 through J-5), which require state agencies to review four conditions of participation and the associated fifty-seven standards. The procedures also give the Department the authority to expand the scope of the survey at any time, based upon survey findings or upon information from other sources. The Department investigates and will continue to investigate all potential regulatory violations. CMS oversees the Department to ensure that the required processes are being followed. At least twice a year, staffs from the federal Regional Office (RO) meet formally with the State Agency (SA) (several informal discussions occur over the course of the year). The intent of these meetings is to update the SA on the survey process and provide verbal feedback based upon look-behind surveys (the last time the RO provided written feedback was August 9, 2000). The RO consistently informs the SA it is meeting federal expectations. Last year, a federal Qualified Mental Retardation Professional from the Denver RO accompanied them. He also emphasized the SA should continue to follow the procedures it has in place. CMS has not identified any performance issues.

Auditor's Concluding Remarks

The Department is correct in stating that federal regulations (42CFR483, Subpart I) identifies federal requirements the provider must meet to comply with federal law. This regulation contains eight conditions of participation comprising over 400 standards. It is the Department's responsibility, as the designated Medicaid agency, to survey each institution <u>at least annually</u> (42CFR456.606) to ensure compliance with all conditions and standards.

Regarding federal regulations on surveys (42CFR483, Subpart I), the conditions of participation apply beyond initial certification. Regulations (42CFR.442.109) also state that a survey agency may certify an intermediate care facility for the developmentally disabled for only 12 months and a Medicaid agency may not enter into a provider agreement or make Medicaid payments to this type of facility unless the facility has been certified (42CFR442.12). A facility cannot be certified if it is not in compliance with all eight conditions of participation.

The Department also cites federal regulation 42CFR488.26 as the source of federally mandated procedures the state agency must follow regarding the survey process. We believe that directions contained in regulation 42CFR488.110 show the regulation cited by the Department do not apply to the facilities in question:

> 42CFR488.26(c)(2) describes the new survey process:
>
> > The survey process uses resident outcomes as the primary means to establish the compliance status of facilities. Specifically surveyors will directly observe the actual provision of care and services to residents, and the effects of that care, to assess whether the care provided meets the needs of individual residents.
>
> 42CFR488.110(a) General defines the applicability of this new survey process:
>
> > Use this survey process for all surveys of SNFs and ICFs-whether free-standing, distinct parts, or dually certified. **Do not use this process for surveys of Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)**,(emphasis added) swing bed hospitals or skilled nursing sections of hospitals that are not separately certified as SNF distinct parts.

The Department further states it has adopted procedures put in place by CMS specifically for the recertification survey. The Department states these procedures require it to survey to reduced standards. However, during our audit, we asked for clarification as to the guidance that the State Auditor's Office should be auditing to, federal law as cited in the Code of Federal Regulations (CFR) or CMS's directives to the states. The Office of the Inspector General indicated that the CFR should be used for guidance even if CMS gives directives to the states that are contrary to it. The Inspector General also stated if the state is not following the law, the State Auditor's Office is obligated to report it as non-compliance and to question all related costs. We have reported these costs to be at risk for noncompliance.

We reaffirm our finding that the Department does not perform certification surveys of intermediate care facilities for the developmentally disabled according to federal law.

Applicable Laws and Regulations

Washington State Medicaid Plan 4.13, states:

> . . . for all providers, the requirements of 42CFR431.107 and 42CFR442 Subparts A and B (if applicable) are met.

42CFR488.110 relates to the outcome-oriented survey process and states in part:

> . . . Do not use this process for surveys of Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) . . . .

42CFR442 Subpart B Provider Agreements, 42CFR442.12(a), states:

> A Medicaid agency may not execute a provider agreement with a facility for nursing facility services nor make Medicaid payments to a facility for those services unless the Secretary or the State survey agency has certified the facility under this part to provide those services.
>
> (c)An agreement must be in accordance with the certification provisions set by the Secretary or the survey agency under subpart C of this part for ICF/MRs.

42CFR442 Subpart C, 42CFR442.100, states:

> A State plan must provide that the requirements of this subpart and part 483 are met.

42CFR442.101, states:

(a) This section states the requirements for obtaining notice of an ICF/MR's certification before a Medicaid agency executes a provider agreement under Sec. 442.12.

(b) The agency must obtain notice of certification from the Secretary for an ICF/MR located on an Indian Reservation.

(c) The agency must obtain notice of certification from the survey agency for all other ICF/MR.

(d) The notice must indicate that one of the following provisions pertains to the ICF/MR:

(1) An ICF/MR meets the conditions of participation set forth in subpart I of part 483 of this chapter.

(2) The ICF/MR has been granted a waiver or variance by CMS or the survey agency under subpart I of part 483 of this chapter.

(3) An ICF/MR has been certified with standard-level deficiencies and

(i) All conditions of participation are found met; and

(ii) The facility submits an acceptable plan of correction covering the remaining deficiencies, subject to other limitations specified in Sec.442.105.

42CFR483, Subpart I, Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded, 42CFR483.400 Basis and purpose, states:

This subpart implements section 1905 (c) and (d) of the Act which gives the Secretary authority to prescribe regulations for intermediate care facility services in facilities for the mentally retarded or persons with related conditions.

Sec. 483.405 relationship to other HHS regulations
Sec. 483.410 Condition of participation: Governing body and management
Sec. 483.420 Condition of participation: Client protection
Sec. 483.430 Condition of participation: Facility Staffing
Sec. 483.440 Condition of participation: Active treatment services
Sec.483.450 Condition of participation: Client behavior and facility practices
Sec. 483.460 Condition of participation: Health care services
Sec. 483.470 Condition of participation: Physical Environment
Sec. 483.480 Condition of participation: Dietetic Services

05-04 The Department of Social and Health Services, Aging and Disability Services Administration does not have a process to impose sanctions, recover funds, schedule or hold hearings for Intermediate Care Facilities for the Developmentally Disabled that are not in substantial compliance with federal health and safety standards.

Background

Under the Medicaid program, states may receive federal funds for medical services for Medicaid clients receiving treatment in Intermediate Care Facilities for the Developmentally Disabled.

Facilities must meet specific health and safety standards that are set forth in federal regulations. The Department's Aging and Disability Services Administration has the primary responsibility for conducting health and safety inspections at these facilities to ensure compliance with federal regulations. If a facility does not substantially comply with these health and safety standards, it may result in the Department issuing sanctions that could include denial, termination or non-renewal of its provider agreement or issuance of a denial-of-payment notice to the facility. The denial-of-payment notice prohibits payment of federal funds for any new Medicaid admissions to the facility until the condition is corrected.

Federal regulations require the state to have an appeals procedure for a facility wishing to challenge the state's finding of noncompliance. The procedure must satisfy certain minimum requirements, be approved by the federal government and be included in the Medicaid State Plan.

While the appeal process will not halt the termination proceedings, a denial of payment will not be put in place until the appeal has been resolved, unless the appeals process is longer than 120 days. Beyond this time, federal law requires that Medicaid funds be stopped. Thus, the date payment to the facility actually stops is dependent on timing of the appeals process. If the appeals process takes 120 days, payment will not stop during that time.

Description of Condition

During our audit for fiscal year 2005, we found the Department has no process or procedures for:

- Instituting a denial of payment and recovering funds that were paid for new Medicaid admissions to a facility that is not in substantial compliance with federal health and safety requirements. We found one facility continued to receive payment for clients during a denial-of-payment period. Costs associated with this totaled $25,392.

- Scheduling and holding appeal hearings for providers that requested such hearings. Staff stated that no hearings had been scheduled or held in the past when requested. Staff reported that they were unsure who would handle or adjudicate the hearing if one was scheduled. We found evidence that one hearing was requested by a provider in 2004. However, we could find no evidence that a hearing was conducted.

Cause of Condition

The Department has stated that implementing the denial-of-payment sanction would be difficult to accomplish and not cost-effective.

Effect of Condition

While the Department offers the provider an opportunity for a hearing, we found no evidence that providers can obtain a hearing from the Department to appeal findings of noncompliance. This is contrary to federal regulations.

Additionally, we found no evidence that the Department has any clear procedures to impose federally required sanctions on providers that are not in compliance with federal health and safety standards. This exposes vulnerable adults to substandard care, abuse and neglect. Such noncompliance can jeopardize future federal funding.

Recommendation

We recommend the Department:

- Establish procedures to schedule and hold appeals hearings.
- Establish a process for instituting denial-of-payment sanctions.
- Establish procedures to recoup funds paid to a facility in denial-of-payment status.

Department's Response

The Department agrees that there should be processes for imposing the Denial of Payment for New Admissions penalty, for scheduling and holding related hearings, and for recouping funds, but the Department disagrees with the audit findings. The Department does have processes that comply with federal law.

The Department is willing to clarify its processes by developing written procedures regarding timeframes for instituting the denial of payment sanction, scheduling and holding related hearings, and recouping funds, by June 30, 2006.

The report reflects a misunderstanding related to the lack of informal hearings during the audit period. The Department did not hold any informal hearings related to denial of payment penalty during the audit period because facilities corrected violations before a hearing was needed. However, such a hearing has been held in the past. No denial of payment for new admissions penalties took effect during the audit period because facilities were able to achieve compliance before the effective date.

For state fiscal year 2005, one denial of payment penalty was issued (July 20, 2004) and resolved before a hearing occurred. For federal fiscal year 2005, one denial of payment penalty was issued (September 23, 2005) and resolved before a hearing occurred.

Auditor's Concluding Remarks

During our audit, the Department did not provide written policies and procedures that address imposition of sanctions, recoupment of funds or scheduling and holding hearings. Additionally, staff did not know who would be responsible for imposing sanctions, recovering funds or scheduling hearings.

The State Auditor's Office agrees the Department did not hold any informal or formal appeal hearings during the audit period. However, this does not negate the requirement that policies and procedures should be in place to regulate this process. The Department operates under the assumption that conditions will be corrected by facilities before the timeline for imposing sanctions and holding appeals hearings runs out and, thus, has not developed appropriate policies and procedures.

We reaffirm our finding that the Department of Social and Health Services, Aging and Disability Services Administration, does not have a process to impose sanctions, recover funds, schedule or hold hearings for Intermediate Care Facilities for the Developmentally Disabled that are not in substantial compliance with federal health and safety standards.

Applicable Laws and Regulations

42CFR442.101, states in part:

> (1) An ICF/MR meets the conditions of participation set forth in subpart I of part 483 of this chapter . . .
>
> > (e)The failure to meet one or more of the applicable conditions of participation is cause for termination or non-renewal of the ICF/MR provider agreement.

42CFR442.117, states:

(a) A survey agency must terminate a facility's certification if it determines that—

(1) The facility no longer meets conditions of participation for ICFs/MR as specified in subpart I of part 483 of this chapter.

(2) The facility's deficiencies pose immediate jeopardy to residents' health and safety.

(b) Subsequent to a certification of a facility's noncompliance, the Medicaid agency must, in terminating the provider agreement, follow the appeals process specified in part 431, subpart D of this chapter.

42CFR442.118, states:

(a) Basis for denial of payments. The Medicaid agency may deny payment for new admissions to an ICF/MR that no longer meets the applicable conditions of participation specified under subpart I of part 483 of this chapter.

(b) Agency procedures. Before denying payments for new admissions, the Medicaid agency must comply with the following requirements:

(1) Provide the facility up to 60 days to correct the cited deficiencies and comply with conditions of participation for ICFs/MR.

(2) If at the end of the specified period the facility has not achieved compliance, give the facility notice of intent to deny payment for new admissions, and opportunity for an informal hearing.

(3) If the facility requests a hearing, provide an informal hearing that includes—

(i) The opportunity for the facility to present, before a State Medicaid official who was not involved in making the initial determination, evidence or documentation, in writing or in person, to refute the decision that the facility is out of compliance with the conditions of
participation for ICFs/MR.

(ii) A written decision setting forth the factual and legal bases pertinent to a resolution of the dispute.

(4) If the decision of the informal hearing is to deny payments for new admissions, provide the facility and the public, at least 15 days before the effective date of the sanction, with a notice that includes the effective date and the reasons for the denial of payments.

42CFR431.151, states:

a) General rules. This subpart sets forth the appeals procedures that a State must make available as follows:

(1) To a nursing facility (NF) that is dissatisfied with a State's finding of noncompliance that has resulted in one of the following adverse actions:

(i) Denial or termination of its provider agreement.

(ii) Imposition of a civil money penalty or other alternative remedy.

(2) To an intermediate care facility for the mentally retarded (ICF/MR) that is dissatisfied with a State's finding of noncompliance that has resulted in the denial, termination, or nonrenewal of its provider agreement.

(3) To an NF or ICF/MR that is dissatisfied with a determination as to the effective date of its provider agreement.

(b) Special rules. This subpart also sets forth the special rules that apply in particular circumstances, the limitations on the grounds for appeal, and the scope of review during a hearing.

05-05 The Department of Health is not conducting hospital surveys according to the frequency stipulated by state law and the Medicaid State Plan.

Background

Hospitals statewide received more than $583 million in state and federal Medicaid funds in calendar year 2004 for services provided to Medicaid clients. To be eligible for federal reimbursement, federal regulations require states to ensure health-care facilities meet prescribed health and safety standards. The Department of Social and Health Services, Medical Assistance Administration, relies on the Department of Health to perform these surveys.

In the past, state law required the Department of Health to complete these surveys annually. To avoid duplication, the law allowed some exceptions when other professional organizations had performed recent, comparable surveys and reported the results to the Department. Hospitals receiving such surveys had to request exclusion from the state surveys.

In our fiscal year 2003 State Accountability Report, we reported that the Department of Health was not performing annual hospital surveys. Of 109 participating hospitals, only 61 (56 percent) had received the required survey by the Department or another qualifying professional organization.

We followed up in this area during the 2004 audit. We found the Department of Health had submitted legislation for the 2005 Legislative session to extend the inspection timeframe to 18 months. In addition, this proposal required a hospital to inform the Department if a survey was performed by another qualifying professional organization.

However, during fiscal year 2004, the Department of Health did not perform annual hospital surveys as required by current state law. Of the state's 102 current hospitals, we found only 50 (49 percent) were evaluated by the Department or by one of the other qualifying professional organizations during calendar year 2003. The remaining 52 hospitals were not surveyed at all during this time.

At that time, the Administration also had drafted an amendment to the Medicaid State Plan that conformed to the state's current survey activity, increasing the required time period between surveys to a longer but indefinite amount of time. However, the Administration had not provided us with confirmation that the amendment had been submitted to or approved by the federal grantor.

Description of Condition

During our current audit we found that proposed changes to the survey frequency had been approved. An amendment to the State Plan was approved by the Center for Medicare and Medicaid Services (CMS), changing the frequency of required surveys to at least once every 18 months. This amendment also granted outside agents who had authority from CMS to perform the state's required hospital surveys. Both were passed into law after our audit period had ended.

Prior to our testing, we knew the state would not be in compliance with the 12-month frequency requirement as the Health Department had stated it would not attempt to meet the standard. The Department stated it was certain the state law and the State Plan would be changed. Since the State Auditor's Office has an obligation to audit to laws in place during the audit period, we audited to the 12-month standard. However, we also wanted to determine if the Department had made improvements to its systems that would bring it into compliance with the new law.

We found that the frequency of hospital surveys failed to meet either frequency standard. For the 95 participating Medicaid hospitals we found:

- 93 facilities (98 percent) were not surveyed according to the annual frequency required by the law in place for the audit period.

- 73 facilities (77 percent) were not surveyed according to the 18-month frequency standard as set out in the new law and applicable to the next audit period.

For the hospitals that were not surveyed according to either standard and were considered exceptions, we performed additional testing and found:

	Survey Standard	
Survey Frequency	**12 Month**	**18 Month**
Range of months elapsing from one survey to the next	13 - 49 months	19 - 49 months
Average survey frequency	24 months	26 months
Survey frequency rate occuring most often	21 months	21 months

Cause of Condition

The Department of Health states it lacks the resources to ensure survey frequency standards are met.

Effect of Condition

The state is making significant payments to hospitals for services to Medicaid clients with little assurance that the Department of Health will conduct timely surveys that evaluate whether hospitals are meeting state health standards and regulatory requirements. The costs associated with the hospitals that were not surveyed were included elsewhere in this report.

Recommendation

We recommend the Department of Health establish and follow controls to ensure compliance with state law and the Medicaid State Plan regarding the frequency of hospital inspections.

Department's Response

We concur with the finding by the State Auditor's office.

The scope of the current SAO audit covered the survey cycle for fiscal years 2004 and 2005. During this time the state law RCW 70.41 required DOH to conduct inspection surveys of all hospitals at least yearly. Furthermore, the law allowed for a hospital surveyed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) within the previous 12 months to be exempt from annual state survey if the department received the results of the JCAHO survey.

At the time of the audit review, DOH acknowledged that it was not accomplishing the annual surveys due to lack of adequate numbers of staff and that a change to the law was being proposed to address this. The 2005 Legislature changed the law to "inspection of hospitals on average at least every 18 months, in addition the Legislature modified the requirement for the JCAHO survey to allow those surveys to be deemed as meeting the 18 month survey requirement. These law changes became effective July 24, 2005 and as of December 31, 2005 all hospitals are now being surveyed according to the 18 month average.

Auditor's Concluding Remarks

We appreciate the steps the Department is taking to resolve this issue. We will review the condition during our next audit.

Applicable Laws and Regulations

In describing the authority of the Medicaid State Plan, Title 42 of the Code of Federal Regulations, Section 430.10, states:

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity

> with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

The Department of Social and Health Services acknowledges the authority of the State Plan and announces its commitment to abide by it in section 1.1 of the State Plan:

> As a condition for receipt of Federal funds under title XIX of the Social Security Act, the Department of Social and Health Services submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

The State of Washington's Medicaid State Plan, page 42, states:

> 4.11 Relations with Standard-setting and Survey Agencies
>
> (a) The State agencies utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions . . . that provide services to Medicaid recipients. These agencies are: the Department of Social and Health Services and the Department of Health.
>
> (b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public and private institutions that provide services to Medicaid recipients are: the Legislature, State Board of Health, State Fire Marshall, the Department of Social and Health Services, and the Department of Health.
>
> (c) Attachment 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are on file and made available to the Center for Medicare and Medicaid Services on request.

Attachment 4.11-A, states in part:

> The standards specified in paragraphs (a) and (b) on Page 42 of the Plan are as follows:
>
> > A. General Hospitals Revised Code of Washington Chapter 70.41 . . .
> >
> > Surveys are conducted in accordance with the Interagency Agreement between the Department of Social and Health Services (SHS) and the Department of Health (DOH).
> >
> > At the request of and funded by Medicare as specified in the Annual Budget Call Letter, DOH's Facilities and Services Licensing Division conducts surveys of facilities participating in Washington State's Medicaid and Medicare programs. The surveys satisfy Medicare requirements as to survey frequency, content, scope, and documentation, and meet the standards and conditions of participation for contracted hospitals in both Medicare and Medicaid programs established by 42 CFE 482.
> >
> > The Facilities and Services Licensing Division conducts Medicare and Medicaid qualifying surveys on a schedule that meets criteria established by the Centers for Medicare and Medicaid Services (CMS).
> >
> > Other agents having deemed status from CMS for performing Medicare hospital surveys, such as the Joint Commission on Accreditation of Healthcare Organizations (JAHO) are deemed agents for Medicare surveys.

RCW 70.41.120, prior to HB 1533 and which applies to the current audit period, states in part:

> The department (DOH) shall make or cause to be made at least yearly an inspection of all hospitals . . . To avoid unnecessary duplication in inspections, the department shall coordinate with the department of social and health services when inspecting facilities over which both agencies have jurisdiction, the facilities including but not necessarily being limited to hospitals with both acute care and skilled nursing or psychiatric nursing functions.

RCW 70.41.120, after the passing of HB1533 and effective July 24, 2005, after the current audit period, states in part:

> The department shall make or cause to be made an inspection of all hospitals on average at least every eighteen months . . .The department may make an examination of all phases of the hospital operation necessary to determine compliance with the law and the standards, rules and regulations . . . .

WAC 246-320-025, states in part:

> The purpose of this section is to provide annual on-site survey requirements in accordance with chapter 70.41 RCW.
>
> (1) The department will:
>
> (a) Conduct at least one on-site licensing survey each calendar year to determine compliance with the provisions in chapter 70.41 RCW and this chapter . . . .

RCW 70.41.122, states in part:

> Surveys conducted by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) or the American Osteopathic Association (AOA) on hospitals accredited by those bodies shall be deemed equivalent to a department survey for purposes of meeting the requirements for the survey specified in RCW 41.70.120 if the department determines that the applicable survey standards of the JCAHO or the AOA are substantially equivalent to its own.

05-06 The Department of Health and the Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), are not ensuring compliance with federal law regarding hospital surveys.

Background

Hospitals statewide received more than $583 million in state and federal Medicaid funds in calendar year 2004 for services provided to Medicaid clients. Federal regulations require states to ensure health-care facilities meet prescribed health and safety standards in order to be eligible for federal reimbursement. The Department of Social and Health Services, Health and Recovery Services Administration, relies on the Department of Health to perform these surveys.

The federal government has developed Conditions of Participation that hospitals must meet in order to participate in the Medicaid program. These minimum health and safety standards are designed to protect the health and safety of patients. In order to be eligible for federal matching funds for reimbursements to Medicaid clients' providers, the Department must ensure these standards are met. Federal regulations state compliance with the Conditions of Participation must be ensured and that the Medicaid agency must designate the forms, methods and procedures to be used by the surveying agency when determining compliance. Additionally, the survey agency must retain documentation and note whether each requirement for which inspection was made had been satisfied.

Conditions of Participation for hospitals are made up of 29 areas related to all aspects of patient care. These include patients' rights, staffing and infection control, as well as requirements for each type of service that the hospital offers such as surgical services and emergency services.

In our fiscal year 2003 audit we reported to the Departments' management that:

- The Department of Social and Health Services did not have the federally required written agreement with the Department of Health regarding survey activities.

- The Department of Health did not comply with federal regulations regarding survey documentation.

During our fiscal year 2004 audit, we reported that although a Memorandum of Understanding for survey activities was signed by the agencies, the Administration (then known as Medical Assistance Administration) did not have a written agreement with the Department of Health for survey activities that met all federal requirements. For example, it did not specify the forms, methods and procedures that surveyors should use.

Description of Condition

During our current audit, we attempted to determine whether progress had been made in correcting the conditions found in previous audits. We found the Department still had not specified survey methods and procedures to be used by the Health Department.

We also found the Health Department could not provide documentation that its employees had conducted the surveys according to federal regulations. Specifically,

- Although required to do so by federal regulation, the Department of Social and Health Services has not provided the Health Department with the methods and procedures it is to use when conducting the surveys. The Health Department does not provide surveyors with instructions on what must be surveyed.

- For hospitals that had been reported to have passed inspections, the only documentation available was a statement that no deficiencies had been found. Federal regulations require that reports note whether each requirement for which inspection is made is satisfied. However, no specifics on what was reviewed were available because the Health Department does not require surveyors to prepare or submit detailed information on what is reviewed.

- For hospitals where deficiencies are noted, surveyors are required to document what the deficiencies are; however, the Department does not require the surveyor to report what areas were examined and what areas were not reviewed for compliance.

- Federal regulations require that the Department of Health, as the surveying agency, keep on file all information and reports relating to whether facilities meet requirements. The Health Department cannot monitor the work performed by surveyors to ensure that surveys are done. This is because surveyors are not required to retain their work papers or provide them to the Department.

Other than a date that the survey was reported to have been conducted and a statement of deficiency or no deficiency, no other documentation was available for our review. Thus, we could not independently review of what the survey consisted or whether it conformed to federal regulations.

Cause of Condition

The Health Department reported it conducts surveys according to Medicare certification guidelines. It states that in fulfilling its responsibility for Medicare certification surveys, it is simultaneously fulfilling its responsibility for Medicaid certification.

The Centers for Medicare and Medicaid Services (CMS) reported the work required by the Medicare contract that it has with the Health Department is not as rigorous as that required for Medicaid surveys. CMS conceded the State Auditor's Office has found inconsistencies between federal law and the instructions CMS has given to states in terms of survey practices. However, reporting only on exceptions is the current practice and the method of reporting approved by the State Operations Manual for Medicare. CMS reported that it considers this manual to be applicable for Medicaid as well.

Effect of Condition

The state is paying hospitals for services to Medicaid clients with little assurance the services provided are meeting state health standards and regulatory requirements. This is because the Department of Health does not provide standard instructions to surveyors and does not require them to submit reports or retain work papers on what was done in the surveys. Payments to the hospitals for the period January 1, 2004 through December 31, 2004, were at least $583,094,104. Of this, $291,547,052 was paid with federal funds and the remainder with state funds.

Survey activities that are not performed according to federal requirements leave Medicaid clients vulnerable to substandard care. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has reported that unexpected occurrences in the nation's health-care facilities, ranging from medication errors to serious injury or death, have increased by three and a half times since 1995. It also reported that approximately 68 percent of these events occur in hospitals. Self-reporting is a primary source of information (66 percent) and survey activity accounts for only 8 percent of the known occurrences. Washington has the fifth highest number of reviewed occurrences in the nation for such events according to the JCAHO report. However, when so little is known about surveys conducted of Washington hospitals, we do not know if Washington's rating is a matter of better self-reporting or poorer conditions in its hospitals.

Recommendation

We recommend:

- CMS provide states with instructions that are consistent with federal Medicaid laws regarding surveys of hospitals receiving Medicaid funds.

- The Department of Social and Health Services designate the forms, methods and procedures that must be used by the Health Department when determining hospital providers' compliance with the federal Conditions of Participation.

- The Department of Health follow procedures provided by the Department of Social and Health Services to ensure hospitals comply with the Conditions of Participation.

- The Department of Health monitor surveys to ensure federal requirements for monitoring Conditions of Participation are performed.

- The Department of Social and Health Services monitor the Department of Health's compliance with survey procedures.

- The Department of Social and Health Services work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid federal funds must be reimbursed as a result of the state's noncompliance.

Departments' Response

This is a joint response on behalf of the Department of Health (DOH) and the Department of Social and Health Services (DSHS).

We concur with the finding to only the extent that hospital survey documents should positively assert that all Conditions of Participation have been met through the certification survey process.

Otherwise, to the best of our understanding we are meeting the requirement for surveys as approved by the Centers for Medicare & Medicaid Services (CMS) State Operations Manual.

Overall policy making responsibility is centralized in CMS where oversight of the State Medicaid program is coordinated. CMS alone is responsible for establishing operational policy for the certification process and conveying operational instructions to State Agencies.

The finding states that CMS has admitted that their requirements are not as rigorous as those required by Federal law, but does not reference the source of this comment within the CMS organization. To date, we have not received any directive from CMS to alter our current survey practices.

We concur with the second and third recommendations provided in the finding only in that survey reports should include a positive assertion that all Conditions of Participation have been reviewed during the survey. This change has been included in the current Memorandum of Understanding between DSHS and DOH. Otherwise, both DOH and DSHS are following the current method of reporting approved by the State Operations Manual provided by CMS. The State Operations Manual specifies forms and procedures that must be followed when determining hospital provider's compliance with the federal Conditions of Participation.

Also included in the list of applicable laws and regulations is a reference to Yellow Book Section 4.03. The Yellow Book, or Generally Accepted Government Auditing Standards (GAGAS), should not be applied to state agency hospital surveys. By virtue of the state agency's adjudicative and regulatory oversight function, it can not adhere to the stringent requirements for organizational independence called for in the standards.

We agree that the hospital surveys should clearly state that all Conditions of Participation have been reviewed, but we do not agree that we need to exceed the current standard of exception reporting or documentation as directed by the CMS State Operations Manual.

Auditor's Concluding Remarks

Federal regulation requires an agreement between the agencies to define the survey process undertaken by the survey agency. It also requires surveyors to complete inspection reports including notations on the report that each requirement inspected during the survey has been satisfied.

Audit standards do not allow us to accept the Department's statement that the Center for Medicare and Medicaid Services may set policy that conflict with federal regulations.

Medicaid was enacted by Congress in 1965 as an amendment to the Social Security Act with the passage of Title XIX. Originally the Social Security Board was responsible for administration of the Social Security Act. Through time, the administrative agencies have changed this responsibility, which currently resides with the U.S. Department of Health and Human Services (HHS). Within HHS, the Center for Medicare and Medicaid Services has responsibility for administering the Medicaid program. Medicaid policy remains the responsibility of Congress.

Our audits are required to ensure that federal program expenditures comply with federal program requirements. To accomplish this, we refer to a hierarchy of authoritative sources. This hierarchy includes:

- Compilation of Social Security Laws containing the full text of the Social Security Act of 1935 as amended in the United States Code.

- Regulations issued by executive branch agencies located in the Code of Federal Regulations (CFR). Proposed and recently adopted regulations are found in the Federal Register. Federal regulations for Medicaid programs are located in Title 42 of the CFR.

During the course of this audit, we discovered conflicting information was provided to states by CMS and specific regulations codified in the CFR. We sought advice from the U.S. Department of Health and Human Services, Office of the Inspector General. The Inspector General is directly responsible for meeting the statutory mission of promoting economy, efficiency and effectiveness in the administration of Social Security Administration programs and operations and to prevent and detect mismanagement in such programs and operations. The Inspector General directs, conducts and supervises a comprehensive program of audits, evaluations and investigations relating to programs and operations of the Social Security Administration. Thus, the Inspector General is the division of HHS that we turn to when seeking greater clarity for strongly controverted issues.

We contacted the Inspector General with our concerns that we did not find sufficient documentation to independently substantiate the state's representation that it is performing surveys, which would ensure that hospital providers are eligible to be Medicaid providers. They responded that an auditor needs such documentation to make an opinion. If there is no documentation, one cannot make an opinion, it becomes reportable, and costs become questionable. They also stated that the federal regulation is our guidance, that CMS cannot direct a state to deviate from the law.

The Yellow Book, Section 4.03c, quoted one of the Generally Accepted Government Auditing Standards for field work that we are required to follow:

> Sufficient, competent and relevant evidence is to be obtained to provide a reasonable basis for the auditors' findings and conclusions.

We quote this citation as an applicable law because, when there is no documentation to audit, we have no evidence to provide a reasonable basis for our opinion. If we opined solely on the Department's representation without any documentation to support our opinion, we would not be fulfilling this standard.

We reaffirm our finding that the Department of Health and the Department of Social and Health Services, Health and Recovery Services Administration, is not ensuring compliance with federal law regarding hospital surveys.

Applicable Laws and Regulations

The Yellow Book, Section 4.03c, states as one of the field work standards:

> Sufficient, competent and relevant evidence is to be obtained to provide a reasonable basis for the auditors' findings and conclusions.

42CFR431.610(f), states in part:

> Written agreement required. The plan must provide for a written agreement between the Medicaid agency and the survey agency . . . covering the activities of the survey agency in carrying out its responsibilities. The agreement must specify that:
>
> > (1) Federal requirements and the forms, methods and procedures that the Administrator designates will be used to determine provider eligibility and certification under Medicaid;
> >
> > (2) Inspectors surveying the premises of a provider will
> > > (i) Complete inspection reports;
> > > (ii) Note on completed reports whether or not each requirement for which an inspection is made is satisfied;
> > > (iii) Document deficiencies in reports
> >
> > (3) The survey agency will keep on file all information and reports used in determining whether participating facilities meet Federal requirements;
> >
> > (4) The survey agency will make the information and reports required under paragraph (f) (3) of this section readily accessible to HHS and the Medicaid agency as necessary
> > > (i) For meeting other requirements under the plan;
> > > (ii) for purposes consistent with the Medicaid agency's effective administration of the program.

In describing the authority of the Medicaid State Plan, Title 42 of the Code of Federal Regulations, Section 430.10, states:

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

The Department of Social and Health Services acknowledges the authority of the Medicaid State Plan and announces its commitment to abide by it in section 1.1 of the State Plan, which states:

> As a condition for receipt of Federal funds under title XIX of the Social Security Act, the Department of Social and Health Services submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

42CFR, Part 482.1 - Conditions of Participation, states in part:

> . . . (5) Section 1905(a) of the Act provides that ``medical assistance" (Medicaid) payments may be applied to various hospital services. Regulations. interpreting those provisions specify that hospitals receiving payment under Medicaid must meet the requirements for participation in Medicare . . .
>
> (b) . . . the provisions of this part serve as the basis of survey activities for the purpose of determining whether a hospital qualifies for a provider agreement under Medicare and Medicaid . . . .

The state of Washington's Medicaid State Plan, 4.11 Relations with Standard-setting and Survey Agencies, page 42, states:

> (a) The State agencies utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions . . . that provide services to Medicaid recipients. These agencies are: the Department of Social and Health Services and the Department of Health.
>
> (b) The State authority (ies) responsible for establishing and maintaining standards, other than those relating to health, for public and private institutions that provide services to Medicaid recipients are: the Legislature, State Board of Health, State Fire Marshall, the Department of Social and Health Services, and the Department of Health.
>
> (c) Attachment 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are on file and made available to the Center for Medicare and Medicaid Services on request.

The state of Washington's Medicaid State Plan, Attachment 4.11-A, states:

> The standards specified in paragraphs (a) and (b) on Page 42 of the Plan are as follows:
>
> A. General Hospitals, Revised Code of Washington Chapter 70.41 . . .

Regarding the Department of Health, RCW 70.41.120, states in part:

> The department shall make or cause to be made at least yearly an inspection of all hospitals . . . The department may make an examination of all phases of the hospital operation necessary to determine compliance with the law and the standards, rules and regulations . . . .

RCW 70.41.122 states in part:

> . . . a hospital accredited by the joint commission on the accreditation of health care organizations or the American osteopathic association is not subject to the annual inspection provided for in RCW 70.41.20 if:
>
> 1) The department determines that the applicable survey standards of the . . . commission . . . or the . . . association are substantially equivalent to its own;
>
> 2) It has been inspected by the . . . commission . . . or the . . . association within the previous twelve months; and
>
> 3) The department receives directly from the . . . commission . . . the . . . association, or the hospital itself copies of the survey reports . . . demonstrating that the hospital meets applicable standards.

05-07 The Department of Health and the Department of Social and Health Services, Health and Recovery Services Administration , agreement covering hospitals' survey activities does not comply with federal requirements.

Background

The Medicaid State Plan must designate the authorities within the state that are responsible for establishing and maintaining health standards for private or public institutions that provide services to Medicaid recipients. In Washington State, the responsibility lies with the Legislature, the State Board of Health, the State Fire Marshal, the Department of Social and Health Services and the Department of Health.

Federal law also requires a written agreement between the Medicaid agency and the survey agency. Certain stipulations must be set forth in the agreement covering the activities that the survey agency must perform in order to carry out its responsibilities. In Washington State, the designated Medicaid agency is the Department of Social and Health Services and the survey agency is the Department of Health.

In our fiscal year 2003 audit, we reported to management that the Department of Social and Health Services had not established a written agreement with the Department of Health for survey activities as required by federal regulation.

During our audit of fiscal year 2004, we found that the Department of Health and the Health and Recovery Services Administration (formerly Medical Assistance Administration) had recently signed a Memorandum of Understanding for survey activities. However, this document did not meet all federal requirements covering survey activities. We found the document lacked four items that the federal government requires:

- The forms, methods and procedures the Health Department was to use to determine provider eligibility and certification under Medicaid.

- That the Health Department must require surveyors to:

    - Complete inspection reports.
    - Note on the report if each requirement is satisfied.
    - Document deficiencies in a report.

- That the Health Department will keep on file all information and reports used in determining whether Medicaid participating facilities meet federal requirements.

- That the Health Department will make information and reports required by federal law readily accessible to the U.S. Department of Health and Human Services and the Medicaid agency.

Description of Condition

In our current audit, we followed up to determine whether progress had been made in correcting the conditions we found in our previous audits. The Department had stated it was modifying the interagency agreement to include all provisions required by law. Staff reported that this work was in progress as part of a review of all interagency contracts.

The Department of Health reported that, for the period being tested, no changes in survey documentation had been made or discussed with the Department and no plans were in place to address these issues in the future. After our testing was concluded and the Administration was notified of this condition, the Health Department told us discussions were under way, but only regarding the sharing of hospital information.

Cause of condition

The Department of Health reported that it is the responsibility of the Department of Social and Health Services, as Medicaid State Plan Administrators, to initiate changes to the agreement that comply with federal requirements for survey activities of hospitals.

Effect of condition

Without an agreement that conforms to federal regulations, the state is making significant payments to hospitals for services to Medicaid clients with little assurance that the Department of Health will conduct surveys that ensure services provided are meeting state health standards and regulatory requirements. Lack of compliance with federal regulations could jeopardize federal funding.

Recommendation

We recommend the Department of Social and Health Services modify the agreement with the Department of Health to include all provisions required by law.

Departments' Response

This response was written jointly by the Department of Health and the Department of Social and Health Services.

We partially concur with the finding by the State Auditor's office.

The Department of Health (DOH) and the Department of Social and Health Services have a signed agreement effective November 1, 2005 that complies with the Medicaid State Plan and Federal requirements. A copy of this agreement is available at the Department of Social and Health Services.

DOH agrees to follow the policies, procedures and guidelines for Medicare surveys as stipulated in the Medicare State Operations Manual, the Medicare Policies of Documentation and the Federal Regulations Interpretive Guidelines.

The Centers for Medicare & Medicaid Services (CMS) are responsible for enforcing these policies and developing procedures to include documentation requirements. CMS conducts an annual performance review of the DOH to determine conformance with their policies/procedures/guidelines and regulations. CMS has conducted these reviews annually for the past three years and found DOH to be in compliance.

Auditor's Concluding Remarks

We appreciate the steps the Department of Social and Health Services and the Department of Health have taken to initiate the resolution of this issue. However, these efforts alone will not bring the state into compliance with federal regulations for surveys of hospitals. The agreement as written does not conform to 42CFR431.610(f). Specifically, it does not provide:

- The survey forms, methods and procedures the Health Department must use to determine provider eligibility and certification under Medicaid.

- That the Health Department must require surveyors to:
  - Complete inspection reports
  - Note on reports if each requirement is satisfied

- Although we note that the Health Department agreed to comply with the mandatory release requirements of certain information in a timely manner, the Department of Health would not be able to comply because it does not have all of the required information and reports on file.

- That the Health Department will make information and reports required by federal law readily accessible to the U.S. Department of Health and Human Services and the Medicaid agency.

Additionally, it provides that Medicaid qualifying surveys will conform to a schedule that meets criteria established by CMS. The agreement does not state the surveys will conform to the 18-month frequency as stipulated in the Medicaid State Plan and state law. Medicare hospital surveys are generally conducted every three years.

The agreement also requires that surveys will be conducted according to provisions in the State Operations Manual. We reported in another area of our audit that this manual, although approved by CMS, does not conform to criteria stipulated in the Code of Federal Regulations. If the state receives federal Medicaid matching funds for expenditures related to Medicaid, the State Auditor's Office is required to determine if there is reasonable assurance that the federal compliance requirements for Medicaid were met. Although the Medicaid program is mentioned in the agreement, compliance with Medicare regulations is the criteria that the Departments' are striving to meet. In following Medicare survey activities as outlined in the State Operations Manual, the state will not be ensuring that all conditions of participation have been surveyed as required by Medicaid regulations. Additionally, in following the Medicare documentation standards for Medicaid surveys, the Health Department will not be in compliance with the Medicaid survey documentation requirements for its surveys since Medicare only requires documentation of exceptions. In another part of our audit, we found that the Health Department does not have documentation on file to substantiate that all areas of a hospital were audited as required by federal regulations for the Medicaid program. The State Auditor's Office cannot conduct compliance audits of hospital survey activities if no documentation exists to audit.

In 2003, CMS conceded that the State Auditor's Office had found inconsistencies between federal law and the instructions CMS has given to states in terms of survey practices. Our guidance from the U.S. Department of Health and Human Services Office of the Inspector General is that we must report compliance according to the current federal regulation.

We reaffirm our finding that the Department of Health and the Department of Social and Health Services are not complying with state law or the provisions of the Medicaid State Plan, which help to ensure compliance with health and safety standards for hospitals.

Applicable Laws and Regulations

In describing the authority of the Medicaid State Plan, Title 42 of the Code of Federal Regulations, Section 430.10, states:

> The State Plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

The Department of Social and Health Services acknowledges the authority of the State Plan and announces its commitment to abide by it in section 1.1 of the State Plan, which states:

> As a condition for receipt of Federal funds under title XIX of the Social Security Act, the Department of Social and Health Services submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

The State of Washington's Medicaid State Plan, 4.11 Relations with Standard-setting and Survey Agencies, page 42, states in part:

> (a) The State agencies utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions . . . that provide services to Medicaid recipients. These agencies are: the Department of Social and Health Services and the Department of Health.
>
> (b) The State authority (ies) responsible for establishing and maintaining standards, other than those relating to health, for public and private institutions that provide services to Medicaid recipients are: the Legislature, State Board of Health, State Fire Marshall, the Department of Social and Health Services, and the Department of Health.
>
> (c) Attachment 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are on file and made available to the Center for Medicare and Medicaid Services on request.

The State of Washington's Medicaid State Plan, Attachment 4.11-A, states in part:

> The standards specified in paragraphs (a) and (b) on Page 42 of the Plan are as follows:
>
> > A. General Hospitals Revised Code of Washington Chapter 70.41 . . . .
> >
> > Surveys are conducted in accordance with the Interagency Agreement between the Department of Social and Health Services (DSHS) and the Department of Health (DOH).

42CFR431.610(f) states in part:

> Written agreement required. The plan must provide for a written agreement between the Medicaid agency and the survey agency . . . covering the activities of the survey agency in carrying out its responsibilities. The agreement must specify that:
>
> > (1) Federal requirements and the forms, methods and procedures that the Administrator designates will be used to determine provider eligibility and certification under Medicaid;
> >
> > (2) Inspectors surveying the premises of a provider will
> >
> > > (i) Complete inspection reports;
> > > (ii) Note on completed reports whether or not each requirement for which an inspection is made is satisfied;
> > > (iii) Document deficiencies in reports
> >
> > (3) The survey agency will keep on file all information and reports used in determining whether participating facilities meet Federal requirements;
> >
> > (4) The survey agency will make the information and reports required under paragraph (f) (3) of this section readily accessible to HHS and the Medicaid agency as necessary
> > > (i) for meeting other requirements under the plan;
> > > (ii) for purposes consistent with the Medicaid agency's effective administration of the program.

05-08 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), received federal Medicaid funds for unallowable services provided to undocumented aliens.

Background

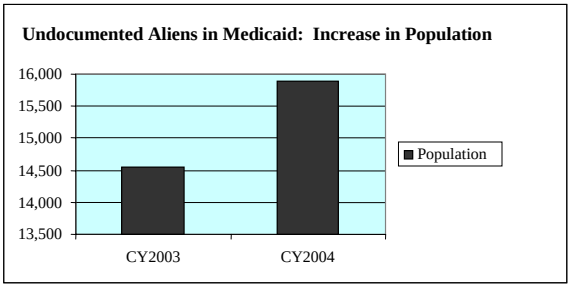
As a requirement for receiving federal Medicaid funds (CFDA 93.778), the Department of Social and Health Services must provide medical benefits to three groups: eligible residents of the United States who are citizens, aliens lawfully admitted for permanent residence, and certain aliens granted lawful temporary resident status. Undocumented aliens are not included in these three groups.

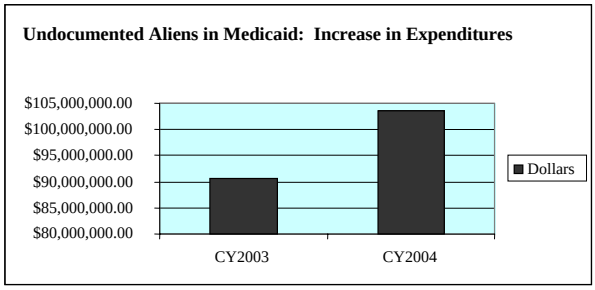
In most cases, if a state chooses to provide medical services to undocumented aliens, it must use its own funds. Federal Medicaid matching funds are available only if the medical services provided are the result of an emergency situation, including obstetrical services at the time of delivery. Emergency medical services are defined in the U.S. Code of Federal Regulations and the Medicaid State Plan. Non-emergency medical services provided to undocumented aliens cannot be charged to the federal government. The Department and the federal government define "emergency medical condition" as the sudden onset of a medical condition so severe that, without immediate medical attention, serious jeopardy to a person's health, serious impairment of bodily functions, or a serious dysfunction of a bodily organ or part would be expected.

In our audit of fiscal year 2003, Department records showed that 9,717 undocumented aliens received medical services from July 2002 through December 2003. Based on our risk analysis, we selected 169 of these patients in six service categories and found that non-emergency procedures, routine medical services and durable medical equipment were provided to undocumented aliens and paid for with Medicaid funds. We found payments for adult day care, massages, dental fillings, routine eye exams, regular office visits and in-home care, as well as supervision of normal pregnancies and routine postpartum follow-up. Medicaid payments were made for eyeglasses and contact lenses, breast pumps, dentures, contraceptive devices, disposable incontinence garments and replacement wheels for wheelchairs. We found payments for conditions such as menopause, cough, breast engorgement and nearsightedness. As a result, we questioned $1,342,420 in state and federal costs.

In our audit of fiscal year 2004, we were unable to determine if the Department made any improvements to its systems because the Department did not allow us access to all the records that we needed to perform our testing. For the testing we were able to accomplish, we found that the Department provided non-emergency services to 274 undocumented aliens totaling $5,141,726. These services included adult day care, dental, nursing home, in-home services and personal care services.

Department records showed that, from January 2003 through December 2003, 14,553 undocumented aliens received services through the Medicaid program for a total of $90,590,401. For the same period in 2004, the Department's records indicated that it provided services to 15,890 undocumented aliens. The Medicaid program paid $103,698,442 for this care. This is an increase of 9 percent in population and 14 percent in expenditures from the previous year.





Description of Condition

In our current audit, we followed up to determine if improvements had been made to the controls, which would ensure that only emergency services were paid for with federal funds. Using the Department's records, we found that 4,692 diagnostic codes, totaling $103,698,442, were reported by providers in the claims they submitted for services provided to undocumented aliens.

The diagnostic code tells what condition the client had that required treatment. The procedure code, on the other hand, shows the actual treatment that the client was given. Generally, these are related in that the services rendered are deemed customary for the client's condition. Our preliminary analysis revealed the procedures for which the claim was paid often were unrelated to the diagnoses. For instance, we found diagnostic codes for sprained ankles or limb contusions associated with durable medical equipment such as breast pumps. This revealed that the diagnostic code alone, as reported in the Department's system, could not be relied upon to determine whether the expenditure was for an emergent or non-emergent service and, thus, allowable for federal Medicaid funds. This required us to perform more detailed testing that would incorporate an analysis of the procedure code as well as the diagnostic code for each transaction that we wished to test.

We reviewed 333 (7 percent) of the 4,692 diagnostic codes and $88,039,565 (85 percent) of the $103,698,442 in expenditures reported in the Department's records for undocumented alien clients. This review included related procedures and associated transactions. In all, we tested 647,131 transactions. Our testing attempted to determine whether or not the diagnostic code and procedure code associated with it adhered to the federal definition of emergent and whether or not the Department had enough information within the accounting system to determine the propriety of the transaction.

Our testing revealed that:

- $28,013,625 (32 percent) was paid for diagnoses and procedures that did not conform to the federal definition of emergent.

- The following expenditures were paid on claims for which information in the Department's system was inadequate to determine the propriety of the transaction.

    - $47,043,702 (53.4 percent) was paid on claims with no procedure codes.

    - $1,648,452 (1.9 percent) was paid on claims with no diagnostic codes.

    - $3,326,866 (3.8 percent) was paid on claims with no diagnostic codes <u>and</u> no procedure codes.

    - $3,167,289 (3.6 percent) was paid on prescription medications when no indication was given for what condition the drug was being used.

    - $3,961,673 (4.5 percent) was paid for diagnoses and procedures that conformed to the federal definition of emergent. $290,645 (0.3 percent) was paid for with state funds.

We did not test diagnostic categories that were related strictly to newborns, as it is reasonable to assume that the newborn may be a citizen even if the mother is an undocumented alien. We did not determine whether these clients were actually born in the United States, but relied on the Department's designation of "newborn" in the accounting records. This total was $877,959.

In general, claims were paid on the following diagnostic categories:

$57,803,194	Pregnancy-related which included prenatal, labor and delivery, postnatal and sterilizations. Of this amount $2,911,194 was for labor and delivery.
$ 2,327,481	Treatments for cancer including chemotherapy and radiation therapy.

$ 2,697,283	Treatments for kidney diseases including transplants.
$ 1,691,934	Dental care including oral evaluations and check ups, cleanings, fillings, bridges, crowns and cosmetic treatments.
$ 245,770	Eye exams, spectacles and contact lenses.
$ 1,055,949	Gynecological procedures including male and female contraceptive devices, contraceptive supervision and annual checkups.
$12,591,709	Miscellaneous diagnostic codes which included hearing exams, physical therapy, carpal tunnel syndrome, in growing nails, acne, irregular menstruation and others.

We found no improvements in the Department's controls from previous years. Social Security numbers are not consistently verified prior to admitting clients into the Medicaid program as federal law requires. Although undocumented aliens do not have Social Security numbers, we have found evidence in which staff has accepted a Social Security card given to them by an undocumented alien. Instances in which the Department has accepted verbal representations of a number by a client are common in its records.

The Department's accounting system continues to be unable to differentiate undocumented aliens who have received emergency services from those who have not. Staff has informed us that the programming needed to perform this function will not be addressed until June 2007 when a new computer system is expected to arrive.

We found no improvements to the procedure manuals that staff is required to use. We found instances in which the guidance provided in the manual conflicts with federal law for the program.

Cause of Condition

- Social Security numbers are not consistently verified prior to admitting clients into the Medicaid program. Further, the Department does not heed federal alerts notifying staff of invalid Social Security numbers.

- The Department's accounting system does not differentiate undocumented aliens who have received emergency services from those who have received non-emergency services.

- When the Department enters an undocumented alien into its system in order to pay for emergency medical costs, it enters that client for a three-month period. During that time, it pays for <u>all</u> medical services provided to that client, emergency or not. At the end of three-months, the client can be approved for an additional amount of time. This appears to occur continually, as we have seen clients in the system over a period of several years.

- Department staff stated the procedure manuals contain insufficient and unclear guidance and are often too technical for non-medical personnel to understand.

- In its eligibility manual, the Department lists certain medical diagnoses that are pre-authorized as emergencies. If a client who is an undocumented alien has a medical diagnosis that is not on the list, staff members are instructed to refer the case to the Department's medical staff. We found these referrals were not being made in a consistent manner.

Effect of Condition

The Census Bureau reported that 45 million Americans did not have health insurance in 2003, an increase of 1.4 million from 2002 and 5.2 million from 2000. People often do not have access to Medicaid because states do not have sufficient funding to provide quality care for all. Economic factors as well as natural disasters force states and individuals to rely on the federal government for assistance and to compete for limited health-care dollars.

Washington State is providing services to thousands of ineligible clients using federal Medicaid money. The majority of these clients were admitted into the program due to unaddressed significant weaknesses in the Department's controls. This is causing the nation's taxpayers to subsidize Washington State's noncompliance. Our testing showed that the state had $83,199,933 in questioned costs, half of which were paid with federal Medicaid funds. Lack of compliance with federal regulations could jeopardize future federal funding.

Recommendation

With respect to compliance with federal regulations, we recommend the Department:

- Revise its policies regarding emergent conditions to conform to federal regulations.
- Work with the U.S. Department of Health and Human Services to determine if any costs related to noncompliance charged to Medicaid must be returned.

With respect to strengthening internal controls, we recommend the Department:

- Develop internal controls that require employees to verify applicants' Social Security numbers and heed alerts sent by the Social Security Administration pertaining to invalid numbers.
- Develop clear and complete policy and procedure manuals.
- Develop an accounting system that will differentiate emergency from non-emergency procedures so that the appropriate funds can be used to pay for the designated services.

With respect to caring for the state's growing undocumented alien population, we recommend the Department:

- Fund a state program that would pay for the additional care that the state wishes to provide.

Department's Response

The Department disagrees with this finding. The Department has made improvements in the policy, tracking and reporting of Alien Emergency Medical (AEM) expenditures.

- *The Department initiated a review of its AEM policies as a result of the FY2003 audit. Since then, it has clarified these policies regarding the allowability of AEM expenditures effective July 2005. We believe the current policies are consistent with federal and state regulations. There have been updates to manuals, forms and procedures within the Department to reflect these changes. The accounting system has been setup to identify these services and implemented a quarterly review of these expenditures.*
- *The Department has also been notified of an Office of Inspector General audit for this program to commence on March 1, 2006. The result of this audit will clarify the Department's interpretation of the AEM policy regarding emergent vs. non-emergent services.*
- *The State Auditor's Office (SAO) recommends the Department fund a state program that would pay for the additional care that the state wishes to provide. The Department suggests the SAO either remove this recommendation from their report or direct the recommendation to the Office of Financial Management or the Legislature. It is not within the Department's authority to create and fund a program using General Fund-State dollars.*

Auditor's Concluding Remarks

- The Department has not brought to our attention any policy changes it has made or intends to make with respect to allowability of expenditures it is making on behalf of undocumented aliens. Any changes that

were implemented after July 1, 2005, were after our audit period and will be reviewed during our fiscal year 2006 audit.

- We are aware that the Office of the Inspector General will conduct an audit regarding the allowability of the Department's expenditures in the Alien Emergency Medical program. The Inspector General's Office has been in contact with the State Auditor's Office.

- If the Department desires to expend federal funds for a purpose that is unallowable, as it has done with its undocumented alien clientele, then it is the Department's responsibility to inform the Office of Financial Management and the Legislature of its needs.

Applicable Laws and Regulations

Allowability and Eligibility

Section 1903 of the Act (41 U.S.C., Section 1396(b)) provides in part:

> (1) No payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or other wise permanently residing in the United States under color of law.
>
> (2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if -
>
> > (A) such care and services are necessary for the treatment of an emergency medical condition of the alien,
> >
> > (B) such alien otherwise meets the eligibility requirement for medical assistance . . . and
> >
> > (C) such care and services are not related to an organ transplant procedure.

Washington Administrative Code 388-500-0005 describes emergency services as follows:

> Emergency medical condition means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
>
> > Placing the patient's health in serious jeopardy;
> > Serious impairment to bodily functions; or
> > Serious dysfunction of any bodily organ or part.

Washington Administrative Code 388-500-0005 also defines emergency medical expense requirements as follows:

> A specified amount of expenses for ambulance, emergency room or hospital services, including physician services in hospital, incurred for an emergency medical condition that a client must incur prior to certification for the medically indigent program.

The Department's *A-Z Eligibility Manual* describes what constitutes an emergency medical condition. It states, in part:

> 1 . . . In order to be eligible for the Alien Emergency Medical (AEM) program, a person must: . . .
>
> > a. Have an emergency medical condition. (Refer to the list of emergency medical conditions in the Medically Indigent section) . . . .

Washington Administrative Code 388-438-0110 describes alien emergency medical as follows:

> An alien, who is not eligible for other medical programs, is eligible for emergency medical care and services:
>
> (1) Regardless of their date of arrival in the United States;
>
> (2) Except for citizenship, meets Medicaid eligibility requirements as described in Washington Administrative Code 388-505-0210, 388-505-0220 or Washington Administrative Code 388-505-0110; and
>
> (3) Limited to the necessary treatment of an alien's emergency medical condition as defined in Washington Administrative Code 388-500-0005, except that organ transplants and related medical care services are not covered.

Washington Administrative Code 388-424-0010 describes alien status and eligibility requirements for medical benefits. Paragraph (3) states the extent of those services:

> An alien who would qualify for Medicaid benefits but is ineligible solely because of his or her alien status, can receive medical coverage as follows:
>
> (a) State-funded categorically needy (CN) scope of care for . . .
>
> (i) Pregnant women, as specified in Washington Administrative Code 388-462-0015

Administrative Code 388-462-0015 states that care to pregnant women who do not meet eligibility requirements due to citizenship status will be provided under state funded programs only:

> A pregnant woman is eligible for CN scope of care under the state-funded pregnant woman program if she is not eligible for programs in subsection (2) of this section due to citizenship, immigrant or Social Security Number requirements.

Revised Code of Washington 43.20A.550 states that rules and regulations in conflict with federal law are deemed inoperative:

> . . . Any section or provision of law dealing with the department, which may be susceptible to more than one construction, shall be interpreted in favor of the construction most likely to comply with federal laws entitling this state to receive federal funds for the various programs of the department. If any law dealing with the department is ruled to be in conflict with federal requirements which are a prescribed condition of the allocation of federal funds to the state, or to any departments or agencies thereof, such conflicting part of chapter 18, Laws of 1970 ex.sess is declared to be inoperative solely to the extent of the conflict.

05-09 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), is not complying with federal requirements to defer Medicaid expenditures related to undocumented aliens.

Background

The federal government requires states to report expenditures for medical assistance and administrative costs on a quarterly basis. This report is referred to as the CMS-64. The federal government reimburses states for a defined percentage of expenditures based on the information submitted in these reports. Line 6, Item 27 of the CMS-64 claim form, Emergency Services Undocumented Aliens, is to be used to report allowable emergency expenditures for undocumented aliens.

In our audits of state fiscal year 2003 and 2004, we found that Department of Social and Health Services was not reporting payments for alien emergency medical (AEM) services on the claim form as required. Instead, it combined payments for both allowable emergency services and unallowable non-emergency services and reported that amount in other categories of the form as allowable expenditures. In our audit of state fiscal year 2004, we reported that the Department was receiving federal Medicaid funds to which it was not entitled.

On May 6, 2005, Centers for Medicare and Medicaid Services (CMS) informed the Department that a deferral of $3,636,690 in federal funds for the quarter ending December 31, 2004, was being made to the Medicaid grant for federal fiscal year 2005. This means the funds drawn for that quarter could not be claimed, pending a determination of allowability. In addition, the following quarter expenditures would have to be reduced by the same amount. CMS also directed the Department not to draw any funds for emergency services for undocumented aliens from the annual grant until the federal government reviewed the expenditures being claimed by the Department. We were informed by the Office of Inspector General that a federal audit of expenditures related to the Alien Emergency Medical program would be conducted sometime in the near future.

Description of Condition

In our audit of state fiscal year 2005 we found:

- We could not confirm the Department's representations that all expenditures for undocumented aliens were deferred in the second quarter of federal fiscal year 2005 as required by the federal government. Since we could not confirm the deferral and since no changes had been made in the Department's procedures in this area we have no reasonable assurance that the deferral occurred in subsequent quarters as well.

- The Department conceded it was not deferring expenditures related to labor and delivery, as they believed that these expenditures were for emergent care. However, in our review of Alien Emergency Medical in another part of our audit, we found, even though a client may have a diagnosis of labor and delivery, the procedures for which the claims were paid included treatments for dental care, eye exams and other non-emergent procedures. We also found what the Department termed "labor and delivery" was actually pregnancy-related expenditures, which often include prenatal and postpartum procedures, which do not conform to the federal definition of emergent.

- The state continues to misrepresent expenditures reported on the claim form when it reports no expenditures for undocumented aliens when, in fact, it is drawing funds for pregnancy-related expenditures paid on behalf of undocumented aliens. These unallowable expenditures that should be deferred are being commingled with other expenditures and reported on lines reserved for clients that have been deemed eligible for the Medicaid program.

Cause of Condition

The Department has no coding in its accounting records to differentiate emergency services from non-emergency services for undocumented aliens. All of these services are included in one accounting category.

The Department believes that all pregnancy-related expenditures qualify as emergent conditions and thus are exempt from deferral. The Department's decision to isolate these expenditures and not defer them as instructed by CMS was solely the Department's. We are not aware of any exemption granted by the federal government.

Effect of Condition

The state may have to repay the federal portion of those expenditures that should have been deferred but were not. The estimated liability to the state ranges from $9,088,295 to $10,704,756 for the second federal fiscal quarter and for each subsequent quarter that deferred expenditures were drawn. Estimated liability for state fiscal year 2005 is $18,176,590 to $21,409,511. As the state continues to draw these funds the liability increases on a quarterly basis. Estimated liability to the state as of September 30, 2005, was approximately $27,264,885 to $32,114,267.

Recommendation

We recommend the Department:

- Develop account coding that would differentiate emergency from non-emergency services for undocumented aliens and report the proper allowable amount on the correct line of the CMS-64 claim form.

- Not draw funds for emergency services for undocumented aliens from the Medicaid award until instructed to do so by the federal government.

- Work with the U.S. Department of Health and Human services to determine if any un-deferred costs charged to Medicaid must be returned.

Department's Response

The Department does not concur with this finding for the reasons outline below:

- *The Department's Office of Accounting Services (OAS) has deferred all AEM expenditures effective October 1, 2004 as required by the Centers for Medicare and Medicaid Services (CMS) in a letter dated May 6, 2004. This deferral requires that the state does not draw down federal matching funds for AEM expenditures, except for labor and delivery. The deferral is shown strictly in the state's accounting system, Agency Financial Reporting System (AFRS), since all payments from the Medicaid Management Information System (MMIS) will continue to show federal match. At the end of each quarter, which coincides with the CMS64 reporting cycle, the OAS prepares an accounting entry in AFRS so that all AEM expenditures are funded with state funds only. This process recognizes that AFRS is the state's official accounting and reporting system and the MMIS is only a payment system.*

- *The Department received written clarification from a CMS official, John Lynch's e-mail dated November 17, 2005, which affirms that labor and delivery charges are excluded from the deferral and have shared this with the State Auditor's Office (SAO). Additionally, this information was shared with the SAO in an e-mail from Susan Lucas on December 15, 2005. Therefore, the Department does not believe that the federal match of approximately $35.0 million per fiscal year is inappropriate. (These email documents are available from DSHS.)*

- *As a result of prior audits, the Department has improved its reporting and monitoring of this program. These changes include establishing necessary account coding so that these expenditures can be properly report on the CMS64; update and clarify the Department's policy on AEM that focus on emergent conditions; and obtain a thorough understanding of the MMIS data as it relates to this program so as to ensure that others would not misinterpret the data. Currently, the Department differentiates emergent vs. non-emergent services through its policy as well as the use of both diagnosis and procedures codes and quarterly review of the AEM expenditures.*

Finally, the Department has received notification of the Office of Inspector's General audit for this program, which will begin on March 1, 2006. We look forward to this audit as it will provide needed clarifications and guidance on the allowability of AEM expenditures.

Auditor's Concluding Remarks

- The Department interprets the instructions issued by the Center for Medicare and Medicaid as a requirement "that the state does not draw down federal matching funds for AEM expenditures, except for labor and delivery". We believe that the letter dated May 6, 2004, is plainly worded:

  > You are advised not to draw funds for emergency services for undocumented aliens from this award because CMS will not provide funding for these expenditures nor approve reimbursement for these claims via the CMS-64 Quarterly Statement of Expenditures Report process until final resolution of this issue.

  Resolution of this issue did not occur in our audit period and to this date remains pending.

- The Department states that an email from the Center for Medicare and Medicaid dated November 17, 2005, provides further clarification and affirms its position "that labor and delivery charges are excluded from the deferral" and that they have shared this with the State Auditor's Office. While the Department's interpretation of the content was shared with us the actual email was first seen with this response.

  Reading beyond the first sentence the email reiterates our position. Specifically,

  - Diagnostic and procedures codes must be present to determine the allowability of the transaction for the Alien Emergency Medical program.

  - In the Department's records there are expenditures under the diagnosis of labor and delivery, which are not allowable.

  In that email, CMS stated:

  > The problem in looking at the accounting codes for the $30 million . . . as Emergency Services for undocumented aliens is that it obviously does not identify the diagnosis/procedure codes for them. In fact in reviewing the acct codes . . . some costs for example EPSDT Screening **(Early and Periodic Screening, Diagnostic, and Treatment, added for clarification)** are listed . . . Obviously these costs are not 'ER for undoc aliens' or Labor & Delivery and should not be reported on the CMS 64 or CMS 21. Also there is Dental-Adult in the amount of $286,089 TC and Dental-Children amount of $40,686 under Subprogram 1277 which are also not Labor & Delivery.

  CMS concluded as follows:

  > Therefore the State should <u>not</u> claim the $30 million Total Computable this quarter (7/1-9/30/05) and send us a CD in Microsoft Access for the detail of these claims/costs for the $30 million TC with the name/client identifier, service date, paid date, diagnosis code, CPT 4 code, ICD 9, etc. (description of service rendered), and if at all possible the subobject code for example M412 Prescription Drugs FP, M510 Dental Adults for each claim. Then we will review the claims and determine which amounts are Labor & Delivery, which can be reclaimed next quarter.

We do not know if the instructions given by CMS in this email were followed.

- The Department states it "differentiates emergent vs. non-emergent services through its policy as well as the use of both diagnosis and procedures codes and quarterly review of the AEM expenditures". We do not know how the Department would be able to do this. Our testing showed that diagnosis and or procedures codes were not always present. We found expenditures with:

Diagnosis codes without procedure codes	$44,571,491.47
No diagnosis or procedure codes	$ 3,326,866.47
Procedure codes without diagnosis codes	$ 1,648,451.61
Prescriptions with no diagnosis codes	$ 3,167,288.51
Total	$52,714,088.06

  Thus, 60 percent of the expenditures tested either had no diagnosis codes or no procedure codes or in some cases neither was present.

  We also found that the Department has no way of determining which transactions are emergent vs. non-emergent for Alien Emergency Medical. Our testing showed that at the end of each quarter the Department downloaded all transactions related to undocumented aliens and transferred these expenditures to an account code designated as Alien Emergency Medical without regard to whether or not the transaction met the definition of emergent. The Department stated that they did not have the time or the expertise to review diagnosis or procedure codes and felt that diagnosis and procedure codes were not necessary in order to pay the claim or to call the transactions emergent.

We reaffirm our finding and our recommendation that the Department needs to develop account coding that would differentiate emergency from non-emergency services for undocumented aliens, report the proper allowable amount on the correct line of the CMS-64 claim form and not draw funds for emergency services for undocumented aliens from the Medicaid award until instructed to do so by the federal government.

Applicable Laws and Regulations

The state of Washington's Office of Financial Management's *State Administrative and Accounting Manual*, Section 50.30.45.2, describes the reporting responsibilities of state agencies that administer or expend federal awards:

> Identify, account for, and report all expenditures of federal awards in accordance with laws, regulations, contract and grant agreements, and requirements included in this and other sections of the OFM *State Administrative and Accounting Manual***.**

Title 45, Code of Federal Regulations, Section 92.20(a), states:

> A State must expend and account for grant funds in accordance with State laws and procedures for expending and accounting for its own funds.

Title 42, Code of Federal Regulations, Section 430.30(c), states:

> Expenditure reports (1) The State must submit Form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) to the central office (with a copy to the regional office) not later than 30 days after the end of each quarter. (2) This report is the State's accounting of actual recorded expenditures. The disposition of Federal funds may not be reported on the basis of estimates.

The U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Subpart C, Section .300, states:

> The auditee shall . . .
>
> > (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs . . . .

05-10 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), has not established sufficient internal controls to support its decisions on eligibility of clients enrolled in Medicaid's Basic Health Plus Program.

Background

Among Medicaid enrollees are children of parents and guardians who participate or who have participated in the state's Basic Health Plan. The Basic Health Plan is designed to provide affordable health insurance to any eligible Washington resident and is administered by the Washington State Health Care Authority. An application for the Basic Health Plan by a parent may also be used as a joint application for Basic Health Plus Program for any child in the household. Children of Basic Health Plan members whose family income meets the net income standards for Basic Health Plus may be eligible for Medicaid benefits. The Health Care Authority provides the insurance coverage under Basic Health Plus, while the Health and Recovery Services Administration (formerly Medical Assistance Administration) pays the premiums.

Federal auditing guidelines require us to follow up on previous years' audit findings to determine if they have been resolved. In our audits of state fiscal years 2001, 2002 and 2003, we reported findings related to weaknesses in the internal control structure in the Administration's management of the Basic Health Plus Program.

- For 2001, we found multiple weaknesses in the internal controls over determining client eligibility. We reviewed 60 client files and found 27 clients (47 percent) exceeded the net income standard for Medicaid eligibility and were not entitled to benefits.

- For 2002, we found that the Administration was restructuring controls and training staff. However, most of the corrective actions did not occur before fiscal year 2002 had ended and the internal control weaknesses that were found in 2001 continued in 2002.

- For 2003, we again reviewed the actions taken by the Administration and found it had made some significant improvements. However, most of the corrective actions did not occur before fiscal year 2003 ended. We also found weaknesses that the Administration had not yet addressed. These included:

    1. For self-employed households, income information was not confirmed with an independent source such as tax returns from the state's Department of Revenue or the Internal Revenue Service. The Department continued to accept self-declarations of income. We reviewed five self-employed clients and found all five were either ineligible for benefits or the Administration could not provide the documentation to substantiate their initial eligibility.

    2. We reviewed five wage-earning clients, as well, and found similar results for three out of the five.
    3. The Administration could not provide evidence of procedures that ensured clients were reporting income changes immediately.

    4. Administration staff had not achieved its quotas for eligibility reviews.

    5. The Administration was not using monthly reports from the Authority informing them of the subscribers who were disenrolled due to noncompliance with the Health Care Authority's recertification process.

- For 2004, the audit liaison systems that the Health Care Authority and the Medical Assistance Administration set up prevented us from obtaining the information and conducting the procedures necessary to complete our audit according to *Generally Accepted Auditing Standards* and in compliance with federal auditing regulations. Due to an agency-imposed scope limitation, we disclaimed an opinion on compliance related to allowable costs and eligibility of Medicaid clients under the Basic Health Plus program.

Description of Condition

In our follow up work for our current audit, we saw some improvement. The Department is no longer accepting declaration of income for its wage-earner clients. However, the Department is not determining if adults other than head-of-household are employed. No improvements have been made for self-employed clients. The Department is not verifying the income of these individuals with an independent source. We found, in most cases, it accepts the client's declaration of income and the Department makes no efforts to determine if the spouse in the household is employed.

For our audit, we selected a valid sample of the 306 clients. We found exceptions for 300 (98 percent) as follows:

- 58 clients in the sample were self-employed. For 56 of these clients, the Department did not have sufficient income documentation to support its determination of eligibility.

- 188 clients in the sample were wage earners. For 184 of these clients, the Department did not have sufficient income documentation to support its determination of eligibility.

- For 60 clients, (20 percent) documentation in the Administration's files was insufficient to determine if these clients were self-employed or wage earners.

For these clients, we also found:

- 27 clients (9 percent) had no applications or incomplete applications on file.

- 13 clients (4 percent) had applications but they were unsigned.

- 10 clients (3 percent) were listed in the Administration's systems but it could provide no documentation on these clients.

- Three clients (1 percent) could not be found in any of the Department's systems other than the payment for their premiums. These are highly susceptible for fraud.

Our computer analysis also revealed clients with family incomes over $75,000 and with less than nine recipients in the household, the threshold for this income level. We found 52 clients with incomes ranging from approximately $75,000 to $140,000. The Department's records reported these households as having eight or less recipients in the family. For these households we found:

- 25 families (48 percent) were at one time enrolled in Basic Health Plus and now are no longer enrolled.

- 25 families (48 percent) were actively enrolled in the program.

- One family (2 percent) would become eligible once a certain amount of medical liability was incurred.

- One family (2 percent) was denied coverage.

Cause of Condition

- The Department reported that it does not verify income from third-party sources such as the Internal Revenue Service, the Department of Revenue and the Employment Security Department because it does not believe the information is accurate for its purposes. The Department believes a client's declaration of income is more up-to-date and thus sufficient.

- The Department reported it does not use the alerts sent by Health Care Authority, informing it of subscribers who have surpassed the income standard for Basic Health and who are disenrolled, because

they do not consider these reports to serve any useful function. The Department believes a parent's disenrollment from Basic Health does not affect the child's eligibility for Basic Health Plus.

Effect of Condition

The Department is not complying with federal requirements to verify income with independent sources to ensure that individuals meet the financial and categorical requirements for Medicaid. This noncompliance has resulted in $29,206,364 in actual and projected questioned costs. $14,603,182 was paid for with federal funds.

Recommendation

We recommend the Department:

- Establish and follow policies and procedures that require staff to corroborate the client's representations and to exercise a level of judgment, care, prudence, determination and activity that a person would reasonably be expected to do when determining eligibility.

- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid federal funds must be reimbursed as a result of this noncompliance.

Department's Response

The Department disagrees with this finding. Specific responses to the items under "cause of condition" are listed below.

1. The auditor states that the Department does not verify income from third party sources. This statement is not accurate. The Department does review the income that is reported on the application/eligibility review provided by the client and follows instructions per agency policy, which requires that workers use any one of the several sources to verify income. These sources include other federal and state agencies' data.

2. The auditor reports that families with incomes over $75,000 were actively enrolled in the Basic Health plus program. We disagree with this finding. The Department follows the income methodology set forth in the Washington Administrative Code, A-Z Manual and federal regulations. The auditor has not shared with the Department the eligibility timeframes reviewed, or the methods it employed to calculate income. It is the Department's belief that the income amounts asserted by the auditors are incorrect and overstated. The Department assumes the State Auditor's Office (SAO) took an entire year or more from Employment Security Division, which overlapped claims paid, but the Department only looks at prospective income at the time of application or eligibility review. The SAO provided no dates for the period of time they pulled income data.

3. The auditor states that the Department does not use alerts received from the Health Care Authority (HCA) on subscribers who are disenrolled because the subscriber has surpassed the income standard. As stated in the SFY03 audit response, the HCA does send individual Basic Health member change notices and those notices are acted upon in accordance with existing Medicaid policies regarding changes in household circumstances. Please note that changes in income do not affect a child's eligibility due to the Department's policy of continuous eligibility for up to 12 months.

4. The Department partially disagrees with the finding related to applications that are not fully documented. For applications that have unverified social security numbers, where there is no client ID in the system and for some of the incomplete or missing applications, Medical Eligibility Determination Section staff were able to verify the necessary information. Documentation was delivered to the auditor on January 10, 2006 & January 23, 2006, but may have been delivered too late to be included in the audit report.

5. For applications that are older than 1998, the application document has been purged from the State's files. We understand the SAO wants to see signed Medicaid applications that cover the period of time claims were paid for these clients, but since this audit review period is for SFY05 (7/04 – 6/05) we note that each

of these cases has a current and signed eligibility review that identifies the reported household circumstances from which the current Medicaid eligibility (if the case is still open) was determined.

Auditor's Concluding Remarks

The Department states it verifies income that is reported on the application/eligibility review provided by the client. We found that, for wage-earners, the Department makes no attempt to ensure all income in the household is reported and verified when individuals apply for Basic Health Plus. For self-employed clients, the Department accepts the client's declaration of income and does not independently verify whether it is correct or whether other adults in the household have income.

When the Department does verify the income of applicants and clients, as in the case of wage earners, we found it only uses a single source, usually pay stubs. By not looking for additional resources through the Employment Security Department, Social Security Administration, Internal Revenue Service and Support Enforcement Agency, or other possible sources of income, the Department may not be aware of an applicant's total income. With the exception of the Internal Revenue Service, the Department's system is interfaced with these other sources of information and thus easily accessed by staff.

We provided the Department with a list of 25 active clients of the Basic Health Plus program whose household income was above $75,000. On January 13, 2006, we provided the Department information we obtained from the Medicaid Management Information System, Health Care Authority and Employment Security Department for these clients. We provided the Department with the dates the information was gathered, the period tested and which month we reviewed in their eligibility system. The Department provided no response to any of this information.

We provided the Department a list of 300 instances in which we questioned eligibility. The Department responded on January 9, 2006, with explanations of why they believed a client was eligible. However, the Department did not provide the State Auditor's Office with evidence to substantiate their assertions. On January 23, 2006, the Department provided us with information on 35 of these individuals. We found documentation proving the eligibility of one of these clients, on whose behalf $1,200 was paid.
The Code of Federal Regulations states that a signed application must be on file for all clients eligible for Medicaid. The Department states that, for applications older than 1998, the document has been purged but eligibility reviews are on file. An eligibility review does not replace an application and does not indicate that the client was eligible at the time of application.

The Department stated that changes in income do not affect a child's eligibility due to the Department's policy of continuous eligibility for up to 12 months. The provision for continuous eligibility for children on Medicaid was an amendment to the state supplemental budget that took effect in April 2005. This condition was not applicable for most of the period under audit, which ended June 30, 2005. However, continuous eligibility is contrary to current federal regulations which state:

> The agency must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility. 42 CFR435.916(c)

Additionally, when state laws and regulations conflict with federal regulations, the Revised Code of Washington 43.20A.550 stipulates that state laws are deemed inoperative:

> . . . Any section or provision of law dealing with the department, which may be susceptible to more than one construction, shall be interpreted in favor of the construction most likely to comply with federal laws entitling this state to receive federal funds for the various programs of the department. If any law dealing with the department is ruled to be in conflict with federal requirements, which are a prescribed condition of the allocation of federal funds to the state, or to any departments or agencies thereof, such conflicting part of chapter 18, Laws of 1970 ex.sess is declared to be inoperative solely to the extent of the conflict.

We reaffirm our finding and our recommendation that the Department establish and follow policies and procedures that ensure the eligibility of clients.

Applicable Laws and Regulations

Title 45, Code of Federal Regulations, Section 92.20(a), states:

> A state must expend and account for grant funds in accordance with state laws and procedures for expending and accounting for its own funds.

Revised Code of Washington 43.88.160(4), states:

> . . . the director of financial management, as agent of the governor, shall:
>
> Develop and maintain a system of internal controls and internal audits comprising methods and procedures to be adopted by each Department that will safeguard its assets, check the accuracy and reliability of its accounting data, promote operational efficiency and encourage adherence to prescribed managerial policies for accounting and financial controls.

The state of Washington Office of Financial Management's *State Administrative and Accounting Manual* addresses basic principles of internal control in Section 20.20.20.a. as follows:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

The U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment A, Section C(1)(d), provides that costs are allowable under federal awards if they meet the following criteria:

> Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.

Title 42, Code of Federal Regulations, Section 435.916(b), states in part:

> . . . The agency must have procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility.

As it pertains to requesting information for the determination of eligibility, Title 42, Code of Federal Regulation, Section 435.948, states in part:

> (a) . . . the agency must request information from the sources specified in this paragraph for verifying Medicaid eligibility and the correct amount of medical assistance payments for each applicant (unless obviously ineligible on the face of his or her application) and recipient. The agency must request -
>
> > State wage information maintained by the SWICA (State Wage Information Collection Agency) during the application period and at least on a quarterly basis. Information about net earnings from self-employment, wage and payment of retirement income, maintained by SSA and available under Section 6103(1)(7)(A) of the Internal Revenue Code of 1954 for applicants during the application period and for recipients for whom the information has not previously been requested.
> >
> > Information about benefit and other eligibility related information available from SSA under Titles II and XVI of the Social Security Act for applicants during the application period and for recipients for whom the information has not previously been requested;

Unearned income information from the Internal Revenue Service available under Section 6103(l)(7)(B) of the Internal Revenue Code of 1954, during the application period and at least yearly;

Unemployment compensation information maintained by the agency administering State unemployment compensation laws (under the provisions of section 3304 of the Internal Revenue Code and section 303 of the Act) as follows:

For an applicant, during the application period and at least for each of the three subsequent months;

For a recipient that reports a loss of employment, at the time the recipient reports that loss and for at least each of the three subsequent months.

For an applicant or a recipient who is found to be receiving unemployment compensation benefits, at least for each month until the benefits are reported to be exhausted.

Any additional income, resource or eligibility information relevant to determinations concerning eligibility or correct amount of medical assistance payments available from agencies in the State or other States administering the following programs as provided in the agency's State plan:

AFDC;
Medicaid;
State-administered supplementary payment programs under Section 1616(a) of the Act;

SWICA;
Unemployment compensation;

Food stamps; and Any State program administered under a plan approved under Title I (assistance to the aged), X (aid to the blind), XIV (aid to the permanently and totally disabled), or XVI (aid to the aged, blind, and disabled in Puerto Rico, Guam, and the Virgin Islands) of the Act.

(b) The agency must request information on applicants from the sources listed in paragraph (a)(1) through (a)(5) of this section at the first opportunity provided by these sources following the receipt of the application. If an applicant cannot provide an SSN at application, the agency must request the information at the next available opportunity after receiving the SSN.

(c) The agency must request the information required in paragraph of this section by SSN, using each SSN furnished by the individual or received through verification

(d) Exception: In cases where the individual is institutionalized, the agency needs to obtain and use information from SWICA only during the application period and on a yearly basis, and from unemployment compensation agencies only during the application period . . .

(e) Exception: Alternate sources.

(1) The Secretary may, upon application from a State agency, permit an agency to request and use income information from a source or sources alternative to those listed in paragraph (a) of this section. The agency must demonstrate to the Secretary that the alternative source(s) is as timely, complete and useful for verifying eligibility and benefit amounts. The Secretary will consult with the Secretary of Agriculture and the Secretary of Labor before determining whether an agency may use an alternate source.

(2) The agency must continue to meet the requirements of this section unless the Secretary has approved the request.

(f) Exception: If . . . SSA determines the eligibility of an applicant or recipient, the requirements of this section do not apply to that applicant or recipient.

The March 2003, U.S. Office of Management and Budget A-133 Compliance Supplement, Section E(1)(b)(2), pages 4-93.778-12 and 4-93.778-13, states the following as it pertains to income verifications for eligibility determination:

There are specific requirements that must be followed to ensure that individuals meet the financial and categorical requirements for Medicaid. These include that the state or its designee shall:

(2) Use the income and eligibility verification system (IVES) to verify eligibility using wage information available from such sources as the agencies administering State unemployment compensation laws, Social Security Administration, and the Internal Revenue Service to verify income eligibility and the amount of eligible benefits. With approval from HHS, States may use alternative sources for income information. States may also: (1) target the items of information for each data source that are most likely; to be most productive in identifying and preventing ineligibility and incorrect payments, and a State is not required to use such information to verity the eligibility of all recipients; (2) with reasonable justification, may exclude categories of information when follow-up is not cost effective; and

(3) can exclude unemployment compensation information from the Internal Revenue Service or earning information from Social Security Administration (SSA) that duplicates information received from another source.

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Subpart C, Section .300, states:

The auditee shall:

(b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs . . . .

The 2005 A-133 compliance supplement sets forth the following with respect to eligibility for individuals for the Medicaid program:

a. The State Medicaid agency or its designee is required to determine client eligibility in accordance with eligibility requirements defined in the approved State plan (42 CFR section 431.10).

b. There are specific requirements that must be followed to ensure that individuals meet the financial and categorical requirements for Medicaid. These include that the State or its designee shall:

(1) Require a written application signed under penalty of perjury and include in each applicant's case records facts to support the agency's decision on the application (42 USC 1320b-7(d); 42 CFR sections 435.907 and 435.913).

(2) Use the income and eligibility verification system (IEVS) to verify eligibility using wage information available from such sources as the agencies administering State unemployment compensation laws, Social Security Administration (SSA), and the Internal Revenue Service to verify income

eligibility and the amount of eligible benefits. With approval from HHS, States may use alternative sources for income information. States also: (a) may target the items of information for each data source that are most likely to be most productive in identifying and preventing ineligibility and incorrect payments, and a State is not required to use such information to verify the eligibility of all recipients; (b) with reasonable justification, may exclude categories of information when follow-up is not cost effective; and (c) can exclude unemployment compensation information from the Internal Revenue Service or earnings information from SSA that duplicates information received from another source (42 USC 1320b-7(a); 42 CFR sections 435.948(e) and 435.953).

(3) Require, as a condition of eligibility, that each individual (including children) requesting Medicaid services furnish his or her social security account numbers (SSN) and the

State shall utilize the SSN in the administration of the program. The State shall not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by SSA. If the applicant cannot recall the SSN or has not been issued a SSN, the agency must assist the applicant in completing an application for an SSN and either send the application to SSA or, if there is evidence that the applicant has been previously issued a SSN, request SSA to furnish the number. A State may give a Medicaid identification number to an applicant who, because of well-established religious objections, refuses to obtain a SSN. In redetermining eligibility, if the case record does not contain the required SSN, the agency must require the recipient to furnish the SSN (42 CFR section 435.920(b)) (42 USC 1320b-7(a)(1); 42 CFR sections 435.910 and 920).

(4) Verify each SSN of each applicant and recipient with SSA to insure that each SSN furnished was issued to that individual and to determine whether any others were issued (42 CFR sections 435.910(g) and 42 CFR 435.920).

(5) Document qualified alien status if the applicant or recipient is not a U.S. citizen (42 USC 1320b-7d).

(6) Redetermine the eligibility of Medicaid recipients with respect to circumstances that may change (e.g., income eligibility), at least every 12 months. The agency may consider blindness and disability as continuing until the review physician or review team determines that the recipient's blindness or disability no longer meets the definition contained in the plan. There must be procedures designed to ensure that recipients make timely and accurate reports of any changes in circumstances that may affect their eligibility. The State must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his or her eligibility (42 CFR section 435.916).

c. Qualified aliens, as defined at 8 USC 1641, who entered the United States on or after August 22, 1996, are not eligible for Medicaid for a period of five years, beginning on the date the alien became a qualified alien, unless the alien is exempt from this five-year bar under the terms of 8 USC 1613. State must provide Medicaid to certain qualified aliens in accordance with the terms of 8 USC 1612(b)(2), provided that they meet all other eligibility requirements. States may provide Medicaid to all other otherwise eligible qualified aliens who are not barred from coverage under 8 USC 1613 (the five-year bar). All aliens who otherwise meet the Medicaid eligibility requirements are eligible for treatment of an emergency medical condition under Medicaid, as defined in 8 USC 1611(b)(1)(A), regardless of immigration status or date of entry.

05-11 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not have procedures to determine whether expenditures for anabolic steroids are allowable under the Medicaid program.

Background

Anabolic steroids are synthetic forms of the male hormone testosterone that can be taken orally, injected or rubbed onto the skin. Under federal law, they cannot be sold without a prescription. They are used to treat conditions associated with body wasting such as in acquired immunodeficiency syndrome, low testosterone levels or in other conditions such as delayed puberty. When used in combination with exercise, training and a high protein diet, anabolic steroids can improve endurance and promote increased muscle size and strength. Because of these effects, they sometimes are used illegally as performance-enhancing drugs to improve competitiveness or appearance.

In 1990, Congress passed the Anabolic Steroids Control Act, adding anabolic steroids to the federal schedule of controlled substances. The Act placed anabolic steroids on Schedule III of the Controlled Substance Act and specifically identified 27 anabolic steroids. The Anabolic Steroid Control Act of 2004 added additional anabolic steroids to Schedule III of the Controlled Substance Act.

The Controlled Substance Act places all regulated substances into one of five schedules. Placement is based on the substance's medicinal value, harmfulness and potential for abuse or addiction. Schedule I is reserved for the most dangerous drugs that have no recognized medical use, while Schedule V is the classification used for the least dangerous drugs. The Act also provides a mechanism for substances to be controlled, added to a schedule, removed from control or transferred from one schedule to another.

Somatropin is a Schedule III anabolic steroid. Somatropin is a synthetic version of human growth hormone and found under a variety of brand names: Nutropin AQ, Nutropin, Genotropin, Humatrope, Norditropin, Saizen and Nutropin Depot. Growth hormone is naturally produced by the pituitary gland and is necessary to stimulate growth in children. Synthetic growth hormone may be used in children who have certain conditions that prevent them from growing. Growth hormone also is used in adults to treat pituitary gland disorders and weight loss caused by AIDS.

Description of Condition

For our current audit, we chose to test one anabolic steroid to determine if the Health and Recovery Services Administration had controls to ensure expenditures paid with federal Medicaid funds for Somatropin and its brand name equivalent were consistent with U.S. Food and Drug Administration (FDA)-approved uses. We also attempted to determine if the Administration had controls to prevent or detect expenditures for off-label uses; that is, prescriptions written for a disease, or at a dose or for a patient type that is different from what the FDA has approved.

For the audit period, the Administration's expenditures for Somatropin totaled $3,170,284. Forty-four providers submitted claims for Somatropin or its brand name equivalent on behalf of 275 clients. We selected 19 providers that received the largest reimbursements for claims relating to this drug (43 percent of the provider population). We then selected all clients with billings for Somatropin for each provider. We examined the transactions for 236 clients (86 percent of the population) and $2,937,415 (93 percent of the total expenditures).

For each client, we examined the diagnosis and drug dosage associated with each transaction, as well as the age of the client and the frequency that the expenditure occurred. We compared this data with the indications for use, the recommended dosage for the age and the recommended frequency of administration with FDA-approved information found in the Physician's Desk Reference. We found 6 percent of the expenditures had no diagnosis associated with the transaction or a diagnosis inconsistent with the approved drug use.

We also found large discrepancies in pricing for the same drug at the same dosage and even for the same provider. An example of some of the price variances we found in the Department's records for this drug is indicated below:

Drug Name	Dosage	Low	High
GENOTROPIN	15 UNIT	$ 258.53 per dose	$1,710.02 per dose
GENOTROPIN	36 UNIT	$1,629.50 per dose	$5,397.32 per dose
HUMATROPE	5MG	$ 149.10 per dose	$2,257.87 per dose
HUMATROPE	18 UNIT	$ 55.56 per dose	$1,368.38 per dose
HUMATROPE	36 UNIT	$ 49.60 per dose	$1,731.20 per dose
HUMATROPE	72 UNIT	$2,266.86 per dose	$5,520.89 per dose
NORDITROPIN	15MG	$ 686.65 per dose	$3,170.53 per dose
NUTROPIN	10MG	$ 168.26 per dose	$5,916.51 per dose
NUTROPIN	5MG	$ 459.73 per dose	$1,824.13 per dose
NUTROPIN AQ	10MG/2ML	$ 25.00 per dose	$2,787.05 per dose
SAIZEN	5MG	$ 727.60 per dose	$3,526.56 per dose
SEROSTIM	6MG	$ 52.45 per dose	$6,072.41 per dose
NUTROPIN DEPOT	18MG	$ 103.10 per dose	$1,564.26 per dose
SAIZEN	8.8MG	$1,443.56 per dose	$5,158.32 per dose
SEROSTIM	5MG	$ 47.79 per dose	$5,061.31 per dose

Cause of Condition

The Administration has no controls to determine allowability of expenditures related to anabolic steroids. No safeguards are programmed into its computer systems to determine whether diagnosis, dosage or client age is consistent with FDA-approved uses before the claim is paid.

With respect to the wide discrepancies in pricing found on claims for Somatropin, the Administration reported that pricing was based on pharmaceutical industry pricing and it had no control over these costs.

Effect of Condition

$269,610 of the expenditures tested for Somatropin did not conform to the criteria deemed necessary to be considered allowable expenditures under Medicaid program and thus are questioned costs. $134,805 was paid for with federal funds.

Recommendation

We recommend the Department:

- Develop procedures to ensure that federal funds used to pay expenditures for anabolic steroids are allowable.

- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid federal funds must be reimbursed.

Department's Response

The Department disagrees with this finding. The Health and Recovery Services Administration's Point of Sale (POS) system has hard edits in place on all anabolic steroids, which means that prior authorization is required for all reimbursements on the products. Each request for the drug is reviewed by a team of clinicians before being approved. This has been the case since the drugs came on the market. A summary of the Prior Authorization requirements and clinical review guidelines for the anabolic products is available from the Administration.

The Department was not provided with details on the exceptions in this finding; in fact no discussion occurred on this finding. If specific claim numbers or client identifiers are provided to us, the Department will examine each closely to determine if the Department has a weakness in our system that needs to be corrected or if the Department has a provider that needs to be investigated.

1) *The audit finding indicates that $2,937,415 or 93% of total expenditures for Somatropin were examined and that 6 percent of the expenditures had no diagnosis associated with the transaction or a diagnosis inconsistent with the approved drug use.*

   The Effect of Condition then states that $269,610.00 of the expenditures tested for Somatropin did not conform to necessary criteria. This figure significantly exceeds 6 percent of examined expenditures or total expenditures for the drugs examined. This appears inconsistent and further explanation of the finding may be required.

2) *The audit finding states that large discrepancies were found in pricing for the same drug at the same dosage and for the same provider. However, the numbers in the finding are displayed by drug name only. This suggests that claim reimbursements were looked at without regard to strengths, forms and dosages of the drug. If one rolls up all the expenses for a drug and then attempts to compare prices per claim or dosage units, there is a complete confusion of amounts, strengths, package sizes, doses and units, syringes vs. capsules, creams etc..*

Since our POS system operates using algorithms which pay consistently, the auditor's concern may be the result of this confusion of different product types and packaging quantities. We would welcome the opportunity to review the specific claims at issue.

Auditor's Concluding Remarks

Our records indicate that, in a meeting on December 22, 2005, the results of testing exceptions and summary report were provided to the Chief Administrative Officer. The Department was asked to respond to the exceptions by January 6, 2006. We did not receive a response to our exceptions.

The Effect of Condition in our finding only states the dollar amount of the exceptions and that the expenditures did not conform to the criteria deemed necessary to be considered allowable under the Medicaid program. Our finding is accurate in that 6 percent did represent the transactions that had no diagnosis provided or a diagnosis inconsistent with the indications for drug use. Another 3 percent were not specifically mentioned because these were clients that had no Social Security numbers and this issue was addressed in another portion of our audit. However, in order to be considered eligible for Medicaid, a client must have a valid Social Security number. We are required to report all transactions that are unallowable that we find during our testing even if it is not part of our original scope. The Department did not ask for an explanation of the percentages that they considered discrepancies when the exceptions were presented to them.

The Department is assuming that the test results were evaluated without regard to strength, form and dosage of the drug. This is not accurate. In fact, when we performed our testing, we took into consideration not only the strength, form and dosage but also whether the drug expenditure was for a generic or its brand name counterpart. We also considered frequency of administration, mode of administration and the age of the client in our determination of allowability. We reviewed each client individually as well as the form of Somatropin used. For all the expenditures we tested, the mode of administration was an injection. We did not roll up expenditures as the Department suggests and thus there was no confusion on our part as to results of our analysis and the price variances.

We did not test the Point of Sale (POS) or the prior authorization systems that the Department refers to in its response because these systems were not brought to our attention at any time during our audit. Thus, we cannot report on the consistency that the POS system operates and the reliability of the algorithm.

We reaffirm our finding and our recommendation that the Department develop procedures to ensure that federal funds used to pay expenditures for anabolic steroids are allowable.

Applicable Laws and Regulations

A-133 Compliance Supplement under Part B, Allowable Costs/Cost Principles, states in part:

Compliance Requirements - Allowability of Costs- General Criteria (applicable to both direct and indirect costs)

The general criteria affecting allowability of costs under Federal awards are:

- Reasonable and Necessary - Costs must be reasonable and necessary for the performance and administration of Federal awards.

- Allocable - Costs must be allocable to the Federal awards under the provisions of the cost principles or CASB Standards, as applicable. A cost is allocable to a particular cost objective (e.g., a specific function, program, project, department or the like) if the goods or services involved are charged or assigned to such cost objective in accordance with relative benefits received.

Internal Control

Consistent with the requirements of OMB Circular A-133, this Part includes generic audit objectives and suggested audit procedures to test internal control. However, the auditor must determine the specific procedures to test internal control on a case-by-case basis considering factors such as the non-Federal entity's internal control, the compliance requirements, the audit objectives for compliance, the auditor's assessment of control risk, and the audit requirement to test internal control as prescribed in OMB Circular A-133.

Improper Payments

Under OMB budgetary guidance and Pub. L. 107-300, Federal agencies are required to review Federal awards and, as applicable, provide an estimate of improper payments. Improper payments mean:

1. Any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements, and includes any payment to an ineligible recipient; and

2. Any payment for an ineligible service, any duplicate payment, any payment for services not received, and any payment that does not account for credit for applicable discounts.

Auditors should be alert to improper payments, particularly when testing A, "Activities Allowed or Unallowed;" B, "Allowable Costs/Cost Principles;" E, "Eligibility;" and, in some cases N, "Special Tests and Provisions."

05-12 The Department of Social and Health Services is not adequately reviewing pharmaceutical claims to identify patterns of fraud and abuse.

Background

Federal regulations require that states perform a retrospective drug use review in order to identify patterns of fraud, abuse, gross overuse and inappropriate or medically unnecessary care among physicians, pharmacists and Medicaid recipients. Among other things, this examination must involve analysis of physician prescribing practices, drug use by individual patients and dispensing practices of pharmacies. This review must be accomplished through the Medicaid Management Information System (MMIS) through analysis of predetermined standards.

A primary purpose of this requirement is to prevent payment for falsified pharmaceutical claims. In an effort to comply, the Department has set up a series of ten mandatory fields that must be completed on the claim by the provider. These fields are as follows:

1. Patient identification
2. Pharmacy number
3. Sale date
4. Date prescription was written
5. Quantity
6. Number of days supply
7. Amount charged
8. Prescription number
9. Drug name
10. Prescriber number

When claims are processed in the Department's computer system, the information contained in these fields is compared to predetermined standards. If the information is validated, the claim is processed and the provider is paid.

Description of Condition

During our audit, we found that the Department could not validate one of the required fields in its control system. The field requiring a prescriber number must be completed with the identification number of the practitioner prescribing the medication. The Department stated that this is to prevent payment for claims submitted for prescriptions by providers who are not authorized to write them. We found that, since February 2002, the Department has allowed two options for the prescriber number field.

- A pharmacy may use the Medicaid provider number assigned to a prescriber by the Health and Recovery Services Administration (formerly Medical Assistance Administration). This option can only be used if the prescriber has applied for this provider number. While many practitioners are Medicaid providers, this information would have to be known to the pharmacy filling the prescription. Our audit found this option was not often used by pharmacies when completing claims.

- A pharmacy may apply to use the prescriber's Drug Enforcement Authority (DEA) number. Although not illegal, DEA strongly discourages the use of this number for any purpose other than certifying that a practitioner is registered to prescribe certain controlled substances. We found, however, that a DEA number is most often used to complete this field.

While the Department is able to verify the Administration's provider numbers by checking them against their master file, it does not verify the validity of the DEA numbers. For our audit, we wanted to determine the effects of this control weakness. We examined 13 pharmacies with a total of $64,378,393 in expenditures. Although we found results varied greatly between pharmacies, we found claims with errors in the prescriber number field were processed and paid. We found claims with the following errors:

- Invalid DEA numbers: $2,231,626

- No DEA number in the required field $38,370
- Expired DEA numbers $82,693
- Veterinarians DEA numbers $561
- Out of State DEA numbers $163,435

This last category represents providers who were registered in DEA's files as being practitioners in other states with some as far away as Maryland and Florida. When we were able, we contacted the practitioner and found most had never practiced in Washington or even knew the client for whom the prescription was written. Some of the providers were not licensed and/or known in their state's registries.

The Department has reported that several DEA numbers have been programmed into its system as not being valid. However, we have no evidence that this action halts a payment to a claim.

Cause of Condition

- The Department stated that the payments are being made to the pharmacy and so the authenticity prescriber is not relevant to the claim.

- The Department does not have controls in place to prevent pharmacy providers from submitting claims with invalid, expired or retired DEA numbers or to detect providers that are using invalid, expired or retired DEA numbers in their claims submission.

- The Department is not conducting a retrospective drug use review of claims data or other records to identify possible fraud and abuse by pharmacy providers who use DEA numbers in the prescriber number field.

Effect of Condition

The federally required review of claims data and other records to ensure the validity of pharmaceutical claims is not being performed. If the prescribing provider number is not verified to be present and valid, controls over pharmaceutical claims are weakened and cannot prevent or deter the unauthorized use of prescription medications. From January 1, 2004 through December 31, 2004, the state made payments of $2,516,685 to 13 providers that either did not enter a number in the required field or entered DEA numbers that were invalid, expired or for out of state providers. We consider these questioned costs. Of this amount, $1,258,343 (50 percent) was paid with federal funds. The other 50 percent was paid with state funds.

Recommendation

We recommend the Department:

- Validate all information required to be submitted on pharmaceutical claims.

- Perform retrospective drug use review of the prescriber number field to identify possible fraud and abuse by pharmacy providers.

- Work with the U.S. Department of Health and Human Services to determine if any costs paid for with federal Medicaid funds must be reimbursed as a result of this noncompliance.

Department's Response

The Department concurs that the Pharmacy Point of Sale (POS) System has been lacking in sufficient controls to check the validity of DEA numbers included with pharmacy claim submissions. Due to system limitations, the

Department has relied on a manual process for managing DEA number exceptions, manually blocking those numbers that have been identified as invalid.

The statement that the authenticity of the prescriber is not relevant to the claim is not an official Department position. The Department has been working diligently over the last year to resolve issues related to the inability to automate the validation of the DEA number at the time of claims adjudication. The following actions have been taken:

1. *Due to system limitations, the Department implemented a manual process for managing identified DEA number exceptions, manually blocking those numbers that have been identified as invalid. The list of invalid DEA numbers manually entered into POS numbers approximately 60 to date.*

2. *Post payment review of invalid DEA numbers has been added to the regular Department Payment Review Program (PRP) algorithm process. PRP ran an algorithm that uses the federal DEA database to identify invalid DEA numbers and has issued overpayment totaling $769,000 to 219 pharmacies state-wide. A current algorithm has identified an additional $20,101 in overpayments, which will be sent out in February 2006.*

3. *The POS vendor has loaded DEA numbers from the national DEA database and the Department has completed a change service request that will utilize this data to validate against the full DEA national database <u>at the time of adjudication</u>. The Department expects to implement this into the POS by April 2006, thus eliminating the need for the Department to rely on a manual process.*

The Department disagrees with the statement that it is not conducting a retrospective drugs use review of claims data. The Department has a rigorous and extensive Drug Use Review Program and is in full compliance with Sec. 456.709. The Department conducts retrospective review of pharmacy claims and has direct contact with prescribers regarding approximately 1,000 Medicaid clients each month. In addition, Washington Medicaid sends out two clinical pharmacists each month to visit face-to-face with at least 120 prescribers. The clinical pharmacists have lists of clients seen by each of the 120 prescribers and the purpose of the visit is to verify that the prescriber did write the prescription and to try to modify any undesirable prescribing behavior that has been targeted in that month's review. A summary of Drug Utilization Reviews conducted by Washington Medicaid for Federal Fiscal Year 2005 is available from the Department of Social and Health Services.

Auditor's Concluding Remarks

We have carefully reviewed the Department's response and reaffirm our finding. The retrospective drug use review program must be accomplished through analysis of information submitted through the Medicaid Management Information System. Information in required fields on claim forms must be validated in order for claims to be authenticated and processed for payment. The Department was not able to validate information in a required control field for pharmaceutical claims payment. Additionally, staff was unaware of the importance of validating this information.
The Department did not bring the summary of its Drug Utilization Reviews for fiscal year 2005 to our attention until it submitted this response. We did not independently review this information because it was submitted to us after our field work was complete.

We will assess the corrective actions reported by the Department during our next audit.

Applicable Laws and Regulations

Sec. 456.709, Retrospective drug use review, states:

> (a) General. The State plan must provide for a retrospective DUR program for ongoing periodic examination (no less frequently than quarterly) of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs. This examination must involve pattern analysis, using predetermined standards,

of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies. This program must be provided through the State's mechanized drug claims processing and information retrieval systems approved by CMS (that is, the Medicaid Management Information System (MMIS)) or an electronic drug claims processing system that is integrated with MMIS. States that do not have MMIS systems may use existing systems provided that the results of the examination of drug claims as described in this section are integrated within their existing system.

(b) Use of predetermined standards. Retrospective DUR includes, but is not limited to, using predetermined standards to monitor for the following:

(1) Therapeutic appropriateness, that is, drug prescribing and dispensing that is in conformity with the predetermined standards.

(2) Overutilization and underutilization, as defined in Sec. 456.702.

(3) Appropriate use of generic products, that is, use of such products in conformity with State product selection laws.

(4) Therapeutic duplication as described in Sec. 456.705(b) (1).

(5) Drug-disease contraindication as described in Sec. 456.705(b) (2).

(6) Drug-drug interaction as described in Sec. 456.705(b) (3).

(7) Incorrect drug dosage as described in Sec. 456.705(b) (4).

(8) Incorrect duration of drug treatment as described in Sec. 456.705(b) (5).

(9) Clinical abuse or misuse as described in Sec. 456.705(b) (7).

05-13 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), is not in compliance with the federal Medicaid requirements for reporting adult victims of residential abuse to the Medicaid Fraud Control Unit.

Background

As a condition for receiving Medicaid funds, a state must establish and operate a State Medicaid Fraud Control Unit. The Fraud Unit must be separate and distinct from the agency administering Medicaid. In Washington, Medicaid is administered by the Department of Social and Health Services, while the Medicaid Fraud Control Unit is administered by the Office of the State Attorney General.

The purpose of the Fraud Unit is to investigate and prosecute Medicaid fraud. Federal regulations also require the Fraud Unit to review allegations of patient abuse in health care facilities that receive Medicaid payments. Residential abuse includes neglect and financial exploitation of those in residential care.

The Attorney General's Office and the Department have an agreement requiring the Department to notify the Fraud Unit of all allegations of residential abuse. The agreement stipulates that the Department's Aging and Disability Services Administration shall immediately report such allegations to the Fraud Unit. To accomplish this, other administrations within the Department must report allegations of residential abuse within their administrations to Aging and Disability Services in a timely manner.

Description of Condition

During our audit in 2004, we found two divisions within the Health and Rehabilitative Services Administration (then known as Medical Assistance Administration) were not complying with the residential abuse reporting requirements. The Division of Alcohol and Substance Abuse and the Mental Health Division's Western State and Eastern State Hospitals were not reporting allegations of residential abuse of vulnerable adults in their care to either Aging and Disability Services or the Medicaid Fraud Control Unit. The Mental Health Division and the Division of Alcohol and Substance Abuse had procedures to investigate residential abuse, but the employees who oversaw those activities were not independent of the division receiving Medicaid funds as required by law.

In our audit of 2005, we found that Eastern and Western State Hospitals, the Mental Health Division Headquarters and the Department of Alcohol and Substance Abuse now include a procedure in their policies to report allegations of abuse and neglect to the Fraud Unit. In most cases, however, the procedures were not in effect during the audit period.

We expanded our review to Aging and Disability Services Administration's Intermediate Care Facilities for the Developmentally Disabled. Here we found that substantiated cases of abuse and neglect of vulnerable adults were not being reported to the Fraud Unit. Federal law requires the Department to conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation for any complaint of fraud or abuse that it receives. If the findings of the preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must refer the case to the State Medicaid Fraud Control Unit. The Fraud Unit will then review these complaints and determine a course of action. Options include further investigation of the complaint, referring the complaint to outside law enforcement authorities or referring the complaint to an appropriate state agency if the potential for criminal prosecution is low.

We reviewed files for 58 cases of alleged abuse and neglect reported to the Department's Complaint Resolution Unit. Of these, one resulted in a written citation by the Department and nine others were referred to law enforcement agencies for further investigation. Only one was referred to the Medicaid Fraud Control Unit.

We also attempted to determine if the Department had taken appropriate action on cases referred to it by the Medicaid Fraud Control Unit. In 2004, the State Auditor's Office received a citizen's complaint alleging that two individuals with disqualifying convictions were employed in facilities where they had unsupervised access to children and vulnerable adults. One individual allegedly had a military conviction for having carnal knowledge of a child and the other was reportedly a convicted murderer and rapist. These cases were referred to the Medicaid Fraud

Control Unit by the State Auditor's Office. When we contacted the Fraud Unit this year to determine the outcome of these cases, we found they had been referred to the Department for background checks. We contacted the Department's Background Criminal Check Unit to determine whether these cases were investigated. We found evidence that background checks on these individuals had been performed by either the Fraud Unit or the Department. However, we found that the checks were incomplete in that only the state database was checked. Military convictions and convictions in other states would not be revealed by checking only state records. We also found that both individuals remain employed in positions where they have access to vulnerable adults and children. Although the contractor indicated that these individuals were working with vulnerable children and adults, we were unable to determine if the access is unsupervised.

Cause of Condition

- Eastern and Western State Hospitals and the Department of Alcohol and Substance Abuse did not have procedures in place during the audit period requiring them to refer allegations of abuse and neglect to the Medicaid Fraud Control Unit.

- Aging and Disability Services Administration does not consistently follow policies and procedures requiring them to refer allegations of abuse and neglect to the Medicaid Fraud Control Unit.

- The Department does not have procedures to ensure that adequate background checks are performed.

Effect of Condition

The Department is not in compliance with federal requirements. Because the Medicaid Fraud Control Unit is not aware of all allegations of residential abuse of Medicaid patients, it is unable to perform its required investigatory role in all cases.

The Department, in not performing background checks on cases reported to it, potentially exposes vulnerable adults to long-term exploitation, abuse and neglect.

These conditions could pose a financial liability to the state. Additionally, the Department’s noncompliance with federal reporting requirements could jeopardize future federal funding.

Recommendation

We recommend the Department:

- Ensure all administrations, serving vulnerable adults in residential care facilities receiving Medicaid funds, have policies and procedures for investigating and reporting allegations of abuse and neglect of its clients.

- Ensure policies reflect the reporting process stipulated in the agreement with the Attorney General’s Office and required by federal law.

- Monitor administrations to ensure procedures are being followed.

- Establish and follow policies requiring Department staff to follow up on cases referred to them by the Medicaid Fraud Control Unit.

Department's Response

The Division of Alcohol and Substance Abuse, 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 law. In conjunction with this response copies of those policies have been provided to the State Auditor's Office. The MHD Compliance Officer currently review 100% of incident and daily reports submitted to the division from the hospitals. These divisions are now in compliance with federal requirements therefore eliminating any liability to the state.

The Department is currently updating the Memorandum of Understanding in conjunction with the Medicaid Fraud Control Unit.

Aging and Disability Services Administration (ADSA) has policies and procedures in place for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) to report all alleged or suspected abuse, neglect, exploitation, financial exploitation, or abandonment to Residential Care Services (RCS). These abuse and neglect reporting policies are consistent with mandatory reporting laws RCW 74.34 and RCW 26.44 and apply to all ICF/MRs. RCS, in turn, has a long-standing Memorandum of Understanding (MOU) with the Medicaid Fraud Unit (MFCU). In compliance with the terms of the MOU, RCS refers all complaint intake allegations to MFCU where it appears that criminal activity has occurred in a Medicaid certified long-term care facility, including ICF/MRs. This referral is made at the time of intake, and prior to RCS investigative activities. If, during the course of any RCS complaint investigation activity a named perpetrator is identified, the name is referred to MFCU through the Complaint Resolution Unit.

The Division of Alcohol and Substance Abuse (DASA) did follow up on the one individual identified as having a criminal history by the Office of the Attorney General's Medicaid Fraud Control Unit. The division determined the individual, an employee of a DASA contractor, could not have unsupervised access to youth because of their criminal history. DASA met with their contractor and the employee was terminated from the position. On receipt of this finding the department reconfirmed with the contractor that the individual is not employed in a position funded through DASA. The department is not in a position to direct contractor's employment decisions for areas of operation and service delivery funded by non-DSHS entities. It remains unclear as to whether or not a fingerprint-based national background check of FBI records would have identified military convictions. The department will explore the military's practice of recording and tracking military convictions to determine the feasibility of incorporating a review of those convictions in the department's background check process. The department will also identify this as an area of concern for review by the legislatively authorized Background Check Task Force.

Auditor's Concluding Remarks

The Department has provided us with representations regarding reporting procedures with its response that were not available to us during our audit. Thus, we have no opinion on these or the Department's compliance with federal regulations. We will review this area in a future audit.

After we completed our audit, the Department provided to us additional information regarding the two individuals identified as having criminal histories. The Department provided us with no supporting documentation. However, we opened this area up to additional testing and we found that both individuals were still employed with the contractor during the period that we tested. Additionally, the contractor is a Medicaid provider. Thus, the Department has the ability to require, in its Core Provider Agreement, compliance with state law regarding background checks.

We reaffirm our finding and recommendations.

Applicable Laws and Regulations

Title 42 of the Code of Federal Regulations, Section 1007.11, stipulates the residential abuse responsibilities of the Fraud Unit, stating in part:

> The unit will also review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan and may review complaints of the misappropriation of patient's private funds in such facilities.

Section IV of the Memorandum of Understanding between the Department and the Attorney General's Office, Medicaid Fraud Control Unit (MFCU), executed in March 2000, states in part:

> The Department operating through AASA (Auditor's note: now Aging and Disability Services Administration) immediately shall make available to the MFCU allegations of resident abuse, neglect, and financial exploitation in residential care facilities receiving Medicaid funds.

05-14 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not perform adequate reviews of providers of durable medical equipment to ensure the providers exist, are properly licensed and have submitted accurate information.

Background

Durable medical equipment is that which can withstand repeated use, primarily serves a medical purpose for a person with an injury or illness and is appropriate for use in the home. Examples include hospital beds, wheelchairs and oxygen delivery systems**.**

Providers of this equipment must be approved by the Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration). Providers submit documentation to the Administration to verify they are able to supply certain products. Required documents include business licenses and completed agreements between the Administration and providers. The Administration is responsible for reviewing the information prior to establishing a provider number for an individual or organization. This number, when accompanied by a claim, causes the Administration's system to generate an approval and payment to the provider.

During our audit in 2004, we attempted to determine whether reviews performed by the Administration were adequate to ensure the provider actually was in business prior to assigning a provider number. We found the Administration did not:

- Verify the provider's business phone number and address.
- Verify the validity and status of the business license.
- Provide criteria for the circumstances that constitute a valid business license for in- and out-of-state providers.
- Program its Medicaid Management Information System to notify staff members when business licenses expire. Currently, this function is operative for professional licenses only.

In that audit, we reviewed the records for 80 providers and conducted site visits for 25 providers in Washington and the border states of Idaho and Oregon. For 23 of the latter, we could find no evidence of an actual business or the information we found concerning the business was inconsistent with the Department's records. Specifically:

- Five businesses had ceased operations but the Administration had not terminated their provider numbers.
- Two businesses could not be located.
- Two businesses appeared to be private residences. It was difficult to determine if business was conducted on those premises.
- Three businesses had changed ownership without reporting the changes to the Administration as required by the Core Provider Agreement.
- Three businesses were listed as inactive on the Department of Licensing or Department of Revenue's Web sites. These businesses did have active city licenses.
- Six businesses had changed address and/or phone numbers but had not reported the changes to the Administration.
- Two providers had expired business licenses.

Description of Condition

During our audit this year, we found no new procedures had been implemented to address the internal control weaknesses we identified during audit year 2004. While the Department has increased staff in provider enrollment, new documentation and review procedures were not put in place until after July 1, 2005. We reviewed the proposed policies and procedures and found:

- Business location will be verified by means of a reverse directory check. However, without on-site visits, the Department cannot be sure a business is actually in operation.

- The Administration has not specified what type of business license will be required for verification. According to the Administrator for Master Business Licensing, Department of Licensing, obtaining a city or county license does not necessarily mean that the business is properly licensed within the state.

- The Administration has no policy instructing staff to contact providers regarding their status if no activity has occurred in a number of years.

The Administration was in the process of following up on the questionable providers we identified in our previous audit. Its review resulted in the termination of eight providers and requests for additional information on eight more. No work was performed to program the Administration's computer system to identify expired licenses. The Department does not plan to make changes to its computer system; it plans to purchase a new system in June 2007.

The Department reported it had established new controls that would include "drive-by" reviews for its 412 providers of durable medical equipment. It reported conducting 48 reviews thus far. We will review this during our next audit as it came to our attention after our work was complete.

Cause of Condition

The Department believes its policies are sufficient to ensure adequate provider verification.

Effect of Condition

These weaknesses could allow providers to submit fraudulent requests for payment that would not be detected in a timely manner, if at all. Because of the costs involved with durable medical equipment, such payments could result in significant losses in a relatively short period of time.

Recommendation

We recommend the Administration:

- Follow the new policies and procedures and ensure adequate verification of provider information is performed.

- Monitor providers for compliance with Core Provider Agreements.

- Provide criteria for the circumstances that constitute a valid business license for in- and out-of-state providers.

- Program the Medicaid Management Information System to identify expired business licenses.

- Review all remaining providers to ensure they have met all licensing and certification requirements.

Department's Response

The Department partially agrees with this finding, given that many of the improvements that have occurred were not in place during the entire year being audited.

The Health and Recovery Services Administration (HRSA) audit staff conducts on-site reviews of Durable Medical Equipment (DME) providers that are referred for audit. These audits are designed to:

- *Determine if services billed and paid were provided;*
- *Identify provider billing and payment irregularities;*
- *Provide a systematic and uniform method for determining compliance with federal and state regulations;*
- *Provide a mechanism for data gathering to assist in establishing or modifying program policies and procedures.*

In addition HRSA audit staff maintains a database of all DME providers that they use to schedule "drive-by" reviews to verify the physical location of the DME provider. Prior to traveling to an audit engagement, the auditor reviews the database to determine if there are any DME's within an approximate radius to the audit location. For those DME's within an approximate radius, a drive-by is performed and the auditors update the database with their observations. During FY06, HRSA will extend access to the database to the Division of Fraud Investigations so their investigators can perform drive-by reviews.

The auditor recommended the Department provide criteria for the circumstances that constitute a valid business license for in- and out-of-state providers. Provider Enrollment (PE) now validates all business licenses by either getting a current copy of the license, or going on-line to view the current information in the state the vendor is registered. It should be noted that each state has different requirements for business licenses. For example, some states do not require a DME business license. In these cases the Department issues a provider number once this fact is verified.

The auditor recommended the Department review all remaining DME providers to ensure they have met all licensing and certification requirements. A project was assigned to check all DME provider files, list what documents are still needed, and contact the providers to obtain those documents. This project was started in October 2005 and the projected completion date is May 1, 2006.

Auditor's Concluding Remarks

Except for the corrective action referred to in the finding, we were not made aware of any other improvements to the control structure. We appreciate the steps the Department is taking to resolve this issue. We will review the condition in our next audit.

Applicable Laws and Regulations

The U.S. Office of Management and Budget Circular A-133 Compliance Supplement states:

> In order to receive Medicaid payments, providers of medical services furnishing services must be licensed in accordance with Federal, State, and local laws and regulations to participate in the Medicaid program . . . and the providers must make certain disclosures to the State . . . .

Circular A-133, Audits of States, Local Governments and Non-Profit Organizations, Subpart C, Section .300, states:

> The auditee shall:
>
> > (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulation, and the provision of contracts or grant agreements that could have a material effect on each of its Federal programs . . . .

Section 20.20.20.a of the *State Administrative and Accounting Manual* states in part:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

The Core Provider Agreement, paragraph 4 c., states in part:

> . . . the Provider agrees to notify the Department of any material and/or substantial changes in information contained on the enrollment application given to the Department by the Provider. This notification must be in writing within thirty (30) days of the event triggering the reporting obligation. Material and/ or substantial changes include, but are not limited to changes in:
>
> a. Ownership
> b. Licensure
> e. Any change in address or telephone number

WAC 388-502-0010 states in part:

> The Department reimburses enrolled providers for covered medical services, equipment and supplies they provide to eligible clients.
>
> (1) To be eligible for enrollment, a provider must:
>
> (a) Be licensed, certified, accredited or registered according to Washington state laws and rules . . . .

05-15 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), has not established sufficient internal controls to prevent Medicaid payments for services provided after a client's death or to prevent payments for services provided to individuals using the Social Security number of a deceased person.

Background

During our 2002 audit, we analyzed the validity of Medicaid clients' Social Security numbers as well as claims that could have been paid after a person had died. During that audit, we sampled 639 Medicaid recipients and found issues related to the validity of the client's Social Security number in 50 percent of the files we reviewed. We found invalid Social Security numbers, Medicaid payments for services rendered after individuals had died and clients who were using a Social Security number assigned to a deceased person. Factors contributing to these conditions included Department staff not heeding or investigating alerts sent by the Social Security Administration, the Department's reliance on family members to voluntarily inform it of a client's death and computer errors that occurred when client data was transmitted between the Department's client eligibility system and the Medicaid Management Information System.

During our 2003 audit, we attempted to determine if the Department had established controls ensuring that only claimants with valid Social Security numbers were enrolled in the program and that people who were deceased were promptly removed from Medicaid eligibility. We found the Department did not have effective procedures that would enable all Community Service Offices to be notified of a client's death in a consistent and timely manner. Additionally, the Department and the Department of Health did not communicate regarding client deaths. We also found internal controls to ensure the validity of Social Security numbers were inconsistent from one Community Service Office to another.

Also during that audit, the Department did not provide us with reliable records in a timely manner. As a result we were unable to determine which unallowable payments were due to inadequate controls. We issued a report stating we could not determine whether payments were valid, and we questioned over $288 million in costs.

For fiscal year 2004, we again attempted to evaluate internal controls and compliance with federal regulations. However, we encountered several difficulties with obtaining access to information for the audit, as follows:

- The U.S. Social Security Administration would not permit us independent access to the State Online Query (SOLQ), which is a system that can verify Social Security numbers. This forced us to depend on the Department, which did have access, to perform all of our Social Security number verifications. As a result, the Department was aware of the transactions under review. When errors were found, the Department made alterations to the sample data in its computer systems that prevented us from completing our tests as planned. This action invalidated our sample and prohibited us from assessing compliance and reaching a conclusion. We were unable to determine if data originally given to us was faulty or if the current data was faulty.

- In some cases, SOLQ data provided a date of death, but the Administration stated the client was still alive because the Health Department had no death certificate. We were unable to obtain independent access to death certificate information to confirm this statement.

From the tests we were able to perform, we attempted to determine if amounts paid through the Medicaid Management Information System were for services provided after a client's death or services provided to persons using the Social Security number of a deceased person. From a total of 2,632 clients for whom these types of payments appeared to have been made, we obtained a valid sample of 188 clients. We found 158 instances (84 percent of the sample tested) in which a deceased relative's Social Security number was used, apparent identity theft of a deceased person's Social Security number, potential identity theft of a living person's name and Social Security number and potential provider fraud.

The total estimate of actual and projected costs for all of these services combined was $4,670,432. However, had we been able to obtain the information we needed independently, actual and projected costs may have been higher.

Description of Condition

During our audit for fiscal year 2005, we again analyzed the validity of Medicaid clients' Social Security numbers as well as claims that could have been paid after a person had died. From the 2,741 clients for whom these types of payments appeared to have been made, we obtained a valid sample of 267 clients. The total dollars of reimbursed claims amounted to $4,638,186. Of that amount, we reviewed $3,221,115. We were able to obtain information about the services we selected. From the review we performed, we found 220 (82.4 percent) resulted in questioned costs as follows:

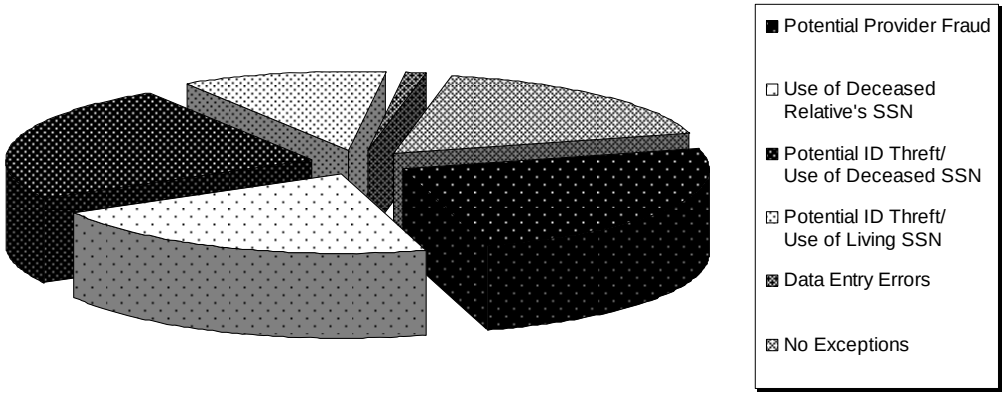
- Potential provider fraud: 66 exceptions (24.7 percent) with actual and estimated projected costs of $315,585.

- Use of deceased relative's Social Security number: 57 instances (21.3 percent) with estimated actual and projected costs of $1,534,126.

- Potential identity theft of a deceased, unrelated person's Social Security number: 65 instances (24.3 percent) with estimated projected costs of $1,254,981. We noted a high risk that the $716,044 of actual identified costs is the result of fraudulent transactions.

- Data entry error by Department: 29 instances (10.9 percent) with estimated actual and projected costs of $577,638.

- Potential identity theft of a living person's name and/or Social Security number: three instances (1.1 percent) with actual and estimated projected costs of $65,447.86.



The testing was performed with the information that was available to us. As in prior years, we had difficulty in obtaining independent access to information for this audit. For instance, the Social Security Administration would not permit our independent access to SOLQ. Because of this condition, we were dependent on the Department of Social and Health Services to perform Social Security number verifications. As a result, the Department had access to our sample selection and all clients that were being tested. However, for the current year, we were able to obtain independent access to death certificate information from the Health Department through the Department of Social and Health Services' systems. This greatly improved audit efficiency.

Our control testing revealed problems seen during previous audits with little or no change in the controls:

- Social Security numbers are not consistently verified prior to admitting clients into the Medicaid program.

- Staff did not heed alerts sent by the Social Security Administration notifying them of potential problems with Social Security numbers entered for processing.

- The Department has no consistent procedures for Community Service Offices to use to determine the deaths of their clients. We saw no evidence of any consistent communications with the Health Department to provide notification of clients' deaths in a timely manner.

- Staff members are able to delete alerts without management's approval and/or knowledge.

- The Department could not provide evidence that the known problems with transfer of some data between Departmental data systems have been corrected.

Cause of Condition

- Department staff at Community Service Offices does not consistently use the system capability to verify the validity of a Social Security number through SOLQ at the time of application.

- While some Community Service Offices have procedures to address alerts informing them of invalid Social Security numbers, the volume of alerts coming in daily precludes correction in a timely manner. The number of alerts would substantially decrease for invalid Social Security numbers if staff would verify them at the time of application.

- The Administration is largely dependent on the provider or family members to report a current client's death.

- No monitoring by supervisory staff to determine whether alerts have been worked.

- Steps had not been taken to ensure staff members understand the new state law (RCW 9.35.020), which took effect July 1, 2004, and which defines identity theft in the first-degree as the use of false identification to obtain anything of value in an aggregate of $1,500.

- The Department reports that it will address data transfer problems between systems when the new computer arrives in June 2007.

Effect of Condition

Failing to verify Social Security numbers can lead to the enrollment of individuals ineligible for Medicaid. Such practices may cause the Department to violate federal regulations and state law.

The Medicaid program is unnecessarily susceptible to loss or misappropriation because of the Department's inability to identify deceased clients in a timely manner. This is caused by unresolved control weaknesses. Most of these issues have yet to be addressed.

Costs for medical services made on behalf of clients without valid Social Security numbers are not eligible for federal matching funds.

The actual and projected questioned costs related to medical services for deceased persons or persons using the Social Security numbers of persons, both living and deceased, totaled $3,746,383. One-half, or $1,873,192, was matched by federal funds.

Recommendation

We recommend the Department develop and follow procedures that:

- Require staff to verify Social Security numbers for all Medicaid clients at initial application through the use of SOLQ.

- Require staff to heed alerts sent by the Social Security Administration.

- Make it impossible for staff to delete alerts without management's approval and/or knowledge.

- Resolve the computer interface issues.

- Establish procedures with the Department of Health that will provide notification of clients' deaths in a timely manner.

- Ensure staff members understand the new state law regarding identity theft.

- Work with the U.S. Department of Health and Human Services to determine if any unallowable costs must be reimbursed.

In addition, we recommend the Administration forward instances of apparent identity theft and provider fraud to its own Post-Payment Review Office or to the appropriate legal authorities.

Department's Response

The Department concurs with the State Auditor's Office (SAO) recommendations that focus on the improvement of the verification of social security numbers (SSN) at the time of initial application. The Department's Corrective Action Plan for Audit Finding 04-02 included a number of corrective steps that are currently in progress.

- *A review of the automated SSN verification at the time of Automated Client Eligibility System (ACES) entry was completed on February 4, 2005. In addition, the Department has enhanced procedures, including modification of the interface with the federal database to update nightly, with income and Medicare eligibility updated daily.*

- *The most significant solution for ensuring correct SSNs is the modification to SOLQ. The promotion of this change in (ACES) is expected by April 2006. The SOLQ user interface is being modified to accommodate user's ability to multiple queries without exiting the system.*
- *Staff are currently required to act on SSN discrepancy Alerts sent by the Social Security Administration (SSA). The Department will continue to provide instruction and written guidance to staff regarding the manner in which Alerts are handled.*
- *Management approval for Alert deletion would require extensive system and staffing modifications. Training and upfront SSN verification with SOLQ should assist with the reduction of SSN discrepancy Alerts.*
- *The Department has initiated a cross-administration SSN Quality Improvement Workgroup and will continue to focus attention on increasing the accuracy of SSNs in ACES and the Medicaid Management Information System (MMIS).*

The Department recognizes that ACES/MMIS Interface problems exist and continues to assess, prioritize and resolve interface issues as they are identified. However, the Department is not aware of any "known problems with the transfer of some data between Departmental data systems" that has not been corrected and disagrees with that specific condition. 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 continues to be a stakeholder in a Department of Health (DOH) initiative that will provide on-line access to DOH death data. Although currently being piloted in two counties; statewide implementation is not anticipated for several years. This application will allow a real-time transfer of data from DOH to the Department of Social and Health Services. However, 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 Department partially concurs with the questioned costs as presented. Detailed analysis of the clients reviewed by the SAO resulted in the following:

- *The Department concurs with the audit finding for some clients where it was verified that the SSN in the DOH Death Certificate Data did belong to the MMIS recipients and the recipients were deceased prior to the date of service on the paid claim. Department analysis verified nine Healthy Options Managed Care clients where the clients' date of death had not been identified prior to premium generation, 13 recipients for whom the Department paid third party insurance premiums after the date of death, and 21 instances where pharmacy and/or durable medical equipment claims were paid after the client's date of death. Upon verification of the date of death, recoupments for these claims were initiated and the following correction actions were taken.*

  - *Effective November 21, 2005, a change was implemented within MMIS that populates the end of eligibility date in the Point of Sale (POS) System with the Date of Death from the MMIS. This results in the immediate denial of claims in the POS when providers submit claims for recipients past the eligibility/death date;*

  - *Analysis identified a gap in the Payment Review Program's Services After Death algorithm logic. This logic has been revised to expand the Department's capability to identify and recover overpayments in the post-payment review process.*

- *The Department disagrees with six clients where the SAO pro-rated the total amount of a claim based on the condition that the end date was after the client's date of death. On some claims, a monthly billing cycle is reflected in the end date on a claim and the Unit field correctly reflected the client's date of death.*

- *The Department disagrees with ten clients where the SSA's SOLQ System and DOH vital statistics data were not in agreement. The Department considers the Washington State DOH Death Certificate to be the authoritative source of death information.*

Analysis of the remainder of the sample showed 162 instances where the first and last name of the client records did not match the records of the deceased individual. In those cases, the Department verified that the client was not deceased. Rather, the SSN on the MMIS eligibility record and used by the SAO for the identification of deceased individuals was in error and belongs to the deceased spouse or parent of the recipient. Individuals (generally a spouse or disabled child) may receive SSA benefits based on a relative's SSA benefits and may appropriately use that SSN when applying for Medicaid benefits. The Department agrees that the SSN in the MMIS should be the client's SSN rather than the relative and has initiated corrective action to ensure that the client's SSN is correctly captured in ACES and transferred to the MMIS.

The Centers for Medicare and Medicaid (CMS) has recently completed a review of Pharmacy Claims Issue 03-10 which was the referral of the 2004 SAO Audit related to Date of Death. The Department agreed with CMS to take the corrective actions noted above to ensure that the recipient's SSN is correct in the MMIS.

Auditor's Concluding Remarks

We appreciate the steps the Department is taking to focus on some improvements. During our next audit, we will review the Department's progress in these areas.

We continue to have concerns regarding the data interface issues between MMIS and ACES as well as the Department's controls regarding identifying its deceased clients in a timely and consistent manner.

With respect to the latter, the Department of Health has initiated an Electronic Death Registration System that will attempt to automate the reporting of deaths as they occur. As reported by the Department, this program will take years to complete. Until the completion of this project, the Department appears to have no plans to implement additional controls to identify client deaths. Rather, the Department stated it will continue to rely on family to inform it of client deaths and recoup funds paid on behalf of deceased clients through its post-payment review process.

The Department indicated in its response that it believes these controls have been successful. We do not agree. We have reported millions of dollars in payments made on behalf of persons with invalid Social Security numbers or made on behalf of deceased individuals since 2002. Additionally, although the Department is required to have a post-payment review program, such a "pay and chase" system is utilized when the Medicaid agency pays the medical bills and then attempts to recover unallowable payments. States are required to try to "cost avoid" claims that should not be paid in the first place. This is because "pay and chase" is not always successful in recouping funds and more may be spent on recoupment efforts than on what the agency may recover in the recoupment itself.

Concerning the Department's response to questioned costs, of the 220 exceptions we gave to the Department for review, we received additional documentation for seven. We rescinded five of those exceptions as follows:

- We had pro-rated the total amount of some client's claims based on the condition that the end date on the claim was after the client's date of death. The Department provided us with additional documentation for five of these clients and questioned costs, in the amount of $293.35, were rescinded prior to computation of final questioned costs. Total questioned costs remain at $3,747,778.

- The State Auditor's Office is aware that errors are made by the Department of Health and the Social Security Administration. For this reason, documentation from one agency was not deemed to carry more weight. In those instances in which different dates for deaths of clients appeared, we attempted to obtain additional evidence through such sources as obituaries. When we were able to obtain additional reliable evidence, we considered the date of death to be that supported by the most evidence. The Department provided us with additional documentation for two clients it considered to belong to this category:

    1. One client submitted for re-examination had already had the date of death verified through the Department of Health and the Social Security Administration. This information had been available to the Department during its review of our workpapers. No questioned costs were rescinded.

    2. For the other client, we received documentation indicating that the Seattle Regional Office of the Social Security Administration had performed an investigation concluding that their records reporting the client's death was erroneous. Evidence offered included nursing home facility progress notes dated 1997, reporting the then 71-year-old client's admission to the facility, and the November 2005 Medicaid coupon issued by the Department. This information was obtained by Social Security Administration from the provider, who was the recipient of approximately $48,000 in claims. For purposes of our audit, we do not consider this documentation as evidence that the client is alive. This is because:

        - We saw no recent facility progress notes, physician's orders, nursing plan of care or other documentation that would indicate on-going treatment and care.

        - We could not consider the Medicaid coupon as evidence as it originated from the Department that we are auditing.

        As a result, we have not rescinded questioned costs totaling $47,989.23 for this individual.

The Department cites 162 instances in which the Social Security number recorded did not match the name of the individual recorded in MMIS. The Department incorrectly states that an individual may appropriately use a Social Security number belonging to someone else when applying for Medicaid benefits. Federal regulations (42 CFR 435.910(a)) specifically require that, as a condition of eligibility, each individual (including children) requesting Medicaid services, furnish each of his or her Social Security numbers.

We reaffirm our finding and recommendations.

Applicable Laws and Regulations

The Code of Federal Regulations is explicit in its directives regarding obtaining and verifying Social Security numbers as a condition of Medicaid eligibility. 42 CFR 435.910 (a) specifically states in part:

> The agency must require, as a condition of eligibility that each individual (including children) requesting Medicaid services furnish each of his or her social security numbers . . . .

Regarding the agency's responsibility for the verification of Social Security numbers (SSN), 42 CFR 435.910 (g) states:

> The agency must verify each SSN of each applicant and recipient with SSA, as prescribed by the commissioner, to insure that each SSN furnished was issued to that individual and to determine whether any others were issued.

If a Medicaid applicant cannot remember or has not been issued a Social Security number, 42 CFR 435.910 (e) (1-3) states that the agency must:

> (1) Assist the applicant in completing an application for an SSN;
>
> (2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and
>
> (3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

For the re-determination of Medicaid eligibility and Social Security numbers, the regulations are also quite precise. 42 CFR 435.916 (a) states in part:

> The agency must re-determine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months . . . .

42 CFR 435.920 (a-c) continues:

> (a) In re-determining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN.
>
> (b) If the case record does not contain the required SSNs, the agency must require the recipient to furnish them and meet other requirements of 435.910.

If the agency initially established eligibility without verification of the Social Security number, 42 CFR 435.920 (c) requires:

> For any recipient whose SSN was established as part of the case record without evidence required under the SSN regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with 435.910.

The Medicaid State Plan incorporates the above references as applicable to Washington State's coverage and eligibility criteria when it states the following:

> The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

RCW 9.35.020 states in part:

> (1) No person may knowingly obtain, possess, use, or transfer a means of identification or financial information of another person, living or dead, with the intent to commit, or to aid or abet, any crime.
>
> (2) Violation of this section when the accused or an accomplice uses the victim's means of identification or financial information and obtains an aggregate total of credit, money, goods, services, or anything else of value in excess of one thousand five hundred dollars in value shall constitute identity theft in the first degree . . . .

05-16 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), did not ensure that home health agencies providing services under the Medicaid program complied with federal surety bond requirements.

Background

Home health care services include skilled nursing care, paraprofessional services, custodial care and high-tech pharmaceutical services. The elderly, a growing population with higher than average health care needs, are among the primary recipients of services offered by home health care agencies. A report from the U.S. Small Business Administration indicated, while most other industries are cutting back, home health agencies are growing.

In 1995, the U.S. Department of Health and Human Services, Office of the Inspector General, reported that home care was consuming a rapidly increasing portion of the federal health budget and that this type of health care service is "particularly vulnerable to fraud and abuse". Examples of fraudulent claims include:

- Claims for services that were never provided.
- Duplicate claims for the same service.
- Claims for services to ineligible clients.

Surety bonds protect against loss if the terms of a contract or obligation are not filled. Unlike an insurance policy that provides against loss to the party buying the policy, a surety bond is an extension of credit in the form of a guarantee that provides protection to the party requiring the bond but provides no insurance to the party buying the bond.

In 1997, Congress enacted a law requiring that all home health agencies providing care to Medicare and Medicaid clients obtain a surety bond for $50,000 or 15 percent of their annual claims for reimbursement, whichever was greater. On January 5, 1998, the Department of Health and Human Services published a final rule containing this statutory requirement. On March 4, 1998, the Federal Register published a notice that reported the federal government intended to make technical revisions to the January rule. In another ruling, also published on March 4, 1998, the original date for compliance with the surety bond requirement was removed and it was announced that the federal government intended to establish a compliance date.

In a letter to state Medicaid directors in July 1998, Centers for Medicare and Medicaid Services (CMS) instructed states not to enforce the surety bond requirement pending a new final ruling. Thus, the practical effect of these documents (the Federal Register and the CMS letter) was to absolve the home health agencies from having to show compliance with the requirements until 60 days following publication of a new final rule but no earlier than February 15, 1999.

However, it did not appear that Congress had ever come back with a revision to the law. The Code of Federal Regulations (CFR), from October 1999 through the present, continued to cite the surety bond regulation as the current law.

Description of Condition

For our audit of fiscal year 2005, we asked the Department of Social and Health Services' Health and Recovery Services (formerly Medical Assistance Administration) about its compliance with the surety bond requirement. It reported that no requirement applied, basing this position on the letter issued by CMS instructing the states that the rule was suspended. Further testing, however, indicated that the Department reported in surveys, administered by the U.S. General Accounting Office, that Washington State was complying with the surety bond requirement for home health agencies.

The apparent inconsistencies with the Department's representations, the instructions given by CMS and the law as stipulated in the federal regulations prompted us to seek guidance from the U.S. Department of Health and Human Services, Office of the Inspector General. We asked the following questions:

1. In the hierarchy of guidance, which would take precedence: the Federal Register, the CFR or CMS' instruction to the states?

2. In view of the discrepancies in the authorities, should the lack of adherence to the regulation be considered non-compliance on the part of the state?

3. What is the State Auditor's obligation to report this?

We received the following instructions:

- The hierarchy of guidance that the State Auditor's Office must follow is the CFR. Thus, we must audit to the law applicable for the current audit period. Regardless of the letter that CMS wrote to Medicaid Directors in 1998 and regardless of the Federal Register citation suspending the compliance date, the regulation for the surety bond is current law.

- If the state does not enforce the surety bond requirement for home health agencies participating in Medicaid, as the law requires, it is in non-compliance despite apparent discrepancies between the Federal Register and the CMS directive. No agency of the federal government has the authority to direct a state not to follow the law.

- If the state is not enforcing the surety bond requirement, as the law provides, the State Auditor's Office is obligated to report it.

Cause of Condition

The Department believed that the surety bond requirement was not in effect based on a CMS letter issued in 1998 to State Medicaid Directors, noting the rule was suspended.

Effect of Condition

The Administration paid $15,269,485 to home health agency providers that rendered care to Medicaid clients but did not comply with the surety bond requirement.

Recommendation

We recommend the Department:

- Require all home health providers that provide services to Medicaid clients provide proof that all surety bond requirements are met as required by federal law.

Department's Response

The Department disagrees with this finding. As the federal funding authority for the Medicaid program, CMS has given direction to the states to not implement the surety bond requirement until specifically directed to do so by CMS. This direction was provided in the Federal Register on July 31, 1998. The Department will follow CMS direction on this issue. In a memo dated February 13, 2006, the Attorney General staff for the Department agreed with this action, as stated in the following excerpt from the memo:

HHS suspended compliance with the surety bond requirement for home health agencies (HHAs) on July 31, 1998, citing "significant concerns expressed by the United States Congress and HHAs." 63 Fed. Reg. 41,070 (July 31, 1998). It further stated that the suspension remains in effect until it has evaluated reports from the General Accounting Office regarding surety bonds and published a final rule on surety bond compliance. There has been no change to this suspension since July 1998.

In my opinion, the Department of Social and Health Services (Department) is not required to verify surety bonds at this time because HHS has suspended compliance with this rule. It is not necessary for the Department to second-guess HHS' action as it is the federal agency charged with interpreting and implementing Medicare and Medicaid regulations.

Auditor's Concluding Remarks

The State Auditor's Office is required to audit for compliance to current law. The surety bond requirement for home health agencies has existed in federal statute since 1998. Although we understand the reason that the Department is out of compliance, we reaffirm our audit finding and recommendations.

Applicable Laws and Regulations

42 United States Code 1395x(o), states in part:

> The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which –
>
> 7) provides the Secretary with a surety bond—
>
> > (A) effective for a period of 4 years (as specified by the Secretary) or in the case of a change in the ownership or control of the agency (as determined by the Secretary) during or after such 4-year period, an additional period of time that the Secretary determines appropriate, such additional period not to exceed 4 years from the date of such change in ownership or control;
> >
> > (B) in a form specified by the Secretary; and
> >
> > (C) for a year in the period described in subparagraph (A) in an amount that is equal to the lesser of $50,000 or 10 percent of the aggregate amount of payments to the agency under this title and title XIX of this chapter [42 USCS 1395 et seq.] for that year, as estimated by the Secretary . . . .

42 CFR Sec. 441.16, Home health agency requirements for surety bonds; Prohibition on Federal Financial Participation, states in part:

> (b) Prohibition. FFP is not available in expenditures for home health services under Sec. 440.70 of this subchapter unless the home health agency furnishing these services meets the surety bond requirements of paragraphs (c) through (l) of this section.
>
> (c) Basic requirement. Except as provided in paragraph (d) of this section, each HHA that is a Medicaid participating HHA or that seeks to become a Medicaid participating HHA must—
>
> > (1) Obtain a surety bond that meets the requirements of this section and instructions issued by the Medicaid agency; and
> >
> > (2) Furnish a copy of the surety bond to the Medicaid agency.
>
> (d) Requirement waived for Government-operated HHAs. An HHA operated by a Federal, State, local, or tribal government agency is deemed to have provided the Medicaid agency with a comparable surety bond under State law, and is therefore exempt from the requirements of this section if, during the preceding 5 years, the HHA has not had any uncollected overpayments.

(e) Parties to the bond. The surety bond must name the HHA as Principal, the Medicaid agency as Obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as Surety . . .

(g) Amount of the bond.

> (1) Basic rule. The amount of the surety bond must be $50,000 or 15 percent of the annual Medicaid payments made to the HHA by the Medicaid agency for home health services furnished under this subchapter for which FFP is available, whichever is greater . . . .

05-17 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not have adequate reviews of home health agencies to ensure providers are licensed, Medicare certified and have signed a Core Provider Agreement as required by law.

Background

Home health care services cover a broad range of services that are offered in a client's home. These include skilled nursing care, paraprofessional services, custodial care and high-tech pharmaceutical services. The elderly, a growing population with higher than average healthcare needs, are among the primary recipients of services offered by home health care agencies.

A home health agency must meet four requirements in order to participate in the Medicaid program. These requirements are:

1. A Washington State business license, unless specifically exempted.

2. Medicare certification.

3. An in-home services license issued by the Health Department. This ensures the provider is qualified to perform the services it will render to Medicaid clients.

4. A Core Provider Agreement on file with the Administration.

After acquiring a business license through the Department of Licensing, the process of becoming a home health provider begins at the Health Department. An in-home services license must first be obtained. This requires completion of the application and submission of required documentation, including:

- Proof of professional liability insurance and property damage insurance.

- Copies of disclosure statements and criminal history background checks, obtained within three months of initial application or renewal, for the administrator and director of clinical services or direct care services.

- A certificate of need for each type of home health service to be provided.

- A copy of a current business license.

- A copy of policies and procedures.

If a provider wishes to render services to Medicaid clients, the home health agency must obtain Medicare certification. In Washington, the provider obtains the certification application from the Health Department. Once the provider completes the application, submits all necessary credentials and passes a Health Department pre-certification survey, the Health Department forwards all required certification documentation to the Center for Medicare and Medicaid Services (CMS) for their review. If approval is given, CMS authorizes official Medicare certification and issues a number. A letter of approval or denial is sent by CMS to the provider, the Health Department and the Department of Social and Health Services. This certification allows the provider to participate in the Medicaid program and makes the state eligible to receive federal matching funds for reimbursements paid to these providers.

Providers must also complete and sign an agreement with the Department of Social and Health Services. The Administration requires completion of the standard Core Provider Agreement. Once this has been received, a provider number is issued. This allows the provider to submit billings for its services.

Description of Condition

In our audit, we obtained lists from the Health Department and the Administration of licensed and certified home health providers that each had in its records. We performed a match of the two lists and found 15 providers on the Administration's records that were not identified in the Health Department's report. We further reviewed these 15 providers to determine why the Administration had more Medicaid providers than the Health Department. We also selected five additional providers appearing on both lists. For these providers, we wanted to determine if all documentation was present that would indicate they were processed according to controls reported by both agencies.

We found the Administration did not have all the required documentation to support that home health agencies were properly licensed and certified for any of the providers that we reviewed. For the 20 providers we found:

- Four did not have Core Provider Agreements on file.
- Nineteen did not have evidence of Medicaid certification in the Administration's records.
- Sixteen did not have business licenses. For these, we found no evidence of exemption.
- Seventeen did not have evidence of in-home services licenses.

Cause of Condition

The Department:

- Does not have controls to ensure that all home health providers meet the criteria for participating in the Medicaid program.
- Has not allocated sufficient resources to ensure that all the requirements are present prior to issuing a provider number.

Effect of Condition

We do not have reasonable assurance that home health providers providing services to Medicaid clients are eligible to be participating providers. We base this opinion on the lack of supporting documentation the Administration had in its files to substantiate representations that providers were eligible to participate in the Medicaid program. The questioned costs attributable to the 20 providers were $417,174 for the period January 1, 2004 through December 31, 2004. Half of these costs were paid with federal Medicaid funds.

Recommendation

We recommend the Department:

- Ensure all home health agencies have all required documentation on file to support a provider's eligibility to participate in the Medicaid program.
- Work with the U.S. Department of Health and Human Services to determine if any unallowable costs charged to federal Medicaid funds should be returned.

Department's Response

The Department concurs with this finding.

The Provider Enr*ollment (PE) Section and the Customer Service Center in the Health and Recovery Services Administration have made the following changes to address this finding.*

Three new positions have been assigned as of May 2005 to PE to assist with the increased application workload, the increased verification procedures and other necessary projects. The impact of these changes have allowed PE to bring the current application process up to standards, make the needed verifications, and bring PE from over 70 days behind in processing applications to less than 15 days. It has also allowed PE to work at file cleanup.

PE has instituted a new process as of July 2005 for working applications which include the reviewing of all necessary documents such as the Core Provider Agreement, Medicare Certification, necessary license from Department of Health, and Washington State business license.

PE also started a project as of November 11, 2005 that brought all the current providers up to date with all the necessary documents as listed above. This project is continuing.

Auditor's Concluding Remarks

We appreciate the steps the Department is taking to resolve this issue. We will review the condition during our next audit.

Applicable Laws and Regulations

Criteria:

Core Provider Agreement

42 CFR 431.107 (b) Agreements, states in part:

> A state plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to:
>
> > (1) keep any records necessary to disclose the extent of the services the provider furnishes to recipients . . . .

DOH In Home Service License

RCW 70.127.080, Licenses -- Application procedure and requirements, states:

> (1) An applicant for an in-home services agency license shall:
>
> > (a) File a written application on a form provided by the department;
> >
> > (b) Demonstrate ability to comply with this chapter and the rules adopted under this chapter;
> >
> > (c) Cooperate with on-site survey conducted by the department except as provided in RCW 70.127.085;
> >
> > (d) Provide evidence of and maintain professional liability, public liability and property damage insurance in an amount established by the department, based on industry standards. This subsection shall not apply to hospice agency applicants that provide hospice care without receiving compensation for delivery of services;
> >
> > (e) Provide documentation of an organizational structure, and the identity of the applicant, officers, administrator, directors of clinical services, partners, managing employees or owners of ten percent or more of the applicant's assets;

(f) File with the department for approval a description of the service area in which the applicant will operate and a description of how the applicant intends to provide management and supervision of services throughout the service area. The department shall adopt rules necessary to establish criteria for approval that are related to appropriate management and supervision of services throughout the service area. In developing the rules, the department may not establish criteria that:

(i) Limit the number or type of agencies in any service area; or

(ii) Limit the number of persons any agency may serve within its service area unless the criteria are related to the need for trained and available staff to provide services within the service area;

(g) File with the department a list of the home health, hospice and home care services provided directly and under contract;

(h) Pay to the department a license fee as provided in RCW 70.127.090

(I) Comply with RCW 43.43.830 for criminal background checks; and

(j) Provide any other information that the department may reasonably require.

(2) A certificate of need under chapter 70.38 RCW is not required for licensure except for the operation of a hospice care center.

RCW 70.127.020 Licenses required after July 1, 1990 – Penalties, states:

(1) After July 1, 1990, a license is required for a person to advertise, operate, manage, conduct, open or maintain an in-home services agency.

(2) An in-home services agency license is required for a nursing home, hospital, or other person that functions as a home health, hospice, hospice care center or home care agency.

(3) Any person violating this section is guilty of a misdemeanor. Each day of a continuing violation is a separate violation.

(4) If any corporation conducts any activity for which a license is required by this chapter without the required license, it may be punished by forfeiture of its corporate charter.

(5) All fines, forfeitures and penalties collected or assessed by a court because of a violation of this section shall be deposited in the department's local fee.

<u>Certification</u>

State Plan approved July 11, 2003.

WAC 388-551-2200, Home health services--Eligible providers. The following may contract with MAA to provide home health services through the home health program, subject to the restrictions or limitations in this section and other applicable published WAC:

(1) A home health agency that:

(a) Is Title XVIII (Medicare) certified;
(b) Is department of health (DOH) licensed as a home health agency;
(c) Submits a completed, signed core provider agreement to MAA; and (d) Is assigned a provider number . . . .

05-18 The Department of Health does not retain documentation that would provide evidence to ensure all home health agency providers performed criminal background checks and obtained disclosures on employees having unsupervised access to vulnerable adults, as the law requires.

Background

Washington State regulations require home health agencies to ensure each employee who has unsupervised access to vulnerable children and adults undergo a criminal background check and make a full disclosure of any crimes committed prior to employment. The Department of Health, as the licensing authority, has the responsibility for assuring home health agencies comply with this regulation.

If home health agencies have not complied with this requirement, the Department may cite the facility and could suspend or revoke the provider's license. The agency would then no longer qualify as a certified Medicare provider. If a home health provider is not Medicare certified, it cannot participate in the Medicaid program.

Federal law also requires the responsible agency to keep on file, and readily accessible, all information and reports used in determining whether Medicaid providers meet federal requirements.

Description of Condition

During our audit we found that the Department of Health materially complied with the requirement to perform criminal background checks and disclosures for administrators of home health agencies during the licensing process. We reviewed the licensing documents for 12 providers and found evidence in the Department's files of criminal background checks and disclosures for all but one provider.

We also attempted to determine if the Department monitors whether home health agencies perform background checks on all employees that have unsupervised access to vulnerable adults. We found no evidence that this is occurring either upon licensure or during the survey process. The Department reported it reviews records for a limited number of randomly selected employees during its surveys of home health agencies. If the results of this review are satisfactory, no other records are reviewed. The Department also reported the support for this review is not retained.

Cause of Condition

The Department stated:

- Although records are retained for administrators, support related to their survey of background checks and disclosures of home health staff having unsupervised access to vulnerable adults are not retained in the interest of confidentiality.

- It is the responsibility of the home health agency, not the Department of Health, to ensure that criminal background checks are performed on individuals having unsupervised access to vulnerable adults.

- State regulations governing Department of Health's responsibility to ensure compliance with licensing requirements are "permissive" and they are not required to ensure that a background check has been completed on every employee at every home health agency.

- It is acting within "exception" reporting guidelines, which requires retention of documents only in cases where exceptions are found.

Effect of Condition

When the Department of Health does not retain documentation, we are unable to review whether it is monitoring home health agencies for compliance with the requirement to perform background checks and obtain necessary disclosures.

Additionally, not retaining survey records is a violation of federal regulations.

Recommendation

We recommend the Department:

- Verify background checks and disclosure statements are completed for employees of home health agencies who have unsupervised access to children and the developmentally disabled.

- Retain surveyor's documentation of their reviews of employee criminal background checks and disclosures statements.

Department's Response

We do not concur with the finding for the reasons enumerated below:

Our current process of reviewing Home Health Agency (HHA) employee files on a limited test basis is intended to determine if HHAs are conducting criminal back ground checks in accordance with state law when hiring new employees. Applicable statutes clearly state that it is the HHA employer responsibility to ensure that criminal back ground checks are performed. It is a Department of Health responsibility to obtain reasonable assurance of compliance, but not to duplicate the HHA process.

The goal of a 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 back ground checks.

If our surveyor determines that the subject HHA is in violation of the requirement 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. We believe that this fulfills the intent of CFR 42 CFR 431.610(f) (3) to retain all information and reports, and is consistent with state law. In addition the process and methodology for our conduct of HHA surveys and reporting conforms to the Centers for Medicare and Medicaid Services (CMS) policies and procedures found in their State Operation Manual and Principles of Doc*umentation Guide.

We appreciate that the auditor's recommendations are intended to provide an additional layer of assurance that criminal background have been performed. However, our agency is striving to utilize our available resources in the most efficient manner possible, and must evaluate any recommended control or policy change in a cost benefit context. We do not feel that additional documentation of compliant entities is necessary, cost effective, required by state or federal law, nor would result in any additional protection for vulnerable residents of HHAs.

Auditor's Concluding Remarks

We have carefully reviewed the Department's response and understand its position; however, we reaffirm our finding.

It is the Department's responsibility to determine that home health agencies perform background checks on all employees with unlimited access to vulnerable adults and children.

By not retaining documentation that the surveyor has verified background checks have been performed, we cannot express assurance that the agency is monitoring for compliance with the law. Government auditing standards, section 4.03 c, require:

> Sufficient, competent and relevant evidence is to be obtained to provide a reasonable basis for the auditors' findings and conclusions.

The Department states it is conducting surveys according to the State Operations Manual obtained from the Centers for Medicare and Medicaid Services. The purpose of that manual is to make the Code of Federal Regulations more understandable for users. The methodology in the manual is not intended to circumvent survey procedures or discard the requirement for audit documentation.

We reaffirm our finding that the Department of Health does not retain documentation, which would provide evidence to ensure all home health agency providers performed criminal background checks and obtained disclosures on employees having unsupervised access to vulnerable adults, as the law requires.

Applicable Laws and Regulations

42 CFR §484.12 (a), states in part:

> . . . The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations . . . .

42 CFR 431.610(f)(3), states in part:

> The survey agency will keep on file all information and reports used in determining whether participating facilities meet Federal requirements . . . .

42 CFR 431.610(f)(4), states in part:

> . . . The survey agency will make the information and reports required under paragraph (f)(3) of this section readily accessible to HHS and the Medicaid agency as necessary . . . .

RCW 43.43.834(2), states in part:

> A business or organization shall require each applicant to disclose to the business or organization whether the applicant:
>
> > (a) Has been convicted of a crime;
> >
> > (b) Has had findings made against him or her in any civil adjudicative proceeding as defined in RCW 43.43.830; or
> >
> > (c) Has both a conviction under (a) of this subsection and findings made against him or her under (b) of this subsection.

RCW 70.127.080, states in part:

> An applicant for an in-home services agency license shall:
>
> > (i) Comply with RCW 43.43.830-.842 for criminal background checks . . . .

RCW 43.43.842, Vulnerable adults -- Additional licensing requirements for agencies, facilities, and individuals providing services, states:

> (1)(a) The secretary of social and health services and the secretary of health shall adopt additional requirements for the licensure or relicensure of agencies, facilities, and licensed individuals who provide care and treatment to vulnerable adults, including nursing pools registered under chapter 18.52C RCW. These additional requirements shall ensure that any person associated with a licensed agency or facility having unsupervised access with a vulnerable adult shall not have been:
>
> > (i) Convicted of a crime against persons as defined in RCW 43.43.830 except as provided in this section;

(ii) convicted of crimes relating to financial exploitation as defined in RCW 43.43.830, except as provided in this section;
(iii) found in any disciplinary board final decision to have abused a vulnerable adult under RCW 43.43.830 or
(iv) the subject in a protective proceeding under chapter 74.34 RCW.

(b) A person associated with a licensed agency or facility who has unsupervised access with a vulnerable adult shall make the disclosures specified in RCW 43.43.834

(2). The person shall make the disclosures in writing, sign, and swear to the contents under penalty of perjury. The person shall, in the disclosures, specify all crimes against children or other persons, all crimes relating to financial exploitation, and all crimes relating to drugs as defined in RCW 43.43.830, committed by the person.

RCW 43.43.830, Background checks -- Access to children or vulnerable persons – Definitions, states in part:

Unless the context clearly requires otherwise, the definitions in this section apply throughout RCW 43.43.830 (1) "Applicant" means:

(a) Any prospective employee who will or may have unsupervised access to children under sixteen years of age or developmentally disabled persons or vulnerable adults during the course of his or her employment or involvement with the business or organization;

RCW 70.127.170, Licenses -- Denial, restriction, conditions, modification, suspension, revocation -- Civil penalties, states in part:

Pursuant to chapter 34.05 RCW and RCW 70.127.180 3), the department may deny, restrict, condition, modify, suspend, or revoke a license under this chapter or, in lieu thereof or in addition thereto, assess monetary penalties of a civil nature not to exceed one thousand dollars per violation, or require a refund of any amounts billed to, and collected from, the consumer or third-party payor in any case in which it finds that the licensee, or any applicant, officer, director, partner, managing employee, or owner of ten percent or more of the applicant's or licensee's assets:

(1) Failed or refused to comply with the requirements of this chapter or the standards or rules adopted under this chapter . . . .

05-19 The Department of Social and Health Services, Aging and Disability Services Administration, does not ensure providers of home health care services are Medicare-certified as required by the Medicaid State Plan.

Background

Home health care services cover a broad range of services offered in a client's home. These include skilled nursing care, paraprofessional services, custodial care and high-tech pharmaceutical services. The elderly, a growing population with higher than average healthcare needs, are among the primary recipients of services offered by home health care agencies.

If a provider wishes to render services to Medicaid clients, the home health agency must obtain Medicare certification. However, states may request waivers of certain federal requirements in order to develop community-based treatment alternatives that are financed by Medicaid. Home and Community-Based Service (HCBS) waivers give states the flexibility to use alternatives to institutionalized care, such as hospitals and nursing homes. The HCBS waiver program recognizes many individuals can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost that is no higher, and often less, than that of institutional care. In Washington, six waivers that the Aging and Disability Services Administration oversees affect home health care clients.

Provisions of the waivers stipulate qualifications that a home health provider must meet in order to give care to clients under the Medicaid program. They indicate provider qualifications by provider type and service type. Thus, some providers can perform some services and not be Medicare-certified, but must be certified to perform other services. For instance, under the Community Options Program Entry System (COPES) waiver, a home health agency does not have to be certified to perform personal care services. However, the waiver does not allow skilled nursing services to be performed by an uncertified home health agency. Thus, if a provider renders services not specifically indicated under the waiver as not requiring certification, it must be a Medicare-certified provider to be eligible to provide those services to Medicaid clients.

Description of Condition

In our audit, we attempted to determine if the Administration had controls in place to ensure home health providers are providing only services they are certified by law and/or qualified by waiver to perform. We found that under the six waivers granted to Washington by the federal government, only three services did not require a home health provider to be Medicare certified. These services were personal care, caregiver/recipient training and respite care.

We selected 27 home health providers for our tests. We found only four were Medicare-certified. We also found that the Administration makes no effort to ensure providers are Medicare-certified.

We then reviewed the services provided by each provider. We wanted to determine if services requiring certification were rendered by certified providers. We found non-certified providers were performing services that only Medicare-certified providers should perform.

Cause of Condition

The Administration does not have controls to ensure that all home health providers meet the criteria for participating in the Medicaid program.

The Administration believes that all services covered under the waivers are exempt from Medicare certification and thus its providers of home health care need not be certified.

Effect of Condition

We do not have reasonable assurance that providers performing services under Home and Community-Based Service waivers, managed by the Aging and Disability Services Administration, are certified to perform the services they render to Medicaid clients. More than $11,449,600, of which $15,611 was paid on behalf of Children's

Administration clients, was paid to providers not certified as required by federal regulations. These are questioned costs. Half of these costs were paid with federal Medicaid funds.

Recommendation

We recommend the Department:

- Develop controls to ensure all home health providers meet the criteria for participating in the Medicaid program.

- Work with the U.S. Department of Health and Human Services to determine if any unallowable costs charged to federal Medicaid funds should be returned.

Department's Response

The Department agrees that home health provider qualifications need to be clarified in the State Plan Amendment and waivers.

Payments for services that are related to skilled nursing:

$6,926,768.43 of the questioned costs relate to nursing services provided by Home Health Agencies. The State Auditors Office (SAO) audit of home health agencies identified that Aging and Disability Services (ADSA) does not ensure providers of home health care services are Medicare certified as required by the Medicaid State Plan. The Department believes the audit identified opportunities for improved documentation related to the qualifications of agencies providing skilled nursing under the State Plan and the Home and Community Services (HCS) and Division of Developmental Disabilities (DDD) waivers. We have already taken steps to clarify who is considered a qualified provider of nursing services in the State Plan and in our waivers.

We do not believe these payments are unallowable when considering the following:

- *Clients served were eligible to receive the services provided;*
- *Skilled nursing services were provided;*
- *The services were performed by appropriately qualified registered nurses as required under the waivers;*
- *In past audits performed by the Centers for Medicare and Medicaid Services (CMS) payments for skilled nursing under the state plan and the HCS waivers performed by licensed home health agencies that are not Medicare certified were not questioned.*

Aging and Disability Services is working with CMS to revise the State Plan and the waivers to more accurately reflect qualified providers of each service as well as where Medicare certification is required and where it is not. We will ensure that home health providers meet the criteria as approved in the amended State Plan and waivers.

Payments for services that are not related to skilled nursing:

The Department does not concur with these findings as they relate to payments for services that are not related to skilled nursing. The SAO questioned $4,507,228.34 in payments that do not relate to skilled nursing.

It is the Department's understanding that in auditing home health agencies, the SAO applied the Medicare Certification provider requirement in the State Medicaid Plan and the Code of Federal Regulations (CFR) for the provision of nursing services even to non-nursing services provided by those agencies to ADSA clients. The State Plan does indicate that home health agencies must be Medicare certified, however, there is no such requirement for the other services provided by these agencies that do not relate to skilled nursing care. The home health agencies identified in the audit also hold other contracts with the Department for services that do not involve skilled nursing such as personal care, environmental modifications, medical equipment and supplies, and adult family home services.

The following information includes a description of services provided by the identified home health agency that are not related to skilled nursing and the dollar total identified in the SAO audit for those services.

1. Personal Care under the State Plan

Defined as assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. It also includes assistance with instrumental activities of daily living such as housekeeping, laundry, meal preparation and transportation. All personal care services are non-medical in nature.

Qualifications:

In both the State Plan and the CFR, the requirement for a personal care provider is that the provider of personal care be a qualified individual who is not a relative of the client. CMS and that state have, since the beginning of the personal care program, agreed that the specific qualification for personal care providers are set by the state and spelled out in Washington Administrative Code (WAC). Consequently, a personal care provider can be an individual or a licensed home care agency – a Medicare certification is not relevant regarding personal care.

In-Home Services licensing requirements for both home care and home health agencies are found in WAC 246-335. Agencies must be licensed in the home care or home health service categories to provide non-medical services such as personal care.

Relevant WAC related to personal care provider qualifications is listed below:

> *WAC 388-106-0010 What definitions apply to this chapter?*
>
> *"Agency provider" means a licensed home care agency or a licensed home health agency having a contract to provide long-term care personal care services to you in your own home.*
>
> *"Individual provider" means a person employed by you to provide personal care services in your own home. See WAC 388-71-0500 through 388-71-05909.*
>
> *"Personal care services" means physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to your functional limitations. Assistance is evaluated with the use of assistive devices.*
>
> *WAC 388-106-0040 Who can provide long-term care services? The following types of providers can provide long-term care services:*
>
> *(1) Individual providers (IPs), who provide services to clients in their own home. IPs must meet the requirements outlined in WAC 388-71-0500 through 388-71-05909.*
>
> *(2) Home care agencies, which provide services to clients in their own home. Home care agencies must be licensed under chapter 70.127, RCW and chapter 246-336, WAC and contracted with area agency on aging.*
>
> *(3) Residential providers, which include licensed adult family homes and boarding homes, who contract with the department to provide assisted living, adult residential care, and enhanced adult residential care services (which may also include specialized dementia care).*
>
> *(4) Providers who have contracted with the department to perform other services.*

Payments for personal care identified by the SAO audit:
$655,174.41 in payments under DDD contracts and $3,190,315.51 in payments under HCS contracts.

In addition, a total of $70,712.39 in payments were made to Adult Family Homes (AFH) to provide residential personal care to clients under HCS and $14,031.36 under DDD as defined in AFH License under Chapter 70.128 of the Revised Code of Washington (RCW) and 388-76 WAC.

2. Environmental Modifications:

Environmental Modifications under the COPES waiver are defined as minor physical adaptations to the client's own home which are authorized in the client's service plan; necessary to ensure the client's health, welfare, and safety; enable the client to function with greater independence in his/her home; are of direct medical or remedial benefit to the client; are in accord with applicable state or local building codes.

Minor physical adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies, which are necessary for the welfare of the individual. Excluded are those adaptations or improvement to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations, which add to the total square footage of the home, are excluded from this benefit.

Qualifications:

The provider must be currently registered as a general or specialty contractor and in good standing with the Department of Labor and Industries under RCW 18.27, except as provided under RCW 18.27.090 Exemptions, or if the provider is a volunteer.

Payments for Environmental Modifications identified in the SAO audit:
$3,187.17 in payments under HCS contracts.

3. Personal Emergency Response Systems (PERS):

Defined as an electronic system whereby an individual can secure help in an emergency through an electronic device that is connected to the individual's phone and programmed to signal a response center, staffed by trained professionals who will immediately summon help for the client. This service provides for system installation and on-going monitoring for emergencies; it does not include such services as medication reminders, well-checks, or any other enhancements available from the contractor. (System specifications are defined in the contract statement of work.)

Qualifications:

A qualified PERS provider is an electronic communication and equipment monitoring agency.

Payments for Personal Emergency Response Systems identified by the SAO audit:
$155,229.99 in payments under HCS contracts.

4. Specialized Medical Equipment and Supplies:

Defined as durable and non-durable medical equipment and supplies which includes devices, controls, or appliances, authorized in a client's service plan, which enable individuals to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan, Medicare or other insurance, and shall exclude those items, which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

Qualifications:

The contractor must be a legal business entity and be legitimately engaged in the business of provision of medical equipment and supplies. Contractors located in the state of Washington must have a Universal Business Identifier and Master Business License, as issued by the state Department of Revenue. Out of state Contractors must possess a Universal Business Identifier and Master Business License only when it is required for Washington State law.

Payments for Specialized Medical Equipment and Supplies identified by the SAO audit:
$62,495.46 in payments under HCS contracts.

5. Respite Care:

Defined as non-medical services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the unpaid care.

Qualifications:

Same as personal care

Payment for Respite Care identified by the SAO audit:
$327,126.04 in payments under DDD.

Auditor's Concluding Remarks

The purpose of our audit was to determine if the Administration had controls in place to ensure home health providers are providing only services they are certified to perform or, if not certified, are duly exempted by waiver. Since we have not reviewed client eligibility for home health services or the qualifications of the staff providing services, we do not render an opinion on this portion of the Department's response.

The waivers allowing the Department to deviate from State Plan Medicare certification requirements stipulate both the type of service that is exempt and the qualifications of the provider rendering such exempted services. These waivers indicate that only training provided to either recipient or caregiver, personal care services and respite care could be provided by non-certified home health agencies. All other services not covered under the waivers must be provided by certified home health agencies per the State Plan. If the entity received Medicaid funds for the services it rendered, but was not Medicare-certified as required by the state plan or not specifically exempted from certification by waiver, we deemed the costs as unallowable.

We reaffirm our finding and our recommendation that the Department develop controls to ensure all home health providers meet the criteria for participating in the Medicaid program.

Applicable Laws and Regulations

Criteria

Core Provider Agreement

42 CFR 431.107 (b) Agreements, states:

A State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to

(1) keep any records necessary to disclose the extent of the services the provider furnishes to recipients;

DOH In Home Service License

RCW 70.127.080, Licenses -- Application procedure and requirements, states:

(1) An applicant for an in-home services agency license shall:

(a) File a written application on a form provided by the department;

(b) Demonstrate ability to comply with this chapter and the rules adopted under this chapter;

(c) Cooperate with on-site survey conducted by the department except as provided in RCW 70.127.085

(d) Provide evidence of and maintain professional liability, public liability, and property damage insurance in an amount established by the department, based on industry standards. This subsection shall not apply to hospice agency applicants that provide hospice care without receiving compensation for delivery of services;

(e) Provide documentation of an organizational structure, and the identity of the applicant, officers, administrator, directors of clinical services, partners, managing employees, or owners of ten percent or more of the applicant's assets;

(f) File with the department for approval a description of the service area in which the applicant will operate and a description of how the applicant intends to provide management and supervision of services throughout the service area. The department shall adopt rules necessary to establish criteria for approval that are related to appropriate management and supervision of services throughout the service area. In developing the rules, the department may not establish criteria that:

(i) Limit the number or type of agencies in any service area; or

(ii) Limit the number of persons any agency may serve within its service area unless the criteria are related to the need for trained and available staff to provide services within the service area;

(g) File with the department a list of the home health, hospice, and home care services provided directly and under contract;

(h) Pay to the department a license fee as provided in RCW 70.127.090

(i) Comply with RCW 43.43.830 for criminal background checks; and

(j) Provide any other information that the department may reasonably require.(2) A certificate of need under chapter 70.38 RCW is not required for licensure except for the operation of a hospice care center.

RCW 70.127.020, Licenses required after July 1, 1990 – Penalties, states:

(1) After July 1, 1990, a license is required for a person to advertise, operate, manage, conduct, open, or maintain an in-home services agency.

(2) An in-home services agency license is required for a nursing home, hospital, or other person that functions as a home health, hospice, hospice care center, or home care agency.

(3) Any person violating this section is guilty of a misdemeanor. Each day of a continuing violation is a separate violation.

(4) If any corporation conducts any activity for which a license is required by this chapter without the required license, it may be punished by forfeiture of its corporate charter.

(5) All fines, forfeitures, and penalties collected or assessed by a court because of a violation of this section shall be deposited in the department's local fee.

Certification

State plan approved July 11, 2003.

WAC 388-551-2200, Home health services--Eligible providers, states in part:

> The following may contract with MAA to provide home health services through the home health program, subject to the restrictions or limitations in this section and other applicable published WAC:
>
> (1) A home health agency that:
>
> (a) Is Title XVIII (Medicare) certified;
> (b) Is department of health (DOH) licensed as a home health agency;
> (c) Submits a completed, signed core provider agreement to MAA; and
> (d) Is assigned a provider number . . . .

05-20 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), is not complying with federal regulations that require people receiving Medicaid benefits to have valid Social Security numbers.

Background

The Department of Social and Health Services must require, as a condition of eligibility, that each individual applying for Medicaid services (including children), furnish his or her Social Security number. Federal regulations also require the Department to verify the number with the Social Security Administration to ensure it was issued to the individual who supplied it and whether any other number has been issued for that individual. If an applicant does not remember or has not been issued a number, the Department must assist the individual in applying for one. Under these circumstances, the Department must obtain evidence to establish the age, citizenship or immigration status and true identity of the applicant.

When the Department approves an applicant for Medicaid, it enters client information into the Department's Automated Client Eligibility System (ACES). This information in ACES is then transferred electronically into the Medical Management Information System (MMIS), which the Department's Medical Assistance Administration uses to process claims and initiate payments. The Administration stated that all Medicaid clients, except those admitted through the Involuntary Treatment Act, should be and are entered into ACES upon enrollment.

Description of Condition

During our audit for fiscal year 2004, we found numerous instances in which no Social Security numbers were listed in the MMIS records for Medicaid clients. We also found instances in which two or more people shared the same number and other cases in which MMIS made payments for medical services for clients who were not listed in ACES. For that year, we reported payments totaling $68,022,531 that were made on behalf of 44,597 clients who did not have a Social Security number in the Department's claims processing system.

For our current audit, we sought to determine what controls the Department had established to ensure clients requesting Medicaid benefits provided their Social Security number, as federal law requires.

For the period January 1, 2004 through December 31, 2004, we reviewed all clients in the MMIS database who received medical services under Medicaid but who did not have a Social Security number in MMIS. We eliminated several groups in an effort to ensure that we were testing only clients for whom Medicaid payments were made and a Social Security number should have been obtained. The groups that we eliminated were:

- Clients in the Alien Emergency Medical Program. These individuals should not have Social Security numbers because they are undocumented aliens. We reviewed these payments in other parts of our audit.

- Clients whose procedures were paid only with state funds.

- All children with a birth date in 2004. Although parents must obtain Social Security numbers for their children, we considered that this would not be a priority for parents whose children are very ill. We believed the exception rate would be unusually high for this group and might skew audit results. After one year of age, however, most parents are likely to have obtained Social Security numbers for their children for tax purposes and the Department would have had sufficient time to obtain those numbers.

After removing these groups, we found that there were 42,933 clients who had no Social Security numbers associated with MMIS payments for medical services provided to them. These payments totaled $57,090,838. To determine if Social Security numbers for these clients were in ACES, where Medicaid clients are almost always enrolled, we selected a valid sample for review. This sample consisted of 323 clients. We found issues with 154 clients (48 percent of those reviewed). These exceptions fell into three areas.

- For 10 percent, we found no record of a Social Security number in either ACES or MMIS. Actual and projected costs for this group were at least $4,127,944.

- For 16 percent, ACES reported the Social Security number was invalid. Actual and projected costs for this group were at least $12,833,652.

- For 21 percent, we found no ACES record indicating these clients had ever been enrolled in Medicaid. The Administration previously indicated it did not believe this situation could occur, yet actual and projected payments to providers for this group were at least $3,988,970. We consider this area highly susceptible to fraud.

Cause of Condition

The Department enrolls a significant number of clients into the Medicaid program who do not provide valid Social Security numbers. It has no consistent procedures to assist clients in obtaining Social Security numbers. Additionally, the Department is not verifying the age, citizenship or immigration status and/or true identity of the applicant before enrollment. In other parts of our audit, we found the Department does not use its access to the Social Security's State On-Line Query system to verify the validity of Social Security numbers presented by clients.

Clients can be entered into the Medicaid program and MMIS without going through the standard application process that enters them into ACES and verifies eligibility.

Effect of Condition

Each claim paid on behalf of a client who has no Social Security number, who has made no application for a number or who possesses an invalid number is an unallowable cost. Approximately half of the actual and projected questioned costs of $20,950,566, or $10,475,283, were paid with federal funds and the other half with state funds.

Recommendation

We recommend the Department:

- Require staff members to obtain client Social Security numbers or assist those without a number to obtain one upon application.

- Require staff members to obtain evidence establishing the true identity of an applicant.

- Verify Social Security numbers for all Medicaid clients using the State On-line Query.

- Require staff members to heed Social Security number alerts sent by the Social Security Administration and to take action to resolve them.

- Work with the U.S. Department of Health and Human Services to determine if any unallowable costs charged to Medicaid must be reimbursed by the state.

Department's Response

The Department concurs with State Auditor's Office (SAO) recommendations that focus on the improvement of the verification of Social Security numbers (SSN) at the time of initial application. Corrective Action Plans for previous audit findings included a number of corrective steps that are currently in progress.

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

- *The most significant solution for ensuring correct social security numbers is the modification to the State On-line Query (SOLQ). The promotion of this change in ACES is expected by April 2006. The SOLQ user interface is being modified to accommodate users' ability to multiple queries without exiting the system.*

When the upgrade is completed staff will be trained to verify the SSN upfront to maximize efficiency and accuracy.

- *Staff are currently required to act on SSN discrepancy Alerts sent by the Social Security Administration. The Department will continue to provide instruction and written guidance to staff regarding the manner in which alerts are handled.*

- *The Department 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 Department disagrees with several statements related to eligibility and Social Security number requirements.

- *In the Background Summary, it is stated, "…that all Medicaid clients, except those admitted through the Involuntary Treatment Act, should be and are entered into ACES upon enrollment." This is an erroneous statement as Take Charge (family planning program) clients are transmitted to MMIS through ACES On-line, a web-based system, which is separate from ACES mainframe.*

- *In the Cause of Condition section, it is stated that, "…the Department does not use its access to Social Security's State On-line Query (SOLQ) system to verify the validity Social Security numbers presented by clients." While automatic verification does not utilize SOLQ, the Department disagrees that SSNs are not verified. In February 2005 the ACES-Federal interface was modified to utilize the State Date Exchange/Wire Third Party Query (WTPY) primarily used for SSN verification. WTPY runs nightly for new clients, clients with upcoming recertification dates, etc.*

The Department partially concurs with the three SAO Social Security number error categories and has the following response. Full analysis details of each category are available.

1. ***No Social Security numbers:*** *Twenty-three (23) of the reported 32 error were not in error. Of those, thirteen (13) were children receiving adoption support services who are deemed eligible for Medicaid and whose confidential information is retained at Children's Administration. Eight (8) clients were found to have a SSN in ACES. Eight (8) of the 32 do not have a Social Security number and were in error.*

2. ***Clients not in ACES:*** *Fifty-four (54) of the 69 clients not found in ACES were Take Charge clients whose eligibility is determined outside of the ACES mainframe. These clients are not currently entered into ACES. An additional eleven (11) clients were found in ACES by Department staff. Two (2) clients were Involuntary Treatment Act clients who are not entered in ACES. One case was in error.*

3. ***Invalid Social Security Numbers:*** *Ten (10) of the 53 clients were children receiving adoption support services and deemed eligible as previously stated above. Five (5) of the 53 clients were correctly terminated after they failed to provide their SSN as requested. The Department is precluded from denying or delaying Medicaid benefits while waiting for the client to obtain a SSN. (42CFR 435.910 (f)). Three (3) of the 53 clients did have a SSN in the electronic case record or ACES remark screens and were correctly deemed eligible for Medicaid. Thirty-five (35) of the 53 clients did not have a SSN and were in error.*

Auditor's Concluding Remarks

We were informed by Department staff that applications for the Medicaid program are entered into the Automated Client Eligibility System (ACES). It is our understanding that this may occur through either ACES mainframe or through on-line access. It is also our understanding that information entered through the on-line system is processed and integrated into ACES mainframe in "real time". Thus, regardless of what system is used to enter the data, the application information including the Social Security number should be in the system.

The State On-Line Query (SOLQ) system is available to all staff that process applications for the Medicaid program. Staff does not systematically use this access to verify Social Security numbers <u>at the time of application</u>. When verifications are made only through the ACES federal interface, a federal alert is sent to the Department informing it of applications processed with invalid Social Security numbers. The Department does not have a system to

routinely monitor alerts sent by the interface. Consequently, clients with invalid social security numbers can remain in the system and receive benefits that they may not be entitled to, sometimes for years.

The Social Security numbers that the Department discusses in its response were not present in its eligibility system during our audit work. There is no audit trail in this system. This means that changes can be made to information in the system without indicating the date or the individual that made the change.

Each recipient of Medicaid is required to have a valid Social Security number. Federal statute mandates that the Department must require, as a condition of eligibility, each individual (including children) requesting Medicaid services furnish each of his or her social security number. This would include Take-Charge clients and children receiving adoption support services. Payments made on behalf of clients without valid Social Security numbers are not allowable costs under the Medicaid program.

We reaffirm our finding that the Department of Social and Health Services, Health and Recovery Services Administration, is not complying with the federal regulations that require people receiving Medicaid benefits to have valid Social Security numbers.

Applicable Laws and Regulations

The Code of Federal Regulations is explicit regarding obtaining and verifying Social Security numbers as a condition of Medicaid eligibility. 42 CFR 435.910 (a) specifically states in part:

> The agency must require, as a condition of eligibility that each individual (including children) requesting Medicaid services furnish each of his or her own social security numbers . . . .

42 CFR 435.910 (g) states:

> The agency must verify each SSN of each applicant and recipient with SSA, as prescribed by the commissioner, to insure that each SSN furnished was issued to that individual and to determine whether any others were issued.

If a Medicaid applicant cannot remember or has not been issued a Social Security number, 42 CFR 435.910 (e) (1-3) states that the agency must:

> (1) Assist the applicant in completing an application for an SSN;
>
> (2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and
>
> (3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

42 CFR 435.916 (a) states in part:

> The agency must re-determine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months . . .

42 CFR 435.920 (a-c) states:

> (a) In re-determining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN.
>
> (b) If the case record does not contain the required SSNs, the agency must require the recipient to furnish them and meet other requirements of 435.910.

If the agency initially established eligibility without verification of the Social Security number, 42 CFR 435.920 (c) requires:

> For any recipient whose SSN was established as part of the case record without evidence required under the SSN regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with 435.910.

The Medicaid State Plan incorporates the above references as applicable to Washington State's coverage and eligibility criteria when it states the following:

> The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

05-21 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), has not established internal controls sufficient to ensure payment rates to its Healthy Options managed care providers are based on accurate data.

Background

Managed care providers receive a uniform, pre-determined, per-patient monthly rate regardless of the number of times they see a client that month and regardless of the services provided, as long as the services are covered under the plan. Although these providers are not paid based on the types of procedures, they still must report to the Administration the types of procedures they have performed. This data is to include demographic, diagnostic and geographic information, as well as actual costs on a summary level.

The Administration contracts with an actuary to analyze the data from managed care providers and to predict the cost of care for the next year. This actuary is responsible for the accuracy of the computations. From this information, the Administration determines a rate for each Healthy Options managed care plan. In general, the plans including sicker people will receive higher rates and the plans including healthier people will be given lower rates. Before assigning these rates, the Administration is to compare them to fee-for-service costs to ensure the managed care rates are not higher.

For the past few years, the federal grantor has considered up-coding to be a significant, common risk in managed care plans. Up-coding occurs when a provider reports a higher level of service than what is actually provided. This gives the impression that the provider is treating sicker people than it really is. Up-coding results in future rates being set higher than they would be if services were reported accurately.

In our 2003 audit, we reviewed the Administration's controls to determine if procedures were in place to review the accuracy of data received from providers and used to determine the rates for its Healthy Options managed care program. We found the following weaknesses:

- The Administration generally did not review its fee-for-service data for reliability and accuracy before passing it on to the actuary. The validity of this data is crucial because it helps to determine what managed care providers will be paid the following year.

- Information comparing the fee-for-service costs to the Healthy Options Managed Care costs was not easily or readily obtainable for analysis. The Administration was unable to provide this data for our review during our audit.

- Although fraud detection, enforcement and prevention procedures were being developed and refined, only certain types of provider billings (for example, dentists and pharmacists) were being analyzed and pursued if issues were noted.

During our 2004 audit, we attempted to determine what progress the Department had made in strengthening internal controls. We found some improvements. Fraud detection, enforcement and prevention procedures have been developed and we found evidence that frauds are reported to the Medicaid Fraud Control Unit as required by federal regulations.

However, we found:

- The Administration still does not review its fee-for-service data for reliability and accuracy before passing it on to the actuary. It relies on automated analyses within the system to detect errors, but these analyses cannot detect all errors, particularly those that involve possible fraud, such as up-coding.

- The Administration has no policies or procedures that include monitoring functions for up-coding.

- The Administration does not compare fee-for-service costs to managed care costs to ensure the managed care costs are not higher.

- Data comparing fee-for-service costs to the managed care costs were not easily or readily obtainable for analysis. The Administration was unable to provide us with this data for our review during our audit.

- The federal grantor stated that, while it approved the Administration's current rate-setting method, it still considered it to be "problematic" because it requires managed care providers to report only demographic data, such as age and gender, without requiring them to report the costs of providing services. This limits usefulness of the data. Because the regulatory requirements for actuarially-sound rate development are new, the federal grantor has given Washington the flexibility to use alternate means of rate development for the next few years, with the understanding that the quality of required provider data will be improved for subsequent contracts. In the meantime, the state is required to submit semi-annual progress reports describing its efforts to improve data quality. We found no documentation supporting that the Administration submitted either of the two reports required during the past year, although the Administration stated it submitted one of them verbally.

Description of Condition

During our current audit, we attempted to determine what improvements the Department had made to strengthen controls and comply with the requirements stipulated by the federal grantor.

We found that the Department submitted the semi-annual progress reports to the Center for Medicare and Medicaid (CMS) as required. CMS reported it was in the process of reviewing the progress reports, but had not been able to reach a definitive conclusion as to whether the Department has satisfactorily addressed the issues.

CMS also reported that, while it approved the Administration's methodology for rate-setting, it still considered the data to be of limited usefulness because the Department requires that managed care providers only report demographic data, such as age and gender, without requiring them to report the costs of providing services.

Cause of Condition

- The Department reported it did not agree with the finding issued in 2003 or 2004 and has made no changes in the manner it monitors data submitted by managed care providers.

- The Department reported it does not compare fee-for-service costs to managed care costs to ensure the managed care costs are not higher because of the limitations of their computer systems.

Effect of Condition

When costs are not analyzed correctly, excessive rates may be paid to managed care providers. Additionally, the effects of fraud caused by up-coding may not be realized until some time in the future if ever.

Up-coding by managed care providers may not be subject to prosecution under the False Claim Act because the managed care plan is not receiving a benefit at the time the treatment is given. When the risk for penalty or sanction is nonexistent, there is no legal deterrent to the submission of false data.

From January 2004 through December 2004, the state made $917,124,619 in payments to managed care providers. This represents the expenditures that the state has made to providers and for which we found no reasonable assurance that the rate was based on accurate data.

Recommendation

We recommend that the Department adequately analyze data used in rate-setting to ensure rates are set based on accurate information.

Department's Response

The Department disagrees with the State Auditor's Office findings related to managed care. Specific responses are listed below.

The auditor asserts that the data the Department requires managed care providers to submit is insufficient to ensure that managed care rates are accurate and that up-coding is an issue the Department is not sufficiently addressing. The auditor does agree that the Centers for Medicare and Medicaid Services (CMS) has reviewed and approved the Department's rate setting process through 2005, and that data received from the plans is sufficient for rate setting purposes. The Department continues to work with CMS to ensure that data received from the plans complies with all federal regulations. A project has begun in which the actuary will review submitted encounter data and compare this data to experience (cost) data to ensure that data used for rate setting purposes is complete and accurate. The project will also allow the Department to analyze if there are incidences of up-coding occurring in the managed care program. Encounter data will be analyzed to identify the expected cost for services provided. This will be compared to actual payment (cost) data to determine if encounter submissions reflect the level of payment provided by the plans to providers. This project is planned for completion by April 30, 2006.

The auditor states that the Department does not compare fee for service costs to managed care costs to ensure that managed care is cost efficient. This activity cannot be done with the data that the Department has access to, because the populations in managed care are fundamentally different from those in fee for service. Most Temporary Assistance for Needy Families Program (TANF) children and pregnant women are enrolled in managed care. It is a mandatory requirement so those populations are not part of the fee for service coverage group. These populations have very different health care needs, service patterns and costs than those in fee for service, which include the elderly and the disabled. In order for the Department to examine whether managed care is more efficient than fee for service, an initiative would have to be mandated and funded to determine the answer to this question. The Department does not have sufficient resources to complete this study.

Auditor's Concluding Remarks

The State Auditor's Office does not agree with "the data received from the plans is sufficient for rate-setting purposes". The Department is not reviewing the data or monitoring for up-coding and so we do not know if the data is sufficient or reliable. The reliability of the data is crucial because it is used by the actuary to determine the rate that will be paid to managed care providers for services they provide to Medicaid clients.

While CMS has approved the <u>process</u> by which rates are set through 2005, it has not approved the rate used by the Department. The federal grantor has required the state to submit periodic progress reports describing efforts to improve data quality. We contacted CMS during our audit and it is reviewing the corrective action plan from an audit it conducted in this area.

The Department states a project has begun in which the actuary will review data submitted by the managed care providers and compare it to cost data to ensure that data used for rate setting purposes is complete and accurate. It is impossible for the actuary to verify that data submitted by the Department on behalf of the providers is either complete or accurate. The actuary, for instance, will not be able to determine the presence of up-coding. Only the Department, in comparing medical records with billing records, can determine this. We will review this project during our next audit.

The Department's statement regarding the sufficiency of its resources to perform its functions cannot be answered in this audit. We will refer this to the Performance Audit Team.

We reaffirm our finding that Department of Social and Health Services, Health and Recovery Services Administration, has not established internal controls sufficient to ensure payment rates to its Healthy Options managed care providers are based on accurate data.

Applicable Laws and Regulations

Office of Management and Budget Circular A-133, Compliance Requirement, states:

> A state may obtain a waiver of statutory requirements in order to develop a system that more effectively addresses the health care needs of its population. A waiver may involve the use of a program of managed care for selected elements of the client population or allow the use of program funds to serve specified populations that would be otherwise ineligible (Sections 1115 and 1915 of the Social Security Act).

The March 2004 federal Office of Management and Budget Circular A-133 Compliance Supplement, page 4-93.778-16, states in part:

> . . . The State plan must provide methods and procedures to safeguard against unnecessary utilization of care and services . . . The State Medicaid agency must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. The agency must have procedures for the ongoing post-payment review, on a sample basis, of the need for and the quality and timeliness of Medicaid services.

Title 42, Code of Federal Regulations, Section 456.3, states the following as it pertains to surveillance and utilization control:

> The Medicaid agency must implement a statewide surveillance and utilization control program that -
>
> > (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;
> >
> > (b) Assesses the quality of those services;
> >
> > (c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part . . . .

05-22 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), made supplemental Medicaid payments to public hospital districts totaling $41,154,000 without a federally approved payment methodology.

Background

Since 1999, the Department of Social and Health Services has provided supplemental Medicaid funds to eligible public hospital districts with nursing home facilities that meet established criteria. These payments are intended to preserve access to health care in rural areas and are subject to the availability of federal matching funds. The Department's Medical Assistance Administration refers to these supplemental funds as Proshare and has provided for Proshare in an amendment to the Washington Medicaid State Plan.

Each state receiving these supplemental funds has the flexibility to determine how to calculate the payments. Federal rules require each state to include in its state plan a detailed description of the specific payment method to be used and this method must be approved by the federal grantor. If this payment method is not included in a state's plan, the state must submit an amendment to describe the method; otherwise, the supplemental payments are not allowable.

During our audit in 2004, we attempted to identify expenditure trends. During our comparison of fiscal year 2004 expenditures to fiscal year 2003 expenditures, we identified a fiscal year 2003 discrepancy of $10 million between the state's official accounting system and the Administration's records. We attempted to determine the cause of this discrepancy. In addition, as our audit proceeded, we found other significant issues, some resulting from previous Proshare payments that caused us to expand our scope. As a result, we also attempted to determine why:

- The Administration adjusted a fiscal year 2002 federal report to correct a $733 million dollar overpayment of state and federal funds it received in state fiscal year 2002.

- During the third quarter of fiscal year 2003, an additional adjustment of $16 million was required to resolve the fiscal year 2002 overpayment.

Due to a client-imposed scope limitation, we were unable to perform the necessary review to determine if payments the state made to public hospital districts, under the Proshare program, were allowable and if the additional issues we noted could be reasonably explained.

The Administration stated that the Medicaid State Plan contains information on the payment method, but we did not find the detailed description of the Administration's method in the State Plan that is required by federal regulations.

The Administration also stated that the three discrepancies were due to errors in calculation method. However, it did not respond to our questions regarding the number of years this incorrect method was used and did not provide us with a description of that method. The Administration also stated that the federal grantor approved its calculations used to adjust all three discrepancies. However, it provided no documentation to support the representation.

Description of Condition

During our current audit, we found that the Department has made two Proshare payments totaling $41,154,000 since December 2004. We found no evidence these payments were made with a payment methodology that was approved by the federal government and included in the Medicaid State Plan. Based on our interviews with staff, our review of the Department's corrective action plan and our examination of the State Plan amendments submitted by the Department to the federal government, no changes were made to correct the internal control weakness identified in the previous audit.

Cause of Condition

The Administration reported that it did not agree with the finding issued in 2004. However, in its corrective action plan, the Department did agree that the Proshare program was not well documented in the Medicaid State Plan.

The Department reported that the Proshare program is to be phased out and will be replaced by the Certified Public Expenditures program as of June 30, 2005. Because of the phase-out, the Department indicated it saw no need to improve the conditions under which the two payments issued under the Proshare program were made.

Effect of Condition

Total intergovernmental transfers attributable to the Proshare program for the period December 2004 through May 2005 were $41,154,000. The state received $20,577,000 in federal Medicaid matching funds for these payments. The intergovernmental transfers represent the amount of money that the state distributed without a documented federally-approved payment methodology.

Recommendation

We recommend the Department:

- Amend the Medicaid State Plan to include a federally-approved payment methodology for any future intergovernmental transfers involving federal Medicaid funds.

Department's Response

The Department concurs with this finding.

The Department has submitted a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS), the federal Medicaid funding authority, to clarify the methodology for nursing home supplemental payments known as "Proshare". The amendment was submitted to CMS for review on July 25, 2005. CMS has asked for information on the amendment; information has been provided as recently as January 31, 2006.

Auditor's Concluding Remarks

We appreciate the steps the Department is taking to resolve this issue. We will review the condition during our next audit.

Applicable Laws and Regulations

The March 2004 federal Office of Management and Budget Circular A-133 Compliance Supplement, page 4-93.778-16, states in part:

> . . . The State plan must provide methods and procedures to safeguard against unnecessary utilization of care and services . . . . The State Medicaid agency must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. The agency must have procedures for the ongoing post-payment review, on a sample basis, of the need for and the quality and timeliness of Medicaid services.

Title 42, Code of Federal Regulations, Section 456.3, states the following regarding surveillance and utilization control:

> The Medicaid agency must implement a statewide surveillance and utilization control program that -
>
> > (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;

(b) Assesses the quality of those services;

(c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part . . . .

05-23 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), does not ensure that providers of motorized wheelchairs have the documentation required to substantiate claims for payment.

Background

Durable medical equipment is equipment that can withstand repeated use by ill or injured people in a home setting. Some durable medical equipment, such as canes, walkers, crutches and wheelchairs, can give a person more mobility and greater independence.

An April 2004 report of the U. S. General Accountability Office (GAO) stated Medicare spending for power wheelchairs rose 450 percent from 1999 through 2003 while overall spending for the program increased 11 percent. This spending growth raises concerns that Medicare may be making improper payments to providers of motorized wheelchairs. These concerns also may apply to Medicaid.

In September 2005, GAO reported that, in fiscal year 2004, the Centers for Medicare and Medicaid Services (CMS) estimated Medicare improperly paid $900 million for durable medical equipment. The report said some of these improper payments were due to fraud by suppliers.

Medicaid claims for power wheelchairs are paid in one of two ways:

1. As a payment for a benefit covered solely by the Medicaid program.

    - In Washington State, Medicaid-only claims require specific documentation prior to payment approval. This documentation must include a prescription signed by a physician or other licensed health practitioner, proof of medical necessity and the patient's confirmation of delivery. In addition, prior written authorization by the Administration is required for some wheelchair claims with five or more line items. Additionally, the estimated length of need for a patient cannot exceed six months for Medicaid-only claims. After that time, the need must be re-evaluated.

2. As a co-payment with Medicare for clients who are eligible for benefits under Medicaid and Medicare.

    - Claims paid by both Medicare and Medicaid are called crossover claims. These claims make up the majority of reimbursements for power wheelchairs in Washington State. In this case, Medicare is the primary payor. If a client's Medicare coverage does not pay the entire claim, any remaining balance is paid by Medicaid. The Administration requires no pre-authorization for these claims.

During our 2004 audit, we found that the Health and Recovery Services Administration (formerly Medical Assistance Administration) only reviewed a selected number of Medicaid-only claims based on irregularities in billing and provider practices. For that audit, we selected three providers of power wheelchairs for on-site review and identified payment documentation weaknesses with all 90 claims reviewed.

Our audit found the Administration relies solely on Medicare to determine the validity of a claim even though Medicaid reimbursement requirements are more restrictive. No prior authorization or secondary review is required. We also found if Medicare later deems a payment ineligible, Medicaid will not be notified and the payment still will be made.

We questioned the costs associated with the 90 claims and concluded the weaknesses we found increased the risk that providers could submit fraudulent requests for payment that would not be detected in a timely manner if at all.

Description of Condition

In 2005, we reviewed this area to determine if the weaknesses found in our previous audit had been resolved. We found:

- No changes in policies or procedures have been made. The Administration has submitted a draft to revise the Washington Administrative Code removing some of the requirements to make it less restrictive for suppliers and more consistent with Medicare billing requirements. However, this did not occur during our audit period.

- The Administration stated it is designing a standardized prescription form. At the time of our audit, this was still under review within the Department.

- The Administration did not follow up on any of the 90 claims identified in our 2004 audit as having inadequate documentation to support the claim.

- The Administration performed no reviews of suppliers of power wheelchairs to ensure compliance with the claim requirements.

Cause of Condition

The Department stated in its corrective action plan that it did not agree with our finding of 2004. It reported it still believes relying on Medicare billing and documentation requirements is adequate for Medicaid.

Effect of Condition

Without ensuring Medicaid claim reimbursements satisfy documentation requirements, we do not have reasonable assurance that the $3,451,017 paid to providers of power wheelchairs for the period January 1, 2005 through December 31, 2005 are allowable expenditures under the Medicaid program. One-half of these questioned costs ($1,725,509) were paid with federal funds.

Recommendation

We recommend that the Administration:

- Ensure its providers are familiar with the differences in documentation requirements for Medicare and Medicaid.

- Standardize prescription and proof of medical necessity forms to facilitate compliance by providers.

- Establish controls to perform adequate reviews of payment support documentation prior to making payments for motorized wheelchairs. Ensure reviews include verification of allowability for the Medicaid portion of costs for Medicare cross-over claims.

- Work with the U.S. Department of Health and Human Services to determine if any unsupported costs charged to Medicaid must be returned.

Department's Response

The Department partially agrees with this finding.

The Department believes that prior authorizations for dual eligible clients would be an unnecessary burden on the Department, on providers and on clients. This requirement would not be cost effective given the medical necessity requirements fall to Medicare and the State's return would only be a co-pay of a few dollars per claim. This potential savings does not offset the overhead costs necessary for a prior authorization activity. Medicare has improved their guidelines including a prior authorization process, which appears to be very stringent.

With respect to the auditor's recommendation for standard Medical Necessity forms for wheelchair reimbursements, the Department currently requires completion of a medical necessity form for client purchased wheelchairs residing in a skilled nursing facility. The medical necessity form for client purchased wheelchairs residing outside of a skilled nursing facility is optional at this time; however, the Department is exploring a process and form for this situation with planned implementation in 2006.

Standardized prescription forms are currently being reviewed internally. Once approved, advance notification to our stakeholders, updated billing instructions, and a possible Washington Administrative Code (WAC) change will be put in place. Implementation is planned for December 2006.

Auditor's Concluding Remarks

The Department reports that the state's portion of reimbursements for motorized wheelchairs for Medicare crossover claims is only "a few dollars per claim". However, our review found these co-pays range from $1,100 to $1,200 per claim.

The Department's claims that Medicare guidelines include a prior authorization process which "appears to be very stringent" is contrary to the reports that we found with respect to Medicare's controls in this area. The U.S. Government Accountability Office issued a report in September 2005, *More Effective Screening and Stronger Enrollment Standards Needed for Medical Equipment Suppliers.* This report was critical of verifications Medicare uses to ensure suppliers meet standards before submitting claims. The report estimated that Medicare improperly paid $900 million in fiscal year 2004 for durable medical equipment. This was due in part to fraud by suppliers.

We reaffirm our finding that without ensuring Medicaid claim reimbursements satisfy documentation requirements, we do not have reasonable assurance that all expenditures for power wheelchairs are eligible for reimbursement by the Medicaid program.

Applicable Laws and Regulations

WAC 388-543-1100 Scope of coverage and coverage limitations for DME and related supplies, prosthetics, orthotics, medical supplies and related services, states:

> The federal government deems **durable medical equipment (DME)** and related supplies, **prosthetics**, **orthotics**, and **medical supplies** as optional services under the **Medicaid** program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment **(EPSDT)** program. The **department** may reduce or eliminate coverage for optional services, consistent with legislative appropriations.
>
> > (1) The medical assistance administration (MAA) covers DME and related supplies, prosthetics, orthotics, medical supplies, related services, repairs and labor charges when all of the following apply. They must be:
> >
> > > (a) Within the scope of an eligible client's medical care program
> > >
> > > (b) Within accepted medical or physical medicine community standards of practice;
> > >
> > > (c) Prior authorized as described in WAC 388-543-1600;
> > >
> > > (d) Prescribed by a qualified **provider,** acting within the scope of the provider's practice. The prescription must state the specific item or service requested, diagnosis, prognosis, estimated length of need (weeks or months, not to exceed six months before being reevaluated), and quantity;
> > >
> > > (e) Billed to the department as the payer of last resort only. MAA does not pay first and then collect from Medicare;

(f) **Medically necessary** as defined in WAC 388-500-0005. The provider or client must submit sufficient objective evidence to establish medical necessity. Information used to establish medical necessity includes, but is not limited to, the following:

(10) MAA covers the following categories of medical equipment and supplies only when they are medically necessary, prescribed by a physician or other licensed practitioner of the healing arts, are within the scope of his or her practice as defined by state law, and are subject to the provisions of this chapter and related WACs:

(a) Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;

(b) Wheelchairs and other DME;

WAC 388-543-1225 states:

Provider requirements.

(1) Providers and suppliers of durable medical equipment (DME) and related supplies, prosthetics and orthotics, medical supplies and related items must meet the general provider documentation and record retention requirements in WAC 388-502-0020. In addition to these requirements, the medical assistance administration (MAA) requires providers to furnish, upon request, documentation of proof of delivery as stated in subsections (2) and (3) of this section.

(2) When a provider delivers an item directly to the client or the client's authorized representative, the provider must be able to furnish proof of delivery when MAA requests that information. All of the following apply:

(a) MAA requires a delivery slip as proof of delivery, and it must:
(i) Be signed and dated by the client or the client's authorized representative (the date of signature must be the date the item was received);
(ii) Include the client's name and a detailed description of the item(s) delivered, including the quantity and brand name; . . . .

WAC 388-502-0100 states in part:

General conditions of payment.

(1) The department reimburses for medical services furnished to an eligible client when all of the following apply:

(a) The service is within the scope of care of the client's medical assistance program;

(b) The service is medically or dentally necessary;

(c) The service is properly authorized;

WAC 388-543-1100 states in part:

Scope of coverage and coverage limitations for DME and related supplies, prosthetics, orthotics, medical supplies and related services.

The federal government deems durable medical equipment (DME) and related supplies, prosthetics, orthotics, and medical supplies as optional services under the Medicaid program, except when prescribed as an integral part of an approved plan of treatment under the home health

program or required under the early and periodic screening, diagnosis and treatment (EPSDT) program. The department may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

(1) The medical assistance administration (MAA) covers DME and related supplies, prosthetics, orthotics, medical supplies, related services, repairs and labor charges when all of the following apply. They must be:

(a) Within the scope of an eligible client's medical care program;

(b) Within accepted medical or physical medicine community standards of practice;

(c) Prior authorized as described in WAC 388-543-1600;

(d) Prescribed by a qualified provider, acting within the scope of the provider's practice. The prescription must state the specific item or service requested, diagnosis, prognosis, estimated length of need (weeks or months, not to exceed six months before being reevaluated), and quantity;

(e) Billed to the department as the payer of last resort only. MAA does not pay first and then collect from Medicare; . . .

(10) MAA covers the following categories of medical equipment and supplies only when they are medically necessary, prescribed by a physician or other licensed practitioner of the healing arts, are within the scope of his or her practice as defined by state law, and are subject to the provisions of this chapter and related WACs:

(a) Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;

(b) Wheelchairs and other DME . . . .

05-24 The Department of Social and Health Services, Office of Financial Recovery and Health and Recovery Services Administration (formerly Medical Assistance Administration), does not have adequate internal controls to ensure that final settlement amounts are refunded to the federal government and in a timely manner.

Background

The federal Medicaid program requires that quarterly federal payments to states must be adjusted for prior overpayments or underpayments. In the event of overpayment, federal regulations require the adjustment be made within 60 days of discovery of the overpayment or within 60 days of when the receivable was established, whichever is earlier. The Department notifies the provider of the overpayment before the receivable is established.

States must refund the federal share of overpayments subject to recovery by reducing the amount claimed for the quarter. If the state is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectible, the state does not have to refund the overpayment.

Description of Condition

For our audit of fiscal year 2005, we wanted to determine if the Administration had controls that would ensure the federal portion of provider overpayments was refunded to the federal government, as regulations require. We obtained a list of fiscal year 2004 overpayments from Health and Recovery Services Administration's (formerly Medical Assistance Administration), Office of Payment Review and Audit. We also obtained a list of amounts due that the Office of Attorney General's Medicaid Fraud Control Unit established in 2003. We wanted to obtain both lists to determine the consistency in which these obligations were included on the claim form filed with the Medicaid program.

We found significant internal control weaknesses. We found the Office of Financial Recovery establishes a receivable based on the date it receives an audit report, rather than the date the receivable is discovered by the Administration, as federal law requires. Also, there appears to be confusion on the amount of recoupment that should be set up as a receivable by the Office of Financial Recovery. This is because the Administration first sends the Office a draft version of the audit report sent to the provider and sometime later the final audit report. We found the Department refunds the amount reported in the draft, in which the amount to be recouped often is significantly higher than the amount noted in the final report. This practice causes erroneous amounts to be sent to the federal government. For example, in one instance, the draft reported the provider owed $17,845,324 while the final audit report required that the provider pay only $376,591. The amounts reported in the draft report are reversed in later months but the Department does not have procedures to refund to the federal government the final settlement amount if a draft report was first issued.

We reviewed 18 overpayments totaling $1,885,315 to determine if the federal portion of the final settlement amount was refunded to the federal government in a timely manner. We found eight payments (54 percent) were not refunded and seven payments (39 percent) were not refunded in a timely manner.

Cause of Condition

- The Department believes the federal portion of the overpayment must be refunded within 60 days of being established as a <u>receivable</u> rather than within 60 days of <u>discovery</u>, as the law requires.

- Administrations within the Department do not communicate regarding Medicaid overpayments.

- Overpayments are not tracked. No one office or person maintains a list of identified Medicaid overpayments and whether they are collected. The Office of Financial Recovery does not know what overpayments are due from areas within the Department or from the Medicaid Fraud Control Unit.

Effect of Condition

- $479,126 is the federal portion of overpayments that was not refunded to the federal government and thus is questioned. $358,709 of the overpayments, the federal portion of which is $181,549, was refunded, but not timely.

- The inadequate internal control system does not offer reasonable assurance that refunds of the federal portion of all Medicaid overpayments would occur within 60 days from the date of discovery as required.

- Due to the lack of communication between Administrations regarding Medicaid overpayments and the differences between the draft and final versions of the audit report, we have no reasonable assurance that overpayments will be refunded to the federal government at all.

Recommendation

We recommend the Department:

- Comply with the federal requirement that it refund the federal share of overpayments at the end of the 60-day period following discovery.

- Health and Recovery Services Administration's Office of Payment Review and Audits send the final version of audit reports to Office of Financial Recovery.

- Work with the U.S. Department of Health and Human Services to determine if the federal portion of un-refunded overpayments charged to Medicaid should be returned.

Department's Response

The Department partially concurs with this finding. The following are responses to each condition in the finding:

- *The Department concurs with the cited condition that the Department was refunding the federal share of overpayments within 60 days of being established as a receivable rather than within 60 days of discovery. The Department is in the process of finalizing new policies and procedures that will ensure the federal share of overpayments are remitted to the Federal government pursuant to Code of Federal Regulations (CFR) 433.312.*

- *The Department partially concurs with the cited condition that the Department does not communicate regarding Medicaid Overpayments. In the past, the Administrations did communicate with each other, however, the communication was informal and on a case by case basis. Within the last few months, staff from the Office of Financial Recovery and the Health and Recovery Services Administration began meeting monthly to monitor the overpayment process.*

- *The Department does not concur with the cited condition that the Department does not track overpayments. The Office of Financial Recovery has exclusive authority to manage and track all Medicaid overpayments and the Office maintains a subsidiary ledger of all Medicaid overpayments.*

Auditor's Concluding Remarks

The Department has indicated that within the last few months staff have begun meeting monthly to monitor the overpayment process. This was never brought to our attention during our audit and the Department has given us no evidence to substantiate these representations. We will review any corrective action that the Department has made to this condition during our next audit.

We are aware that the Office of Financial Recovery tracks all overpayments that it knows of from establishment of the receivable through the repayment by the provider to the Department of Social and Health Services. However, the Office is not tracking that the recouped overpayments are refunded to the federal government or that the correct amount is refunded.

We reaffirm our finding and our recommendation that the Department track overpayments through the entire refunding process and ensure that the federal government receives the proper refund amount in a timely manner.

Applicable Laws and Regulations

[Code of Federal Regulations]
[Title 12, Volume 1]
[Revised as of January 1, 2003]
From the U.S. Government Printing Office via GPO Access
[CITE: 42CFR433.312]

Subpart F--Refunding of Federal Share of Medicaid Overpayments to Providers, Sec. 433.312 Basic requirements for refunds, states:

(a) Basic rules.

(1) Except as provided in paragraph (b) of this section, the Medicaid agency has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.

(2) The agency must refund the Federal share of overpayments at the end of the 60-day period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider.

(b) Exception.

The agency is not required to refund the Federal share of an overpayment made to a provider when the State is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business in accordance with Sec. 433.318.

(c) Applicability.

(1) The requirements of this subpart apply to overpayments made to Medicaid providers that occur and are discovered in any quarter that begins on or after October 1, 1985.

(2) The date upon which an overpayment occurs is the date upon which a State, using its normal method of reimbursement for a particular class of provider (e.g., check, interfund transfer), makes the payment involving unallowable costs to a provider.

Subpart F--Refunding of Federal Share of Medicaid Overpayments to Providers, 42CFR433.318, Overpayments involving providers who are bankrupt or out of business, states in part:

(a) Basic rules.

(1) The agency is not required to refund the Federal share of an overpayment made to a provider as required by Sec. 433.312(a) to the extent that the State is unable to recover the overpayment because the provider has been determined bankrupt or out of business in accordance with the provisions of this section . . .

(b) Overpayment debts that the State need not refund. Overpayments are considered debts that the State is unable to recover within the 60-day period following discovery if the following criteria are met:

(1) The provider has filed for bankruptcy, as specified in paragraph (c) of this section; or

(2) The provider has gone out of business and the State is unable to locate the provider and its assets, as specified in paragraph (d) of this section . . .

(e) Circumstances requiring refunds. If the 60-day recovery period has expired before an overpayment is found to be uncollectible under the provisions of this section, if the State recovers an overpayment amount under a court-approved discharge of bankruptcy, or if a bankruptcy petition is denied, the agency must refund the Federal share of the overpayment in accordance with the procedures specified in Sec. 433.320.

Subpart F--Refunding of Federal Share of Medicaid Overpayments to Providers 42CFR 433.320, Procedures for refunds to CMS, state in part:

(a) Basic requirements.

(1) The agency must refund the Federal share of overpayments that are subject to recovery to CMS through a credit on its Quarterly Statement of Expenditures (Form CMS-64).

(2) The Federal share of overpayments subject to recovery must be credited on the Form CMS-64 report submitted for the quarter in which the 60-day period following discovery, established in accordance with Sec. 433.316, ends.

(3) A credit on the Form CMS-64 must be made whether or not the overpayment has been recovered by the State from the provider.

(b) Effect of reporting collections and submitting reduced expenditure claims.

(1) The State is not required to refund the Federal share of an overpayment when the State reports a collection or submits an expenditure claim reduced by a discrete amount to recover an overpayment prior to the end of the 60-day period following discovery.

(2) The State is not required to report on the Form CMS-64 any collections made on overpayment amounts for which the Federal share has been refunded previously.

(3) If a State has refunded the Federal share of an overpayment as required under this subpart and the State subsequently makes recovery by reducing future provider payments by a discrete amount, the State need not reflect that reduction in its claim for Federal financial participation . . .

(d) Expiration of 60-day recovery period. If an overpayment has not been determined uncollectible in accordance with the requirements of Sec. 433.318 at the end of the 60-day period following discovery of the overpayment, the agency must refund the Federal share of the overpayment to CMS in accordance with the procedures specified in paragraph (a) of this section.

05-25 The Department of Social and Health Services' Office of Accounting Services does not have adequate internal controls to ensure the federal portion of uncashed and cancelled warrants is refunded at the appropriate rate to the federal Medicaid Program.

Background

The state is required to pay part of the costs of providing health care under the Medicaid Program. Different state participation rates apply to medical assistance payments. Federal financial participation rates also differ depending on the types of costs incurred in administering the Medicaid Program, such as administration, family planning, training, computer and other costs.

Approximately 80 percent of Medicaid payments in Washington State are made with warrants. Some of the warrants to providers are never cashed and some are cancelled by the Department due to errors. At the end of each calendar quarter, the state must identify which warrants were cancelled or remain uncashed for more than 180 days. The state must refund, quarterly, the federal portion of those warrants by adjusting the electronic claim for reimbursement. If the state does not refund the appropriate amount, it will be disallowed.

The federal portion initially received for a particular Medicaid expenditure is determined by the type of service that was provided. This will in turn determine the federal financial participation rate, also called the Federal Medicaid Assistance Percentage. These rates are set by the Centers for Medicare and Medicaid Services.

Description of Condition

The electronic claim the state submits is pre-programmed with the appropriate percentage for each particular type of expenditure. As expenditures are entered into the report by the Department, the correct reimbursements are automatically calculated.

However, automatic processing is not available for refunds the state must pay to the federal government for uncashed and cancelled warrants. It is the responsibility of the state to determine the appropriate percentage.

We reviewed 876 cancelled and uncashed warrants, from July 2003 through February 2005, to determine if the percentage was correct for each warrant. We found:

Results by Warrants Processed

Time Period Tested	Number of Warrants Tested	Warrants Processed with Correct FMAP	Warrants Processed with Incorrect FMAP	Amount Refunded Incorrectly
07/03 - 06/04	566	136	430	(14,309.31)
07/04 - 12/04	176	0	176	5,852.83
07/04 - 02/05	134	100	34	887.95
Totals	**876**	**236**	**640**	**(7,568.53)**

Results by FMAP

Time Period Tested	Number of Warrants Tested	FMAP Used to Claim Reimbursement on Expenditure	FMAP Used to Process Reimbursement Refund	Amount Refunded Incorrectly
07/03 - 06/04	85	50.00%	52.95%	(15,197.27)
	345	53.32%	52.95%	887.96
	136	52.95%	52.95%	0.00
07/04 - 12/04	176	52.95%	50.00%	5,852.83
07/04 - 02/05	134	52.95%	50.00%	887.95
Totals	**876**			**(7568.53)**

Cause of Condition

The Department has no procedures to ensure the federal portion of cancelled and uncashed warrants is refunded at the correct percentage. The Department reported that its technology staff is unable to change the computer program that reports the correct percentage for cancelled warrants.

Effect of Condition

The federal portion of uncashed and cancelled warrants is being refunded at an erroneous match rate. For 876 warrants, only 236 were processed using the correct percentage. The remaining 640 warrants (73 percent of those tested) were processed using an inaccurate percentage. For the warrants we reviewed, we found the Department overpaid the federal government $7,569.

Recommendation

We recommend that the Department establish procedures to ensure the correct percentage is used for all amounts refunded to the federal government.

Department's Response

The Department concurs with this finding.

Per the recommendation of the State Auditor, 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.

Prior to February 2006, staff was not aware that the allocation code for which a payment was made would not necessarily be the allocation code with which the warrant should be cancelled. The Medicaid program is the only federal program that requires a five year adjustment history. Given that warrants are cancelled 180 days after issuance, the situations where only Medicaid warrants would be cancelled with an incorrect rate is limited to a the first six months of the Federal Fiscal year. In addition, there was no change in the federal rate between the last quarter of Federal Fiscal year 2004, all of Federal Fiscal year 2005 and Federal Fiscal year 2006.

Auditor's Concluding Remarks

We appreciate the steps the Department is taking to resolve this issue. We will review the condition during our next audit.

Applicable Laws and Regulations

Title 42, Code of Federal Regulations, Section 433.40, states in part:

> (d) Refund of FFP for cancelled (voided) checks-
>
> > (1) General provision. If the State has claimed and received FFP for the amount of a cancelled (voided) check, it must refund the amount of FFP received.
> >
> > (2) Report of refund. At the end of each calendar quarter, the State agency must identify those checks which were cancelled (voided). The State must refund all FFP that it received for cancelled (voided) checks by adjusting the Quarterly Statement of Expenditures for that quarter.
> >
> > (3) If the State does not refund the appropriate amount as specified in paragraph (d)(2) of this section, the amount will be disallowed.

Title 42, Code of Federal Regulations, Section 433.40, states in part:

> (c) Refund of Federal financial participation (FFP) for uncashed checks-
>
> > (1) General provisions. If a check remains uncashed beyond a period of 180 days from the date it was issued; i.e., the date of the check, it will no longer be regarded as an allowable program expenditure. If the State has claimed and received FFP for the amount of the uncashed check, it must refund the amount of FFP received.
> >
> > (2) Report of refund. At the end of each calendar quarter, the State must identify those checks which remain uncashed beyond a period of 180 days after issuance. The State agency must refund all FFP that it received for uncashed checks by adjusting the Quarterly Statement of Expenditures for that quarter . . .
> >
> > (3) If the State does not refund the appropriate amount as specified in paragraph (c) (2) of this section, the amount will be disallowed.

Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, states in Attachment A, Section C.4.a, states:

> Applicable credits refer to those receipts or reduction of expenditure-type transactions that offset or reduce expense items allocable to Federal awards as direct or indirect costs. Examples of such transactions are: purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds or rebates, and adjustments of overpayments or erroneous charges. To the extent that such credits accruing to or received by the governmental unit relate to allowable costs, they shall be credited to the Federal award either as a cost reduction or cash refund, as appropriate.

05-26 The Department of Social and Health Services' Office of Accounting Services does not have sufficient controls to ensure that the federal portion of uncashed warrants is refunded to the Medicaid Program in a timely manner.

Background

Approximately 80 percent of Medicaid payments are made with warrants issued by the Medical Assistance Administration. Some of the warrants to providers are never cashed, largely because the warrants cannot be delivered due to address changes. If a warrant is not cashed by 180 days after it was issued, it is no longer regarded as an allowable federal expenditure even though the state still has a liability to the vendor. The amount that was provided by the federal government must be refunded to Medicaid in the quarter the warrant was cancelled. Interest penalties accrue on transactions greater than $50,000 that are not refunded within the appropriate quarter.

The State Treasurer's Office regularly updates its computer data to identify uncashed warrants that have reached the 180-day limit and that will be automatically cancelled by the Treasurer. The Department's Office of Accounting Services is responsible for checking this information periodically and canceling the warrants through the state's Agency Financial Reporting System.

The Medical Assistance Administration is responsible for processing erroneous warrants through the Medicaid Management Information System and creating a tape which is sent to the Office of Accounting Services. The Office is responsible for creating the automated journal voucher, which will cancel the warrant in the state's Agency Financial Reporting System. The Office is to notify the State Treasurer's Office of the cancellation.

Description of Condition

In our audit of state fiscal year 2004, we found that the Office of Accounting Services had not reviewed the Treasurer's data and had not processed refunds from uncashed warrants since June 2003. The unprocessed refunds totaled $843,294. At that time, the Department was 244 days late in refunding the federal portion of $421,647 to the federal Medicaid Program and had accrued interest penalties. We found the cause of the condition was that one employee was primarily responsible for the refunding process and that this employee was away for an extended period of time.

During our audit for state fiscal year 2005, we found improvement in some of the Office's refunding procedures; however, we still found weaknesses. For the period from July 2004 through December 2004, we selected 212 warrants that had exceeded the 180-day limit. These warrants totaled $198,401, of which the federal portion was $61,316. We attempted to determine whether the warrants were processed and whether the federal portion was refunded to the Medicaid Program in the correct quarter. We found all warrants were processed and evidence that the federal portion was repaid to the Medicaid Program. However only 29 of them, of which the federal portion totaled $12,727, were refunded in the correct quarter.

In our audit of 2004, we recommended that the Department cross-train staff in all aspects of warrant cancellation and the refunding process. In our audit for the current year we found these changes had not been made. We found one employee was primarily responsible for performing this function. Our audit work in this area was initially delayed because that individual was on leave.

Cause of Condition

The refund process is time-consuming. One person is primarily responsible and sufficiently trained to perform all aspects of the refunding process for both Medicaid and non-Medicaid programs. When this employee is not in the Office, refunding activity does not occur.

Effect of Condition

The Department has not refunded $48,589 to the federal Medicaid Program in the correct quarter.

Recommendation

We recommend the Department:

- Cross train staff in all aspects of warrant cancellation and the refunding process.
- Improve the refunding process so that federal funds are repaid to the federal government in the correct quarter.
- Establish effective monitoring procedures to ensure all warrants are processed in a timely manner.

Department's Response

The Department concurs with this finding.

The Office of Accounting Services (Office) believes we have appropriate staff to address this function and have cross-trained a sufficient number of individuals to ensure adequate coverage for processing the Statute of Limitation (SOL) warrants. The Office has also improved its monitoring procedures that provide increased management oversight to ensure staffs are processing the transactions in a timely and accurate manner.

During the audit period, the Office had identified and implemented corrective action steps needed to address the finding from the prior year audit. During the on-site audit period, the primary individual assigned to this function was on annual leave and the secondary individual was out on extended medical leave. Due to this situation and other staffing changes in the Office, two additional staffs were assigned to the SOL process in February 2005. This allowed the Office to cross train additional staff and bring the Federal repayment process current for the last three federal fiscal quarters of FFY05 and forward. 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.

Auditor's Concluding Remarks

We appreciate the steps the Department is taking to resolve this issue. We will review the condition during our next audit.

Applicable Laws and Regulations

Title 42, Code of Federal Regulations, Section 433.40, states in part:

> (c) Refund of Federal financial participation (FFP) for uncashed checks-
>
> > (1) General provisions. If a check remains uncashed beyond a period of 180 days from the date it was issued; i.e., the date of the check, it will no longer be regarded as an allowable program expenditure. If the State has claimed and received FFP for the amount of the uncashed check, it must refund the amount of FFP received.
> >
> > (2) Report of refund. At the end of each calendar quarter, the State must identify those checks which remain uncashed beyond a period of 180 days after issuance. The State agency must refund all FFP that it received for uncashed checks by adjusting the Quarterly Statement of Expenditures for that quarter . . .
> >
> > (3) If the State does not refund the appropriate amount as specified in paragraph (c)(2) of this section, the amount will be disallowed.

Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, states in Attachment A, Section C.4.a:

> Applicable credits refer to those receipts or reduction of expenditure-type transactions that offset or reduce expense items allocable to Federal awards as direct or indirect costs. Examples of such transactions are: purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds or rebates, and adjustments of overpayments or erroneous charges. To the extent that such credits accruing to or received by the governmental unit relate to allowable costs, they shall be credited to the Federal award either as a cost reduction or cash refund, as appropriate.

05-27 The Department of Social and Health Services, Aging and Disability Services Administration and Health and Recovery Services Administration (formerly Medical Assistance Administration), has not set up an effective system to ensure Medicaid payments are not being made to nursing homes that are not in compliance with federally mandated health and safety standards.

Background

Under the Medicaid program, states may receive federal financial assistance for patients receiving services in nursing homes. To qualify for federal participation, nursing homes must meet certain health and safety standards.

Although the Department's Health and Recovery Services Administration has primary responsibility for ensuring that ineligible providers are not reimbursed, the Department's Aging and Disability Services Administration has primary responsibility for conducting health and safety inspections at nursing homes. If Aging and Disability Services finds a nursing home is not meeting federal standards, it notifies the U.S. Department of Health and Human Services, which then sends a denial of payment notice to the facility and to the Aging and Disability Services and Health and Recovery Services Administration. This notice prohibits the payment of federal funds for any new Medicaid admissions to the facility until the condition is corrected.

Description of Condition

During our 2002 and 2003 audits, we found neither Aging and Disability Services nor Health and Recovery Services Administrations had a complete record of nursing homes placed in denial-of-payment status. We compared both Administrations' records with the list maintained by the federal government and found Aging and Disability Services to have a 14 percent discrepancy rate in 2002 and Medical Assistance to have 33 percent and 53 percent discrepancy rates in 2002 and 2003, respectively. Additionally, we found Health and Recovery Services Administration did not monitor to ensure nursing homes in denial-of-payment status were not paid for new Medicaid admissions.

During our 2004 audit, we attempted to follow up on this issue as federal regulations require. However, we encountered difficulties in obtaining access to information. We were not allowed to access the Aging and Disabilities Services Administration's Denial-of-Payment Log and so could not complete our review. Also, we were not permitted to have one-on-one access to Health and Recovery Services Administration's line staff to complete our assessment of internal controls in that area.

In 2002 and 2003, the Department reported it had instituted a corrective action plan in which Health and Recovery Services Administration would track the denial-of-payment notices directly with the federal government rather than relying on Aging and Disability Services, as it had in the past.

During our 2005 audit, we sought to determine whether direct communications between the federal government and Health and Recovery Services Administration had improved the accuracy of the Administration's records. Health and Recovery Services Administration staff reported difficulties in obtaining timely notification for facilities in denial-of-payment status from the federal government. Health and Recovery Services Administration also reported it tried to obtain the information from Aging and Disabilities Services but was unable to do so. Staff conceded many errors are made and they often must attempt to obtain the notification letters directly from the nursing homes.

Health and Recovery Services Administration provided us with letters that the federal government had sent to the nursing homes informing them of noncompliance with standards and the dates that the facilities were to be placed in denial of payment. We found 25 percent of the entries in the federal government's log were not consistent with letters they had sent to the facilities.

Cause of Condition

Health and Recovery Services Administration does not have an effective, reliable means of receiving notification that a nursing home has been placed in denial-of-payment status. Additionally, the denial of payment information in the federal government's logs is not consistent with information given to the nursing homes.

Effect of Condition

The Department's controls will not prevent payment of federal Medicaid funds to nursing homes that are not in compliance with federal health and safety regulations. We found that the Department paid $6,138 for three clients in the 14 nursing homes we examined.

Recommendation

We recommend:

The Centers for Medicare and Medicaid Services ensure:

- Timely notification to the Department of facilities in denial of payment.
- Its records are consistent with the information given to the nursing homes.

The Department:

- Continues to improve its system for tracking the denial-of-payment notices issued by the federal government.
- Monitor the allowability of payments to nursing homes that are in denial of payment status.

Department's Response

The Department agrees with the audit finding and will continue to pursue more effective means of receiving timely notifications. Although not perfect, the Department has been routinely receiving E-mail notifications of denial of payment situations from the Centers for Medicare and Medicaid Services (CMS) in lieu of relying on receipt of notifications through the regular mail system and feel there has been some improvement since this was implemented in calendar year 2005. On November 1, 2005, the State Auditor's Office (SAO) sent an E-mail to our office which included information provided by CMS (E-mail dated August 12, 2005) providing the name of a contact to potentially obtain access to the ASPEN Enforcement Management (AEM) system. The Department did initiate contact on November 5, 2005 and were told that they would check into our request and get back to us. During this conversation some issues were raised by CMS. ASPEN is not a stand alone system, it is an Oracle driven database that has many components and ASPEN is only a portion of the system. The Department was told that our request is being reviewed (checking to see if there is a data use agreement so that information can be shared with State Medicaid Agencies). They have indicated that if it is possible there would be significant staff training associated with this access and there may be a cost involved.

The Department will pursue conversations with CMS to see if can obtain information more reliably and more quickly.

Auditor's Concluding Remarks

We appreciate the steps the Department is taking to resolve this issue. We will review the condition during our next audit.

Applicable Laws and Regulations

The Office of Management and Budget's Circular No. A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section .500(e) states:

> The auditor shall follow-up on prior audit findings, perform procedures to assess the reasonableness of the summary schedule of prior audit findings prepared by the auditee in accordance with section .315(b) . . . .

Compliance

Title 42 of the Code of Federal Regulations, Section 442.12 (a), states:

> The Medicaid agency may not execute a provider agreement or make Medicaid payments to a facility unless the Secretary or the State survey agency has certified the facility.

42 CFR 483.1 describes all of the conditions which must be met before certification can take place.

42 CFR 488.454 (b) states:

> In the cases of State monitoring and denial of payment imposed for repeated substandard quality of care, remedies continue until
>
> (1) CMS or the State determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or
>
> (2) CMS or the State terminates the provider agreement.

U.S. Office of Management and budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* subpart C, Section .300, states in part:

> The auditee shall:
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs . . . .

05-28 The Department of Social and Health Services paid providers with Medicaid funds through the Social Services Payment System for services to clients using Social Security numbers belonging to deceased persons.

Background

While most Department of Social and Health Services payments to providers from Medicaid funds are processed through the Medicaid Management Information System, some are processed through the Social Services Payment System (SSPS). Medicaid program services paid through SSPS include the Community Options Program Entry System, Supported Living Services and Medicaid Personal Care. Eligibility for these Medicaid programs is based on many factors; however, in general, a valid Social Security number is required, even for children.

In our fiscal year 2004 Medicaid Report and State of Washington Single Audit Report, we described concerns about payments to providers for clients whose Social Security numbers were the same as others reported to be deceased but whose names did not match.

Description of Condition

During this audit, we selected all SSPS records that showed payments totaling more than $300 for clients whose Social Security numbers matched those of deceased persons but whose names did not match. We found 491 exceptions indicating possible identity theft of a deceased person and potential noncompliance with Medicaid requirements.

Of the 491 reviewed, we found:

- Use of a deceased relative's Social Security number: 321 exceptions (65 percent).
- Apparent identity theft of a deceased unrelated person's Social Security number: 90 exceptions (18 percent).
- Data entry error by the Department: 83 exceptions (17 percent).

We shared our detailed results with the Department and requested any additional information it had regarding the exceptions. The Department stated that these Social Security numbers are correct in its Automated Client Eligibility System (ACES) but incorrect in the SSPS. However, data in ACES can be changed at any time, with no history maintained of these changes. Therefore, we have no assurance that ACES Social Security numbers were actually correct and supported the payments when made, or they were changed after we brought this information to the attention of the Department. Since SSPS is the payment system used, we believe its data to support payments should be accurate.

Cause of Condition

The Department has not made verification of Social Security numbers a high priority.

Effect of Condition

The Medicaid program is unnecessarily susceptible to loss because the Department cannot identify, in a timely manner, clients using Social Security numbers of deceased persons. Questioned costs as a result of this issue include federal funds of $2,232,301 and state funds of $ 2,257,783, for a total of $4,490,084.

Recommendation

We recommend the Department:

- Require staff to verify accuracy of Social Security numbers for those Medicaid clients identified in federal regulations.

- Work with the U.S. Department of Health and Human Services to determine if any unallowable costs charged to Medicaid must be reimbursed.

- Ensure staff members understand the new state law (RCW 9.35.020), which took effect July 1, 2004, and which defines first-degree identity theft as the use of false identification to obtain anything of value in an aggregate of $1,500.

In addition, we recommend the Department forward the instances of apparent identity theft to its own Post-Payment Review Office or to the appropriate legal authorities.

Department's Response

Require staff to verify Social Security Numbers for all Medicaid Clients

The auditor has determined that SSN's correctly identified in ACES are not sufficient for preventing identity theft because "data in ACES can be changed at any time, with no history maintained of these changes. Therefore, we have no assurance that ACES Social Security numbers were actually correct and supported the payments when made or if they were changed after we brought this information to the attention of the Department."

In fact, changes to SSN's are recorded in ACES on the "DEM 1" screen. The changed SSN, the financial worker's ID, and the date of the change are recorded in the "SSNA" screen, and are maintained as a record in ACES. Also included in the "SSNA" screen are the effective date for financial payments associated with the revised SSN, and verification (V) and federal verification (FV) codes that show the current status of the SSN based on the verification processes described below.

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". SSNs 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 an SSN." SSN discrepancies in Numident generate alerts to the workers as described in the ACES User Manual at http://www1.dshs.wa.gov/esa/acesman/Sections/alerts/alert_188.htm. Alert "253" describes alerts to workers when there is an SSN discrepancy in State Data Exchange (SDX), Beneficiary Data Exchange (BENDEX) or Numident.

Furthermore, 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 SSPS is the same as the SSN recorded in ACES. They report discrepancies, using ACES as the correct record of the SSN.

Most of the errors identified by the auditor are either typos, or the spouse of the deceased person receiving valid services under a correct ACES SSN that is incorrect in SSPS. It does not appear that payments for services were made in error, even though SSN's recorded in SSPS may not reconcile to ACES. The SSPS system has no capability to update or revise SSN's, and it cannot be updated to reflect the establishment or collection of overpayments; for these reasons, it cannot function as the system of record for client SSN's or payments made based on an SSN.
The problems we face 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.

Ensure staff understand the new state law (RCW 9.35.020)

A management bulletin was posted for all staff on June 2, 2005, which included a copy of Revised Code of Washington (RCW) 9.35.020.

Forward instances of apparent identify theft

Any instances of apparent identify theft will be referred appropriately. 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 Unit for recovery. No instances of identity theft were found as a result of last year's audit.

Auditor's Concluding Remarks

We reaffirm our finding, as SSPS was the system used to make the payments questioned in this year's finding. We continue to recommend that the Department use procedures to verify accuracy of the Social Security numbers that are recorded in SSPS until the new system is in place.

Applicable Laws and Regulations

The Code of Federal Regulations is explicit regarding obtaining and verifying Social Security numbers as a condition of Medicaid eligibility. 42 CFR 435.910 (a) specifically states in part:

> The agency must require, as a condition of eligibility that each individual (including children) requesting Medicaid services furnish each of his or her social security numbers (SSNs).

42 CFR 435.910 (g) states:

> The agency must verify each SSN of each applicant and recipient with SSA, as prescribed by the Commissioner, to insure that each SSN furnished was issued to that individual and to determine whether any others were issued.

If a Medicaid applicant cannot remember or has not been issued a Social Security number, 42 CFR 435.910 (e) (1-3) states that the agency must:

> (1) Assist the applicant in completing an application for an SSN;
>
> (2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and
>
> (3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

42 CFR 435.916 (a) states in part:

> The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months . . .

42 CFR 435.920 states:

> (a) In redetermining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN.
>
> (b) If the case record does not contain the required SSNs, the agency must require the recipient to furnish them and meet other requirements of Sec. 435.910.

> (c) For any recipient whose SSN was established as part of the case record without evidence required under the SSA regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with Sec. 435.910.

The Medicaid State Plan incorporates the above references as applicable to Washington State's coverage and eligibility criteria when it states the following:

> The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

RCW 9.35.020 states in part:

> (3) No person may knowingly obtain, possess, use, or transfer a means of identification or financial information of another person, living or dead, with the intent to commit, or to aid or abet, any crime.

Violation of this section when the accused or an accomplice uses the victim's means of identification or financial information and obtains an aggregate total of credit, money, goods, services, or anything else of value in excess of one thousand five hundred dollars in value shall constitute identity theft in the first degree . . . .

05-29 The Department of Social and Health Services does not have adequate internal controls over the processing of expenditures through the Agency Financial Reporting System.

Background

The Agency Financial Reporting System is the state of Washington's official accounting system. State agencies are required to enter their financial data, including accounts payable, into this System. The System has security features that, when used effectively, can reduce the risk of error or fraud in financial transactions.

Designated security administrators in each agency are responsible for determining the level of access granted to individuals within the agency and for removing access when appropriate. Access controls are available within the System to preclude any one person from having total control over a particular type of transaction.

We identified and reported internal control weaknesses related to access to the System in two previous Statewide Accountability Reports: Finding 03-15 in the fiscal year 2003 report and Finding 04-17 in the fiscal year 2004 report.

Description of Condition

This year we again reviewed to determine if the Department had improved access controls. We reviewed the types of System access the Department has granted to employees with accounts payable functions and found the Department still does not use the System's internal control features that allow for an adequate segregation of duties. Access to the accounts payable function is not secure, as described below.

a. We found that 475 Department employees have incompatible duties, with the capability of entering and approving payment batches, bypassing management review. All of these employees could process a fictitious payment without oversight or approval by anyone.

b. In addition, all 475 employees are capable of processing payments to unauthorized vendors by using certain designated codes intended for one-time, rather than recurring, payments. For fiscal year 2005, payments processed through these codes amounted to $51,972,913. Such payments do not require that the vendor be formally and independently approved and established in the System. Instead, these 475 employees can set up any vendors they wish in the System and then generate payments to them with these codes. This condition creates a risk that employees could set themselves up as vendors for these one-time payments.

c. We also noted numerous instances in which one-time payment codes were used for multiple payments to the same vendor. For instance, during the fiscal year the Department issued 46 warrants to one particular legitimate vendor using these codes. This condition increases the risk described in item b.

d. The Department's System security administrators rely on management in the hundreds of Departmental offices to notify them of requests for access, changes in access, and terminations of access. Currently, this communication is not successful. We found access to the accounts payable function through the mainframe was still in place for four of the 10 former employees whose records we reviewed in detail.

Cause of Condition

The Department stated in its response last year that it did not concur with our concerns or recommendations. It believed it has adequate compensating controls for the weaknesses we found. We analyzed the Department's corrective action plan for the fiscal year 2004 finding and concluded that the controls it described as current did not adequately alleviate the risks.

However, the Department is establishing written policies and procedures that require an adequate separation of duties and timely access changes in any of its offices with an accounts payable function. We will review the adequacy of these policies and procedures during our next audit.

Effect of Condition

These control weaknesses increase to a high degree the risk that error or misappropriation could occur and not be detected by management in a timely manner, if at all.

Recommendation

We again recommend the Department develop and follow written policies and procedures for its accounts payable function that would ensure:

- An adequate separation of duties for those involved in making payments in the System.
- Timely changes to and removals from System access when appropriate.

Department's Response

The Department partially concurs with this finding. As the Department responded the last two years, the finding is based solely on the review of system security accesses. There was not a review of compensating internal controls the Department has in place.

The finding asserts inadequate internal controls based solely on the Department's choice not to implement segregation of duties based on system access. The Department believes compensating controls are employed to provide sufficient internal control over the processing of expenditures. No audit evidence has been presented to assert the generally accepted compensating controls are insufficient.

The following are responses to each condition in the finding:

a. Management has been addressing this issue since it became an audit finding. Over the past several months, DSHS has been reviewing AFRS access. Through the August 2005 - December 2005 timeframe, the following changes have occurred:

- *Staff with the ability to Input and Release a Batch has decreased 22%.*
- *The total number of AFRS Users has decreased 17.5%.*

In February 2006, a DSHS AFRS security policy, along with a new security form, was implemented. DSHS management at each location will apply the AFRS control of separation of input and release functions where applicable. Where this security level is not adopted, staff independent of the input and release function will perform a 100% review of all data processed. The control of 100% post review has been determined by DSHS management to be a stronger control in detecting irregular payments in that AFRS does not require the reviewer scroll through the items input prior to releasing a batch. Therefore, the batch releaser could just release the batch without performing any review and the only thing we accomplished was separating the input and release function.

b. The Department partially concurs with the condition that via the use of certain designated codes (V0D1), employees can generate a warrant to anyone.
The audit report does not identify testing of compensating controls to prevent this from occurring. Compensating controls are provided through separation of payment/warrant distribution from payment generation capabilities and the review of output reports and registers. In addition, headquarters' fiscal staff reviews the V0D1 usage quarterly, for improper usage. The agency will review the current processed/controls in place to determine if they can be strengthened even though the finding does not indicate that any payments were improperly made.

c. The Department does not fully concur that there is an issue with making payments to a vendor through the V0D1 process. The agency is currently looking at ways to reduce the number of warrants generated by the V0D1 option, however, the complete elimination of this method of making payments will not occur because of

business needs. The use of making payments through V0D1 is appropriate for such items as making payments to other Washington governmental entities for garnishments, lost stolen warrant reissues, SSPS provider tax refunds and several other types of transactions that do not require registering the payee.

d. The Department partially concurs with the condition that communication has not been successful to timely terminate system access for some terminated employees. Steps have been taken to identify those individuals with inappropriate access as well as improve the access documentation processes. In the Fiscal Year 2003 finding, SAO noted 40 cases. This year they noted 4 cases which illustrates the Department has been addressing this item. Efforts have been initiated to explore alternatives to relying solely on manager communication for access terminations. Such alternatives being reviewed include performing an agency AFRS user access review every April and October.

Auditor's Concluding Remarks

We agree that the Department has some compensating controls in place which may **detect** errors or misappropriations after the fact. We are recommending a proper separation of duties in System access to help **prevent** errors or misappropriation from occurring. Since the Department issues billions of dollars in payments each year through the AFRS system, preventative controls are necessary. The Office of Financial Management has stated there is no System limit to the amount of one payment; therefore, an employee could input and release as large a check as desired for personal use and leave town before any of the Department's detection activities found the misappropriation. We reaffirm our finding and recommendations.

Applicable Laws and Regulations

The State of Washington Office of Financial Management's *State Administrative and Accounting Manual*, Section 20.20.20.a states in part:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

Section 20.20.70.a states in part:

> Control activities are the policies and procedures that help ensure management directives are carried out.
>
> **Segregation of duties** - Duties are divided, or segregated, among different people to reduce the risk of error or inappropriate actions. For example, responsibilities for authorizing transactions, recording them, and handling the related assets should be separated.

05-30 The Department of Social and Health Services, Division of Child Care and Early Learning, does not have adequate internal controls over support for payments to child care providers.

Background

The Department of Social and Health Services administers programs that pay child care centers and licensed family home child care providers for child care services for eligible families. The Department either pays the providers directly or pays clients directly, with the expectation that the clients will then use the funds for child care services. The Department has assigned responsibility for the Program to the Economic Services Administration, Division of Child Care and Early Learning. Payments are made from various funding sources, including several federal programs, and amounted to the following for fiscal year 2005:

- Federal – CFDA 93.575 – Child Care Development Fund-Discretionary $111,627,141
- Federal – CFDA 93.596 – Child Care Development Fund Mandatory/Matching $ 65,573,192
- Federal – CFDA 93.558 – Temporary Assistance to Needy Families $ 25,278,853
- Federal – CFDA 93.667 - Social Services Block Grant 22,369
- State $ 51,075,381

During our fiscal year 2003 and 2004 audits, we found the Division did not require adequate supporting documentation in the form of attendance records from all of its providers. The Division did not require that child care centers and family home child care providers have the parent or custodian sign the child in and out of care and note the time of arrival and departure. Attendance records that were available were not always adequate. In addition, the Division did not monitor its providers to determine if they had any attendance records to support their billings.

Description of Condition

During fiscal year 2005, the Division required family home providers and child care centers to use a standard format for signing children in and out of the facility and to maintain adequate attendance records to support their billings. We found the Division did not adequately monitor provider compliance with these requirements.

We visited nine child care centers to review attendance records. The records we chose were for the same days the licensors stated they had reviewed during on-site monitoring visits. We found many of the attendance records at the nine centers were not in compliance with the required format. For instance, parents must sign their children in and out using their full legal signatures. An exception to this requirement allows a provider to sign for school-age children who leave from and return to the provider's care during the school day. We found many cases in which various methods were used to sign children in and out with other than a full legal signature, but none of these cases related to the allowable exception. Frequently we found no signatures at all. However, seven of the licensors' monitoring checklists stated the records were in compliance. One checklist noted a discussion with the provider but no additional follow-up. Only one checklist noted noncompliance, with a follow-up comment in the compliance agreement.

We also asked 18 family home providers to send their records to us for review; only nine responded. We found attendance records for six of the nine were not in the required format and many were inadequate to support billings. The condition of the records of the nine family home providers who did not respond is unknown.

We also requested on-site monitoring documentation from the Division offices in charge of monitoring the nine child care centers and 18 family home providers. We received and reviewed monitoring checklists for all nine child care centers and 17 of the family home providers. We found the following:

- The Division did not monitor four of the nine child care centers in the required 12-month time period and did not monitor seven of the 17 family home child care providers within the required 18-month time period The monitoring visits were up to 38 months apart. The lack of monitoring documentation for the 18th family home child care provider indicates no recent monitoring has occurred there.

- The Division requires licensors to write a compliance agreement that addresses issues of non-compliance and to follow-up to ensure the issues are corrected. Non-compliance issues were identified by licensors during monitoring visits, but frequently we saw no evidence of follow-up or correction.

Cause of Condition

The Division stated it is not currently funded to conduct comprehensive monitoring of child care centers and family home providers.

Effect of Condition

The Division still cannot be assured it is paying child care providers only for the hours children actually are in care. During fiscal year 2005, the Division established overpayments to child care providers that totaled approximately $1.2 million. We believe this amount would be larger if the Division strengthened its monitoring procedures and determined overpayments for all unsupported amounts. We question the $1.2 million in overpayments made from various funding sources, including several federal programs.

(Note: For purposes of the single audit, we estimate $800,000 of this amount is federal questioned cost.)

Recommendation

We recommend the Division monitor to ensure all child care providers:

- Use the required standard attendance record format.
- Have the parent or custodian of each child sign the attendance record when the child arrives and departs from care, noting the arrival and departure times.
- Maintain adequate attendance records to support the payments made to them.

Department's Response

The Department partially concurs with these findings.

The Division of Child Care and Early Learning (DCCEL) cannot adequately address the findings regarding monitoring visit timeframes and the lack of compliance agreements without more detailed information about the cases reviewed. We have requested this information from the State Auditor's Office, and will be able to more adequately address the two issues once we've received and reviewed the information.

DCCEL has a self-imposed timeframe for monitoring visits; 12 months for centers and 18 months for family homes. In the past year specific attention has been placed on improving performance in this area. We've established in the GMAP a goal of completing 95% of monitoring visits within those timeframes. DCCEL's Eastern Region has exceeded that goal since August 2005 for both centers and family homes. Our Northwest Region has exceeded the goal since December 2005 for family homes and January 2006 for centers. The Southwest region has exceeded the goal for centers since October 2005 and for family homes since December 2005.

DCCEL Staff write licensing compliance agreements and discuss attendance record requirements with the providers. We have developed standards and training for staff, to provide information and guidelines related to attendance records, compliance agreements and necessary follow-up. Again, In order to adequately respond to this finding, we will need to review the information requested from the State Auditor's Office.

DCCEL concurs there are not adequate internal controls over support for payments made to licensed family home child care providers. DCCEL is coordinating with Division of Management & Resource Services (DMRS) Quality Assurance staff to conduct a review of family home child care providers. This audit is scheduled for April 2006. The audit will include the review of attendance records for compliance with attendance record quality requirements. DCCEL continues to work with Payment Review Program to identify and collect overpayments through the use of algorithms.

The Washington Administrative Code (WAC) requires parents to sign their children in and out of care. DCCEL has an attendance form which providers may use for attendance keeping. This is not a required form. If providers choose to develop their own attendance form, it must contain all the elements of the form developed by the department, as required by WAC. Those elements are: date, child's name, time in with parent's full signature and time out with parent's full signature. Facility staff may sign children in and out when children leave to and return from school or other scheduled activities. This is what Quality Assurance staff will look for as they audit the family home provider's attendance records.

We believe the Department will improve it's oversight of attendance records if and when the e-Child Care program is implemented. The e-Child Care program is an automated system that will be designed to improve effectiveness and efficiency of the licensing and subsidy programs. One of the many benefits will be electronic sign in and sign out in some form, which will greatly improve the quality of provider's attendance records.

Auditor's Concluding Remarks

We appreciate the Department's thorough response. We will review the new monitoring procedures and other controls implemented by the Department during our fiscal year 2006 audit.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment A, Section C, Basic Guidelines, states in part:

Factors affecting allowability of costs.

1. To be allowable under Federal awards, costs must meet the following general criteria:

    j. Be adequately documented.

The same section of the circular states in part:

> 4.a. Applicable credits refer to those receipts or reductions of expenditure-type transactions that offset or reduce expense items allocable to Federal awards as direct or indirect costs. Examples of such transactions are:…rebates or allowances, recoveries or indemnities on losses,...charges. To the extent that such credits accruing to or received by the governmental unit relate to allowable costs, they shall be credited to the Federal award either as a cost reduction or cash refund, as appropriate.

The State Plan for the Child Care Development Block Grant, October 1, 2003 – September 30, 2005, states:

> Washington State requires full licensing of child care centers and homes including on-site inspections. Centers and homes are required to renew their licenses every three years. Child care centers receive unannounced annual monitoring visits and family child care homes receive an unannounced interim monitoring visit within the three year licensing cycle. During the initial licensing period, licensors may make frequent visits to help licensees meet regulatory requirements. When licensees are issued a probationary license, licensors make frequent visits to ensure compliance with the probationary agreement. In addition, DCCEL Health Specialists inspect child care centers to determine compliance with health and safety regulations; certify, deny or revoke health certifications; and provide technical assistance to providers. These visits are conducted upon initial licensure and again before full licensure is granted.
>
> Corrective action usually includes a statement of deficiencies and a plan of correction. It can also include a probationary license, and civil penalty, license revocation or suspension....

The Department's *Licensing Methods and Practices Manual* states under "Monitoring":

Center licensors should monitor facilities annually to determine compliance with WACs. FCC licensors should monitor homes at least once every 18 months to determine compliance with WACs."

WAC 388-296-0520 states:

(1) A child's presence in the child care must be documented, on a daily basis, by the child's parent or guardian or an authorized person by using the sign-in and sign-out procedure for each child in attendance. The parent, guardian or authorized person must use their full signature when signing the child in and out of the child care.

(2) When the school age child arrives at or leaves the child care home due to school or off-site activities as authorized by the parent, you or your staff must sign out the child, and sign in the child on return to the home.

(3) Daily attendance records, listing the dates and hours of attendance of each child must be kept up-to-date and maintained in the licensed space of the family home child care for five years.

05-31 The Department of Social and Health Services, Division of Child Care and Early Learning and Children's Administration, did not perform adequate background checks.

Background

The Department of Social and Health Services administers the Child Care program, which pays child care centers and licensed family home child care providers for services provided to eligible families. The Department has assigned responsibility for the Program to the Economic Services Administration, Division of Child Care and Early Learning. The Division develops the policies and procedures used to license child care providers. About 8000 of these providers are licensed in Washington State.

The Children's Administration pays licensed foster care providers for services provided to eligible children. The Administration develops the policies and procedures used to license foster care providers. About 6000 of these providers are licensed in Washington State.

The background check process is the same for both child care and foster care provider applicants. Potential providers and anyone 16 or older who will have unsupervised or regular access to the children in care must complete a Background Check Authorization Form. This includes assistants, volunteers and members of the applicant's household. The form is used to check whether these individuals have criminal backgrounds that would disqualify them from becoming licensed child care or foster care providers, associates, or volunteers. Applicants are not licensed if household members or others with access to the children are found to have disqualifying criminal backgrounds.

On the form, the person is required to document his or her current name, date of birth and other names by which they have been known. Provision of a Social Security number is optional.

These forms are sent to the Department's Background Check Central Unit. The Unit enters the data provided into the Department database, which draws information from the Washington State Patrol's criminal history database and from the Department.

The Patrol's database includes only Washington arrests; therefore, a search of this database does not provide criminal background information in other states. Individuals can be included in the Patrol's database for several reasons:

- When someone is arrested in Washington State, the arrest cards (including fingerprints) are sent to the Patrol. After the finger prints have been searched and verified, the Patrol enters this data into the criminal history database. Once final disposition of the case is made, it is entered into the Washington Identification System.

- Fingerprints of all Washington State criminal justice employee applicants are entered into the criminal history database.

- Convicted sex/kidnap offenders are required to register with the sheriff in the county of residence. The requirement to register includes offenders who move into Washington from another state. County sheriffs send these fingerprints and photographs to be entered by the Patrol into the criminal history database.

- The Patrol allows individuals meeting certain criteria to provide their own personal identification fingerprint cards to the Patrol for inclusion in the database.

If a person reports residency in the state for more than three years, the background search does not require a fingerprint check. The Background Unit conducts the search in the Patrol's criminal history database by using the exact name and exact date of birth as given by the applicant. Other elements can match, such as Social Security numbers; however, the primary search is based on name and date of birth. Matches, if any, produce a Report of Arrest and Prosecution sheet that shows the criminal history record for this person. Sometimes this sheet includes a Washington State Department of Corrections number that the Background Unit will research. If the Background Unit finds that the person did not commit a crime in Washington State, yet has a Corrections number, it may indicate

that the person has been imprisoned or is under Correction's supervision in this state for a crime committed in another state.

If a person reports residency in Washington State for less than three years, state law gives the Department authority to require a fingerprint-based background check. The Background Unit forwards these fingerprints to the Washington State Patrol. The Patrol performs a statewide search by comparing the fingerprints on the fingerprint card to the fingerprints in the Identification System. The fingerprints are forwarded electronically, by the Patrol, to the Federal Bureau of Investigation for a nationwide search. The FBI forwards its search results electronically to the Patrol, which then switches them to the Background Unit. The statewide search results are mailed by the Patrol to the Background Unit. The Patrol and FBI search results are entered into the Department's Background Check Central Unit database as received. The results are mailed to the Division licensors.

We issued special investigation report, No. 6370, on May 28, 2003. In this report, we communicated inadequacies in the background check process performed by the Department. In our fiscal year 2003 and 2004 State Accountability Reports, we reported that the weaknesses continued.

Description of Condition

Children's Administration

This year we expanded our review of background checks to include the procedures used when licensing foster care providers. We found the Children's Administration does not require licensors to see the individuals in person and at the same time compare information provided on their Department Background Check Authorization Form to any piece of original identifying information to verify the background check will be performed on the correct person. Those individuals who will drive foster children in a car must provide only a photocopy of a driver's license. The Division does not ask for any identifying information from other providers or individuals who will have unsupervised or regular access to the children in care. In addition, applicants are not required to provide documentation of the length of their state residency.

Division of Child Care and Early Learning

To follow-up on previous audit weaknesses, we visited nine child care centers licensed and paid by the Division. We again found that applicants are not required to provide documentation of the length of their state residency.

We reviewed 98 personnel files at the nine centers for evidence of criminal background checks and adequate monitoring. We also verified criminal background check information with the Background Check Central Unit.

Seven of the nine centers could not always provide evidence of adequate criminal background checks for their employees and/or of adequate monitoring in this area by Division licensors. The following are examples of weaknesses we found:

- Thirty-nine of the 98 files did not include evidence that adequate background checks had been performed.
    - Fifteen employees at five centers were currently working even though no criminal background checks had ever been performed for them. They had been employed from 90 days to over six years.
    - Six background checks were processed using incorrect names.
    - Photo identification, such as a driver's license, was not matched to the background check application. For 33 employees, photo identification was not available in the personnel file..
- Forty-five of the 98 files had been included in monitoring reviews, but 10 of these were not adequately monitored for timeliness, completeness, and accuracy of background checks. Licensors indicated they found evidence of current criminal background checks for these 10. We reviewed the same 10 files and found background checks were not current for them at the time of the licensor's visit.

- In eight of the 45 files, monitors did not follow-up to ensure background checks were performed after previously noting that background checks were not completed.

- Licensors did not perform additional testing when inadequate background checks were identified.

- Licensors do not always perform independent reviews. They routinely select the same employee positions for review or allow providers to select the files to be reviewed.

- Files for some employees are never reviewed. Licensors do not verify criminal background checks for individuals who are no longer employed on the day of the monitoring visit. In other instances, employees are seasonal and may not be employed during the monitoring visit.

- When licensors identified noncompliance issues for background checks, they did not always follow up to ensure that the issues were corrected. We found that follow-up was not consistent, not completed in a timely manner, and frequently not completed at all.

- At four child care facilities, the Division did not monitor on a timely basis to verify that criminal background checks for employees were performed.

We also requested monitoring documentation from the Division for 18 family home providers. We received information for 17 and found the Division did not monitor seven of them on a timely basis to ensure background checks were performed.

Cause of Condition

The Department stated it does not have enough funds to correct deficiencies in criminal background check performance and monitoring.

Effect of Condition

The Department could license and pay child care and foster care providers who do not meet licensing standards or who have associates or household members who do not meet the standards of adequate background checks.

A person can provide any name or date of birth on the Background Check Authorization Form. In such a case, the background check would be performed on a name and date of birth that may be false or stolen. In addition, an applicant could falsely state residency of more than three years to avoid the fingerprinting process and nationwide search.

Recommendation

We recommend the Department:

- Require licensors to perform a visual confirmation of the person and original photo identification for each person who will have unsupervised or regular access to the children in care. This includes the applicant, assistants, volunteers and members of the applicant's household. The information written on the Background Check Authorization Form should be compared to other original documentation supporting the identity of the applicant. This review would provide some assurance that the Department is performing a background check on the person completing the form.

- Require applicants to provide documentation of the length of their state residency.

- Conduct nationwide checks on all applicants who cannot adequately document they have lived in the state at least three years.

- Provide training to licensors to ensure that monitoring of criminal background checks at child care centers and follow-up to issues identified are adequate to ensure compliance with background check requirements.

Department's Response

The Department does not concur with the finding that licensors with the Division of Child Care and Early Learning (DCCEL) and Children's Administration (CA) are not conducting adequate background checks. The Department trains licensors in all aspects of conducting and monitoring background checks. The licensors cite providers when they are out of compliance. Because the auditor did not have an opportunity to review their findings with Department staff prior to issuing the draft finding we can neither concur nor disagree with the specific findings related to the Division of Child Care and Early Learning. The Department will request and review the auditor's working papers to confirm the results of their review and develop an appropriate corrective action plan to address any identified deficiencies in our practice.

The Department is constantly looking for ways to increase safety to children in out-of-home care and to strengthen the background check process. A statutory change and additional resources would be needed to address the recommendations in this audit report. The Joint Legislative Task Force on Background Checks intends to review the legislative, fiscal, stakeholder, and information technology infrastructure changes required to implement fingerprint checks for child care providers and foster care applicants as a priority agenda item for next year.

The Department's Background Checks Central Unit performs approximately 35,000 name and date of birth background checks each year for child care and about 16,500 for foster care. Performing a visual confirmation of each person to their photo identification is not possible for such a large number of background checks.

There is no uniform, widely accepted documentation to prove Washington state residency. Voter registration cards, driver's licenses, and tax returns are not available to many licensees, including some immigrants.

Auditor's Concluding Remarks

We discussed these issues with the Department prior to releasing the draft finding to it. We also provided the Department with the list of childcare centers that we visited during our audit. Department management assured us it is aware that improvements over the performance of background checks are needed. We reaffirm our finding.

Applicable Laws and Regulations

The Office of Financial Management *State Administrative and Accounting Manual,* Section 85.32.10, states in part:

> ...At a minimum, agencies are...to establish and implement the following:
>
> 1. Controls to ensure that all expenditures/expenses and disbursements are for lawful and proper purposes....

Revised Code of Washington 74.15.030 states in part:

> The secretary shall have the power and it shall be the secretary's duty:
>
> (2) In consultation with the children's services advisory committee, and with the advice and assistance of persons representative of the various type agencies to be licensed, to adopt and publish minimum requirements for licensing applicable to each of the various categories of agencies to be licensed.
>
> The minimum requirements shall be limited to:
>
> (b) The character, suitability and competence of an agency and other persons associated with an agency directly responsible for the care and treatment of children, expectant mothers or developmentally disabled persons....In order to determine the suitability of applicants for an agency license, licensees, their employees, and other persons who have unsupervised access to children in care, and who have not resided in the state of Washington during the three-year period before being authorized to care for children shall be fingerprinted.

Washington Administrative Code 388-296-0180 states:

(1) At the time you apply for a license you must submit a completed background check form and finger print card if required to the background check central unit (BCCU) for each person who will have unsupervised access to children in your care. This includes:

(a) You;

(b) Members of your household sixteen years and older;

(c) Staff;

(d) Volunteers; and

(e) Other persons living at the same address as you.

(2) When you plan to have new staff or volunteers, you must require each person to complete and submit to you by the date of hire a criminal history and background check form:

(a) You must submit this form to the BCCU for the employee and volunteer, within seven calendar days of the employee's or volunteer's first day of work, permitting a criminal and background history check.

(b) The employee and volunteer must not have unsupervised access to the children in care until they have been cleared by a full background check.

WAC 388-295-7050 states:

(1) Each employee and volunteer who has unsupervised access to a child in care must complete the following forms on or before their date of hire:

(a) an application for employment on a form prescribed by us, or on a comparable form approved by the department; and

(b) A criminal history and background inquiry form.

(2) You must submit the criminal history and background inquiry form to us within seven calendar days of the employee's first day of work. The form authorizes a criminal history background inquiry for that person.

WAC 388-295-0070 states in part:

(1) You, your staff and volunteers must have the following personal characteristics in order to operate or work in a child care facility:

(a) The understanding, ability, physical health, emotional stability, good judgment and personality suited to meet the physical, intellectual, mental, emotional, and social needs of the children in care;

(b) Be qualified by our background inquiry check prior to having unsupervised access to children. To "be qualified" means not having been convicted of, or have charges pending for, crimes posted on the DSHS secretary's list of permanently disqualifying convictions for ESA. You can find the complete list at http://www.dshs.wa.gov/esa/dccel/policy.shtml. This includes not having committed or been convicted of child abuse or any crime involving harm to another person; and....

Washington State requires full licensing of child care centers and homes including on-site inspections. Centers and homes are required to renew their licenses every three years. Child care centers receive unannounced annual monitoring visits and family child care homes receive an unannounced interim monitoring visit within the three year licensing cycle. During the initial licensing period, licensors may make frequent visits to help licensees meet regulatory requirements. When licensees are issued a probationary license, licensors make frequent visits to ensure compliance with the probationary agreement. In addition, DCCEL Health Specialists inspect child care centers to determine compliance with health and safety regulations; certify, deny or revoke health certifications; and provide technical assistance to providers. These visits are conducted upon initial licensure and again before full licensure is granted.

Corrective action usually includes a statement of deficiencies and a plan of correction. It can also include a probationary license, and civil penalty, license revocation or suspension. Background checks are performed on all child care providers, assistants and volunteers of licensed child care centers and on providers and members of family child care households (sixteen years of age or older) who have unsupervised or regular access to children in care.

The Department of Social and Health Services *Licensing Methods and Practices Manual* states the following:

Center licensors should monitor facilities annually to determine compliance with WACs. FCC licensors should monitor homes at least once every 18 months to determine compliance with WACs.

Title 45 of the Code of Federal Regulations, Section 1356.30 (a) and (b) states:

(a) Unless an election provided for in paragraph (d) of this section is made, the State must provide documentation that criminal records checks have been conducted with respect to prospective foster and adoptive parents.

(b) The State may not approve or license any prospective foster or adoptive parent, nor may the State claim FFP for any foster care maintenance or adoption assistance payment made on behalf of a child placed in a foster home operated under the auspices of a child placing agency or on behalf of a child placed in an adoptive home through a private adoption agency, if the State finds that, based on a criminal records check conducted in accordance with paragraph (a) of this section, a court of competent jurisdiction has determined that the prospective foster or adoptive parent has been convicted of a felony involving:

(1) Child abuse or neglect;
(2) Spousal abuse;
(3) A crime against a child or children (including child pornography); or,
(4) A crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery.

(c) The State may not approve or license any prospective foster or adoptive parent, nor may the State claim FFP for any foster care maintenance or adoption assistance payment made on behalf of a child placed in a foster home operated under the auspices of a child placing agency or on behalf of a child placed in an adoptive home through a private adoption agency, if the State finds, based on a criminal records check conducted in accordance with paragraph (a) of this section, that a court of competent jurisdiction has determined that the prospective foster or adoptive parent has, within the last five years, been convicted of a felony involving:

(1) Physical assault;
(2) Battery; or,
(3) A drug-related offense.

(d)(1) The State may elect not to conduct or require criminal records checks on prospective foster or adoptive parents by:

(i) Notifying the Secretary in a letter from the Governor; or

(ii) Enacting State legislation.

(2) Such an election also removes the State's obligation to comport with paragraphs (b) and (c) of this section.

(e) In all cases where the State opts out of the criminal records check requirement, the licensing file for that foster or adoptive family must contain documentation which verifies that safety considerations with respect to the caretaker(s) have been addressed.

(f) In order for a child care institution to be eligible for title IV-E funding, the licensing file for the institution must contain documentation which verifies that safety considerations with respect to the staff of the institution have been addressed.

05-32 The Department of Social and Health Services, Economic Services Administration, reimbursed contractors for services that were not adequately supported.

Background

During fiscal year 2005, the Department of Social and Health Services, Economic Services Administration's Basic Food, Education, and Outreach Program contracted with nine non-profit organizations and one Indian tribe to educate potential applicants about food stamps and to assist them in completing applications. Contractors may sub-contract with other organizations to assist in these services. For these 10 contracts, federal funds from the federal State Administration Matching Grants for the Food Stamp Program (CFDA 10.561) provided 50 percent of the total fiscal year 2005 payments of $2,101,099, with the remaining amount supplied by state and local funds.

The Program reimburses contractors each time they perform intake contacts, during which they provide informational assistance to potential clients. As defined in the contract, an intake contact is a five- to thirty minute discussion between the contractor and a potential client to provide information on how to apply for the Program. Intake contacts can occur in the contractor's office or in the client's home but must be in person. Contractors are reimbursed $30 to $90 per intake contact, depending on the amount stipulated in the contract. Contractors also may be paid for providing group presentations and for assisting clients in completing applications.

To bill the Department for its services, a contractor's billings must include an invoice, a summary of monthly contacts, and an on-line Basic Food Education Outreach Monthly Activity Report. This report is submitted through the on-line system by all contractors.

During our fiscal year 2004 audit, we questioned approximately $1.1 million dollars paid to one contractor for contacts that did not occur. We found the Department did not require any supporting documentation such as documents signed by clients acknowledging services were received. We also concluded the Department's monitoring was inadequate to ensure payments were allowable.

Description of Condition

This year we found the Department did not:

- Obtain sufficient documentation to support contractor reimbursements. For fiscal year 2005, we found 7,271 client records in the system that lacked assistance dates. This system does not process payments; however, it is used by the Department to reconcile invoice data prior to payment. Payments for services that did not include a service date totaled $270,681.

- Require all contractors to obtain evidence of client consultations and group presentations, such as documents signed by clients verifying services were provided. For instance, the Department reimbursed a subcontractor for five group presentations without receiving sufficient documentation to support the presentations had occurred. A document listing the presentation dates was signed by two witnesses; however, those witnesses were employees of the sub-contractor. No client names were included. Total payments for these presentations were $1,250.

- Review billings adequately before payment.

    - We found 38 instances totaling $1,687 in which the Department reimbursed contractors a month prior to the clients' assistance dates. This suggests payments were made in advance.

    - We found several instances, totaling $163, in which a contractor billed and received payment for the same client more than once per month.

Cause of Condition

The Department has not established written policies and procedures describing and requiring adequate monitoring activities for these contracts.

Effect of Condition

Conditions that allowed last year's contractor misappropriation to occur and go undetected still exist. We question a total of $273,781, one half of which, or $136,891, was funded with federal dollars.

Recommendation

To improve its internal controls, we recommend the Department establish written policies and procedures to:

- Verify with clients, on a routine basis, that services have been received.
- Monitor contractors to ensure they maintain supporting documentation for client consultations, including a document or log signed by each client and by the contractor's employee performing the consultation. At a minimum, this document should include the client's name, date of birth, signature, and contact information.
- Require an assistance date for all clients input into the Basic Food Education Online Reporting System and reimbursed by the Department.
- Pay contractors only after the service has been provided.
- Analyze reported client contacts to determine if the number of contacts per client is reasonable.

Department's Response

The department partially concurs with the above findings.

Contractors are currently not required to provide the dates of contacts or assistance provided in the online reporting system. However, there is documented assurance available upon request at the site of the contractor. We sampled about 75% of the 7,271 contacts and were able to verify that a contact or assistance occurred in each of the samples by reviewing the available documentation. We also verified that the date of the contact exactly matched the billing date for the contact. The Food Assistance Outreach program will add a requirement to input the assistance date into the Online Reporting System to contract requirements of all contractors for the next contract period.

The Department disagrees with the question cost amount of $273,781, and the federal share of $136,891 as we have documented assurance the payments were both accurate and correct under the contract.

Contractors are currently not required to provide signature documentation verifying the client received intake contacts. Contractors are currently ***required*** *to provide signature documentation verifying the client received application assistance.*
Effective March 1, 2006 contractors will be required to have a signed verification sheet for:

- *In person client intake contacts;*
- *Group presentations; and*
- *Application assistance.*

Currently, outreach contractors ask clients for a phone number or address that can be used by the department to obtain verification of services.

The Department has reviewed the list of names provided by the State Auditor's Office in which it appears contractors were reimbursed a month prior to the client's assistance dates. The department can find no instances in which the Department reimbursed contractors a month prior to the clients' assistance dates.

The contractor works with several sub-contractors who work with the same clients and are allowed to bill and receive payment for these services. The Department has identified the instances in which it appears a contractor was reimbursed for the same client more than once per month and reviewed these cases to determine the accuracy of these payments. When the program compiled all subcontractor contacts and the primary contacts under the primary contractor we understand there may be $147 in questioned costs paid to the same primary contractor for distribution to two different subcontractors.

The department has instituted a process to analyze reported client contacts to determine if the number of contacts per client is reasonable.

Auditor's Concluding Remarks

We appreciate the Department's thorough response and its commitment to resolving these issues. We will review the additional requirements and controls that the Department is implementing during our fiscal year 2006 audit.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states in part:

> The auditee shall...
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs . . .

Subpart A, Section .105 of Circular A-133 further states in part:

> Questioned cost means a cost that is questioned by the auditor because of an audit finding....(2) Where the costs, at the time of the audit, are not supported by adequate documentation....

U.S. Office of Management and Budget Circular A-87, Cost Principles for State, Local and Indian Tribal Governments, Attachment C, states in part:

1. ...To be allowed under Federal awards, costs must meet the following general criteria:

    a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.

    b. Be authorized or not prohibited under State or local laws or regulations....

2. Reasonable costs. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. The question of reasonableness is particularly important when governmental units or components are predominately federally funded....

The Office of Financial Management State Administrative and Accounting Manual, Section 85.32.10, states in part:

> ...At a minimum, agencies are...to establish and implement the following:
>
> 1. Controls to ensure that all expenditures/expenses and disbursements are for lawful and proper purposes....

Section 85.32.40 (a) states in part:

> ...The following information, at a minimum, is to be indicated either on the disbursement documentation or in an automated system for compliance with federal regulatory agencies and internal control policies:...
>
> - Receipt dates for goods and services

The Department's Administrative Policy 13.11, General Contract Monitoring, states its purpose is to provide Department staff with general contract monitoring guidance that can reasonably ensure:

(1) The Department receives goods and services that are paid through the contracting process.

(2) The contractor meets the scope of work and specifications identified in the contract.

05-33 The Department of Social and Health Services made unallowable duplicate payments through the Social Services Payment System.

Background

The Department of Social and Health Services developed the Social Services Payment System to perform a variety of services, including initiating the payment process for purchased services. The System is used by approximately 3,500 social workers across the state to authorize in excess of $1 billion in payments to more than 109,000 service providers annually. It is the largest cross-divisional services-based system in the Department and supports payments authorized by three Department administrations: Children's, Aging and Disability Services, and Economic Services.

Description of Condition

We reviewed the System to determine if the Department had paid more than once for the same transaction. We identified the following duplicate payments made with funds from various sources:

	Children's Administration	Aging & Disability Services Admin.	Totals
Number of Clients	5	8	13
Medicaid Funding CFDA 93.778	$ 1,276.35	$ 34,121.49	$ 35,397.84
State Funding	$ 29,700.45	$ 42,333.38	$ 72,033.83
Foster Care Title IV E Funding CFDA 93.658	$ 6,480.50		$ 6,480.50
Adoption Support Funding CFDA 93.659	$ 3,000.00		$ 3,000.00
Total by Administration	$ 40,457.30	$ 76,454.87	$116,912.17

We shared these results with the Department and requested any additional information it had regarding the transactions. We received a response from the Department agreeing that the above amounts were overpayments. The Department was aware of and had begun recovery proceedings for only $18,583.91 of the total amount prior to learning of the results of our work.

Cause of Condition

The Department does not have adequate internal controls to ensure payments are not duplicated. A variety of case worker errors led to these duplicate payments; in most cases, no subsequent reviews identified them.

Effect of Condition

Federal and state funds are susceptible to loss because the Department cannot identify in a timely manner duplicate payments made to providers. We question the costs displayed above of $116,912.

Recommendations

We recommend the Department:

- Strengthen its reviews of SSPS payments to help prevent future duplicate payments.
- Pursue recovery of overpayments.
- Work with the U.S. Department of Health and Human Services to determine if any unallowable, unrecovered federal costs must be reimbursed.

Department's Response

The Department partially concurs with this finding.

- ***Strengthen reviews of SSPS payments to help prevent future duplicate payments:***

  Both ADSA and CA sent all questionable duplicate payments identified by the auditor to their field offices for review and reconciliation. Of the approximately $1,352,000 payments identified as questionable by the auditor, ADSA's review determined that $76,455 were in fact duplicate payments. A total of 32 duplicate payments were made to 8 providers for services to 8 clients. This amount represents .00008% of the approximately $934 million in payments made by ADSA via the SSPS payment system in FY05. ADSA provided the auditor with client level results for each questioned payment, and proof that the respective overpayments had been established with OFR. The Children's Administration reviewed and provided information to the auditor on approximately $1.5 million in payments referred by the auditor. Upon receipt of the finding CA requested and received copies of the auditor's workpapers that identified the 5 payments totaling $40,457.30 in questioned costs. CA's subsequent review of those cases documents that only one of the five is a duplicate payment. CA verbally notified the SAO of the additional information on the four cases on March 15, 2006. CA will provide documentation of the appropriateness of these payments to the SAO by March 31, 2006, for their use in next year's follow-up review.

  The administrations invest time and resources in the department's Payment Review Program (PRP). The PRP has developed and uses algorithms to detect duplicate payments and will continue to work closely with PRP to ensure duplicate payments are adequately addressed. Additionally, in 2004 CA hired fiduciary specialists specifically to address various aspects of the payment process which includes identifying duplicate payments and proper processing procedures.

  DSHS will continue to provide staff training, supervisory overview and quality review of payment procedures used in the field.

- ***Pursue recovery of overpayments:***

  ADSA has established overpayments on all duplicate payments that were identified in the audit process. CA established an overpayment for the $5180 exception in October 2004 and that overpayment has been collected by the Department's Office of Financial Recovery.
- ***Work with the U.S. Department of Health and Human Services to help prevent duplicate payments:***

  The Department will work with HHS should any costs be determined unallowable

Auditor's Concluding Remarks

We appreciate the Department's thorough response. We will review this area during our fiscal year 2006 audit.

Applicable Laws and Regulations

The Office of Financial Management's *State Administrative and Accounting Manual*, Section 20.20.20.a, states:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

05-34 The Department of Social and Health Services does not ensure that all recovered overpayments are credited to the appropriate funding source.

Background

The Department of Social and Health Services administers child care programs that pay child care centers and licensed family home child care providers for child care services for eligible families. The Department either pays the providers directly or pays clients directly, with the expectation that the clients will use the funds for child care services. Program payments are made from both state and federal funds. The Department has assigned responsibility for the Program to the Economic Services Administration, Division of Child Care and Early Learning.

Child care overpayments are primarily identified by case workers during eligibility update reviews. The field offices report identified overpayments to the Department's Office of Financial Recovery. The Department has also recently started using computerized processes to identify overpayments.

Client overpayments identified but not yet recovered as of June 30, 2005, were approximately $7,542,000. Overpayments identified in a current fiscal year may not be recovered until a future fiscal year.

During the fiscal year 2003 and 2004 audits, we found that the Department did not ensure that all funds recovered from client overpayments were returned to the proper funding source. The Department stated that approximately $248,000 was recovered from client overpayments during fiscal years 2003 and 2004. However, the Department was not able to determine how much of this amount was initially paid with federal and state funds and to which funding source funds should be returned. We reported this weakness in the Statewide Accountability Report and in the State of Washington Single Audit Report in both prior audit years.

Description of Condition

We found the Department still did not ensure all funds recovered from client overpayments were returned to the proper funding source. The Department stated it recovered $358,000 in client overpayments during fiscal year 2005, leaving the above balance of $7,542,000. However the Department still was not able to determine how much of the recovered amount was initially paid with federal and state funds and to which funding sources funds should be returned.

Cause of Condition

The computer system used for client overpayments was inadequate for tracking the original funding sources, and the Department had not developed an alternative method of determining to which funding sources client overpayments should be returned. During the fiscal year 2005 audit, the Department stated that it corrected this in October 2005, and it will now be able to ensure all funds recovered from client overpayments are returned to the proper source. However, that date fell outside of the current audit period. In our next audit, we will review any corrective actions taken during fiscal year 2006.

Effect of Condition

The Department may not be returning recoveries of federal funds to the proper funding sources as required by federal regulations. Payments originally made with federal program funds may be returned and credited to entirely different federal programs or to state funds.

Recommendation

We recommend the Department develop an adequate method of ensuring that all funds recovered are returned to their proper sources.

Department's Response

The Department concurs with this finding and has taken the measures described below to ensure that recovered funds are correctly credited to the appropriate funding sources.

The Office of Financial Recovery and the Information Technology Office have worked together to create a new Social Services Payment System (SSPS) account code history table that cross-matches SSPS program codes (service, source, reason) to the Agency Financial Reporting System account codes for the period of time in which they were used for warrant processing. The history table is rebuilt daily and tracks data from November 2000 through current date.

Also, a Modified Client Receivable System (CRS) accounting module has been created to distribute payment recoveries according to the distribution of the SSPS program code lines.

The above measures were implemented on October 1, 2005, the beginning of the federal fiscal year.

Auditor's Concluding Remark

We appreciate the Department's prompt and thorough response and its commitment to resolving these issues.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment A, Section C, Basic Guidelines, states in part:

> 4.a. Applicable credits refer to those receipts or reductions of expenditure-type transactions that offset or reduce expense items allocable to Federal awards as direct or indirect costs. Examples of such transactions are...rebates or allowances, recoveries or indemnities on losses,...charges. To the extent that such credits accruing to or received by the governmental unit relate to allowable costs, they shall be credited to the Federal award either as a cost reduction or cash refund, as appropriate.

05-35 The Department of Social and Health Services does not have adequate internal controls over the Social Service Payment System.

Background

The Department of Social and Health Services developed the Social Service Payment System in the late 1970s to:

- Authorize the delivery and/or purchase of social services for clients.
- Collect social services client data required for state and federal reporting.
- Initiate the payment process for purchased services.

The System is used by approximately 3,500 social workers across the state to authorize payments and collect information about services provided to more than 210,000 clients. The system authorizes payments in excess of $1.3 billion annually to more than 109,000 service providers.

The System is the largest cross-divisional services-based system in the Department and supports payments and management information authorized by Children's Administration, Aging and Disability Services Administration, and Economic Services Administration. The System runs on a Unisys mainframe computer system and interfaces with a number of other department systems.

During our fiscal year 2004 audit we identified and reported internal control weaknesses related to the system.

Description of Condition

This year we followed-up on last year's finding to determine if adequate internal controls over the system had been implemented.

We found the following internal control weaknesses still exist:

- Unisys does not record the creator or modifier of each transaction. The Department cannot determine accountability for transactions created or updated within the mainframe.
- The Department does not have adequate controls over electronic access to the Social Service Payment System.
    - Unisys is not capable of generating a list of operator identification (ID) and the associated user name. Because of this weakness, the Department maintains a separate database of user names, operator IDs, and access rights as a compensating control. However, our tests indicate that the database is not a complete and accurate record of users of the Social Service Payment System.
    - The Department uses "generic" (shared) Social Service Payment System operator IDs and passwords to allow inquiry-only access to the System databases; this significantly increases the possibility of unauthorized access to confidential information.
    - Four individuals have more than one operator ID. Assigning duplicate operator IDs allows users additional access that is not required for performance of their assigned duties.
    - The Department does not require the use of hardened passwords. The Information Services Board's *Information Technology Security* S*tandards* define hardened passwords as having a minimum of eight characters and containing at least one special character and two of the following three character classes: upper case letters, lower case letters, and numerals.
    - The Department is not using a lock-out mechanism to deter access to the System. Lock-out mechanisms limit the number of unsuccessful attempts to log-in to a computer system. Without a

limit on authentication attempts, unauthorized users have a much greater chance of cracking passwords.

- The Department does not have adequate controls in place to limit users establishing providers (vendors) in the System to the electronic access necessary to perform their assigned duties. A service provider must be established in the provider file in order to receive payment for services. Our tests indicate there are 12 individuals with access to provider file input who do not need this level of access to perform their assigned duties.

- Ten operator IDs have provider file input access rights and access rights that authorize payments to providers. Operator IDs that have provider file input access rights and authorization input access rights would be able to establish a provider and then authorize payment to that provider.

  There is no read-only access to the computer input screen that is used to add, delete, and view worker IDs. All individuals with access to this screen can add and delete worker IDs.

- The Department is not performing reconciliations of Social Service Payment System records.

  - The System does not contain transactions or other information on payments that required manual intervention or adjustment. This results in inaccurate and incomplete payment information in the System payment history and summary reports.

  - Expenditures authorized through the System are not reconciled to financial records in the state's Agency Financial Reporting System.

- The Department does not have adequate controls over authentication of users with access to the system.

  - The Social Service Payment System does not require users to change the operator ID password periodically; this increases the opportunity for inappropriate access to the System.

- The Department does not have adequate controls over Social Service Payment System computer programs.

  - The software that controls the changes to the System computer programs does not adequately maintain a record of the changes. The program change control software for SSPS does not record who made a change, record the changes made, track multiple versions, or prevent two people from checking out the same program at the same time. Accountability cannot be assigned for program changes.

  - Department personnel can re-point Executive Control Language. This could result in unauthorized computer programs being run.

- Authorization for payments can be made for services that were performed after the service providers have been designated as closed, deceased, or otherwise restricted. This could lead to payments to providers who should no longer be receiving them.

- The information displayed on System user screens is not appropriate to meet the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements.

Cause of Condition

The Social Service Payment System is a 25 year old legacy system with 300,000 lines of code in Cobol programming language. It is limited by its original design with minimal security and lack of Unisys software to track transactions created or updated within the mainframe. The system is inadequate and unable to perform higher level functions that today's technology allows.

Effect of Condition

These control weaknesses increase to a high degree the risk that error or misappropriation could occur and not be detected by management in a timely manner, if at all.

Recommendation

We recommend the Department establish and follow adequate internal controls over the Social Service Payment System.

Department's Response

The Department would like to take the opportunity to respond to the items within the finding as each are a unique contributor to the primary finding and each have a separate response. We concur with the State Auditor's Office (SAO) statements that the cause of the condition is directly related to the Social Service Payment System (SSPS) being a 25 year old legacy system written in extensive COBOL programming language. The original design, purpose, and security features were adequate to the task at the time of its inception and many modifications have been made to attempt to provide improvements in functionality and security over the years. However, the system programming and a lack of UNISYS software to track transactions, created or updated within the mainframe, have required the use of external systems and programs to make up for the system's deficits when compared to the requirements of today's technology. The Department plans to replace the system with the new technology of the ProviderOne system and is in the design phases of that process.

Recently the Department has been able to initiate a re-write of the WebConnect front-end system interfacing with the Social Service Program System that will provide additional security features not available in the UNISYS realm. This re-write has an anticipated release date of April 1, 2006. Since it is written in C# (C-sharp), it affords and utilizes modern features and security, supplementing the UNISYS system's areas of deficiency. The Department has also created several Sequel program routines that make up for the shortcomings of the system and aid in producing the accurate accounting and reconciliation processes necessary in the proper management of state funds. As the Department responds to each of the items, we would like to include the new features of these systems that specifically respond to each item.

- *Unisys does not record the creator or modifier of each transaction. The Department cannot determine accountability for transactions created or updated within the mainframe.*

The Department concurs with this item. UNISYS does not allow for the tracking of transaction activities within the system. The new WebConnect re-write will allow for the tracking of transactions within the system. The program will store a string of data for each transaction that is linked to the user profile.

- *The Department does not have adequate controls over electronic access to the Social Service Payment System.*
    - *Unisys is not capable of generating a list of operator identification (ID) and the associated user name. Because of this weakness, the Department maintains a separate database of user names, operator IDs, and access rights as a compensating control. However, our tests indicate that the database is not a complete and accurate record of users of the Social Service Payment System.*

This statement is correct concerning UNISYS. The Department has made a concerted effort to reduce the operator ID database and to keep it as complete and accurate as possible. This has been done by reviewing the database on a monthly schedule, removing individuals and duplicates as soon as the need to do so becomes known, and adding only individuals that are appropriate. The Information System Services Division (ISSD) and SSPS staffs routinely review and update the files. The Automated Client Eligibility System (ACES) changes and Department of Personnel updates are also used to keep the file accurate. Individuals, not requiring access because they have other front-end access, have their operator ID removed to prevent double access. All individuals noted by the SAO as needing removal or further identification have been removed or identified.

On April 1, 2006, SSPS will initiate a new front-end WebConnect version and replace the current Com Object with a web service program. Neither requires operator IDs but associate the name and personal security permissions of each user who logs on. The new WebConnect front-end system will record a string of data and will relate it directly to the user profile on the individual's system account.

- *The Department uses "generic" (shared) Social Service Payment System operator IDs and passwords to allow inquiry-only access to the System databases; this significantly increases the possibility of unauthorized access to confidential information.*

This finding is correct for the system as it is today. There is no way to allow operators to have the inquiry only access necessary to do their work and avoid duplicate payment, without a generic operator ID. This allows them to see only information within their area of work responsibility. With the new WebConnect re-write, there will be no generic operator IDs. Workers will access their own computer system and will have specific assigned user profiles for SSPS that are based on their work needs.

It should be noted that the SSPS is behind ISSD and state Department of Information Services (DIS) firewalls and only accessible by Department or contracted agencies' staffs that need the SSPS to carry out Department business. They have to go through a setup process in order to view SSPS information and must have the legal right to view all information on the SSPS.

- *Four individuals have more than one operator ID. Assigning duplicate operator IDs allows users additional access that is not required for performance of their assigned duties.*

All individuals, found through file searches or identified by the SAO, have been removed. Systematic checks for duplicates are performed monthly.

- *The Department does not require the use of hardened passwords. The Information Services Board's Information Technology Security Standards define hardened passwords as having a minimum of eight characters and containing at least one special character and two of the following three character classes: upper case letters, lower case letters, and numerals.*

The Department concurs that the current system is not protected with "hardened" passwords, which is a limitation of the UNYSYS system. Therefore, the new WebConnect re-write utilizes the "hardened" password of each individual user upon entry to their individual computer system. This not only makes use of the required "hardened" passwords, but it also requires the changing of passwords every 120 days, further increasing security.

- *The Department is not using a lock-out mechanism to deter access to the System. Lock-out mechanisms limit the number of unsuccessful attempts to log-in to a computer system. Without a limit on authentication attempts, unauthorized users have a much greater chance of cracking passwords.*

The Department has used a "lock-out" mechanism since the inception of the Social Service Payment System. Through numerous updates and changes to SSPS, the "lock-out" mechanism became inactive. SSPS, ISSD, and DIS have unsuccessfully attempted to locate and reinstall the "lock-out" mechanism. The Department continued to try to reinstate it, but this will become a moot point shortly with the activation of the new WebConnect front-end for the system. WebConnect will take advantage of the "hardened" password and 'lock-out" mechanism of each user's computer system access.

- *The Department does not have adequate controls in place to limit users establishing providers (vendors) in the System to the electronic access necessary to perform their assigned duties. A service provider must be established in the provider file in order to receive payment for services. Our tests indicate there are 12 individuals with access to provider file input who do not need this level of access to perform their assigned duties.*

The Department has substantially reduced the number of individuals that have access to provider file input from 32 to 12. Of these, five are in the Office of Accounting Services (OAS) and use the provider file in their job on an ongoing basis to establish or deactivate liens. Two SSPS program managers use provider file access to establish

direct deposit and/or stops related to their daily work; two SSPS operations staff have access to process information regarding payment adjustments; and three SSPS program managers have access to provider files to modify rates and service codes for program payments. These activities require a high degree of knowledge related to program needs and activities, so must be done by program managers rather than provider file data integrity staff.

In the new WebConnect front-end system, the changing of anything in the provider file will be recorded as a string of data and will relate directly to the user profile on the individuals system account. This will allow for the tracing of changes made to the provider file and who made them.

- *Ten operator IDs have provider file input access rights and access rights that authorize payments to providers. Operator IDs that have provider file input access rights and authorization input access rights would be able to establish a provider and then authorize payment to that provider.*

This has been recognized as a weakness that the Department has sought to reduce and/or eliminate. The number of individuals has been reduced to eight. Of these, the individuals are all SSPS program managers and one SSPS provider file supervisor. The dual access is used to correct tax related information and reduce IRS errors or to facilitate correction, modification, or testing of data in the system. To further reduce the risk, a Sequel program that compares providers and payments to state employee personnel data is run monthly with auditing and verification of correct payment process monitoring.

As stated above, the WebConnect front-end system will allow tracking of changes. While this is not a total separation of duties, the Department believes that it will enable the Department to successfully complete SSPS functions while reducing risk to the lowest denominator possible.

- *There is no read-only access to the computer input screen that is used to add, delete, and view worker IDs. All individuals with access to this screen can add and delete worker IDs.*

The system currently allows all individuals with access to the input screen to add and delete worker IDs. The new WebConnect front-end will allow for a view only <u>or</u> a view, add, or modify access to this screen controlled through the user profile.

- *The Department is not performing reconciliations of Social Service Payment System records.*
  - *The System does not contain transactions or other information on payments that required manual intervention or adjustment. This results in inaccurate and incomplete payment information in the System payment history and summary reports.*
  - *Expenditures authorized through the System are not reconciled to financial records in the state's Agency Financial Reporting System.*

SSPS and OAS have developed a secondary process to supplement the inadequacies of the legacy system for reconciliation and incorporation of payment information from outside of the legacy system. To record transactions and information on payments that require manual intervention, SSPS has created a Sequel database that stores and compiles this information for processing with internal system information. Per the SAO, at a December 29, 2005 meeting, the SSPS Sequel database fulfills the SSPS portion of this process. As a project sponsor, the SSPS Chief understands that this database will reconcile with OAS quarterly from now on. The information was also used in the preparation of 2005 tax documents without issue.

- *The Department does not have adequate controls over authentication of users with access to the system.*
  - *The Social Service Payment System does not require users to change the operator ID password periodically; this increases the opportunity for inappropriate access to the System.*

The Department concurs that this is an accurate statement but cannot correct it in the UNYSIS system. The new WebConnect re-write utilizes the "hardened" password of each individual user upon entry to their individual computer system. This not only makes use of the required "hardened" passwords, but it also requires the changing of passwords every 120 days, further increasing security.

The Department does not have adequate controls over Social Service Payment System computer programs.

- *The software that controls the changes to the System computer programs does not adequately maintain a record of the changes. The program change control software for SSPS does not record who made a change, record the changes made, track multiple versions, or prevent two people from checking out the same program at the same time. Accountability cannot be assigned for program changes.*

The Department concurs with these statements. The Department has made a concerted effort to locate UNISYS software for this function. SSPS has not been aware of any affordable available software for the UNISYS mainframe having the functionality to maintain a record of the changes made by staff. Such software is available for the IBM. However, as recent as February 2006 it remains unavailable for the UNISYS from UNISYS software distributors. Rumors of software that may serve the function indicate a $200,000 cost, far beyond the budget of a system slated for replacement in the near future.

There is a possibility that a portion of the less costly Visual Studio Pro and Source Safe may be capable of recording who made the changes to programs and what changes they made. It may also track multiple versions. However, it can only record that someone has checked a program out, not prevent two people from checking it out. This would be a strong move towards the auditor's recommendations and may run $11,000 to $22,000 per year depending on the number of licenses needed. Since this just came to the attention of SSPS, its full functionality and the ability of the Department to purchase it on a yearly basis will need to be investigated. Until such time software becomes available for UNISYS, SSPS will continue to use its current manual process for risk reduction. The current process requires a sign-on and sign-off identity specific to an individual user and creates an audit trail that is verifiable. Extra supervision is maintained over the safeguards to ensure proper usage of the system since automation is not available for the current system. To date, no problems with this security issue have been detected.

- *Department personnel can re-point Executive Control Language. This could result in unauthorized computer programs being run.*

The Department does not concur with this portion of the finding. The Department has the controls in place that do not allow unauthorized programs to run, because the Executive Control Language change is reported to a temporary authorized production environment controlled by ISSD. This controlled flexibility is necessary to ensure payment occurs timely if a problem occurs outside regular working hours. Only authorized on-call staff members have access rights. All parties have been unable to locate UNISYS or other software to perform this function on the mainframe.

- *Authorization for payments can be made for services that were performed after the service providers have been designated as closed, deceased, or otherwise restricted. This could lead to payments to providers who should no longer be receiving them.*

Blocking payment to restricted providers removes the ability to make payments that may still be due to those providers or their estates. Several of the divisional front-end systems to SSPS block field staff from opening or extending authorizations that attempt to pay providers that have a 1, 2 or 4 status code in the SSPS Provider File. Those systems are CAMIS, CASIS, CARES, WCAP, and ICMS. Although not fully designed at present, it is planned to have a pop-up warning in the S03 screen (authorization screen) for providers that are status 1, 2, or 4. This will prevent inappropriate new authorizations to these provider status types within the new SSPS WebConnect front-end system that users outside of divisional programs would use. This would reduce many of the possible inappropriate uses of these providers and reduce overpayments.

Use of status 4 code is not intended to prevent payment. It alerts the authorizing worker that a provider has some type of finding against them after being given due process; however, rules barring use of a provider vary from program to program. In most instances, a status 4 coded file does not contain an address, thereby ensuring SSPS is contacted and an informed decision is made before any payment is made.

The Department continues to look for more secure processes that will allow payment within the system and not allow the possibility of errors.

- *The information displayed on System user screens is not appropriate to meet the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements.*

As stated above, the SSPS is behind ISSD and DIS firewalls. Staffs must go through a setup process in order to view SSPS information and must have the legal right to view all information on the SSPS.

Auditor's Concluding Remarks

We appreciate the Department's thorough response and its commitment to resolving these issues. We will review the security features in the WebConnect front-end system and evaluate the identified compensating controls during our next review.

Applicable Laws and Regulations

The State of Washington Office of Financial Management's *State Administrative and Accounting Manual*, Section 20.20.20.a states in part:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

The Washington State Department of Social and Health Services' *Information Technology Security Policy Manual,* Chapter 4: Access Security, Identification, & Authorization, states in part:

> 4.2.2 AUTHENTICATION REQUIREMENTS
> **Policy Statement 4.2.2**
>
> > Adequate controls must be in place to authenticate users accessing department computers, networks, and applications; see DSHS IT Security References R4.2.2 Authentication Requirements, for further detail.
>
> **Standards**
>
> > **S1.** Users and other entities such as applications or servers must be authenticated using such methods as login IDs and passwords, digital certificates, smart cards, or tokens.
>
> 4.2.3 USER IDS
>
> 4.2.3.1 General User ID Requirements
> **Policy Statement 4.2.3.1**
>
> > Each system or application must have established procedures to ensure that each user ID is uniquely associated with a user. . . .
>
> **Standards**
>
> > **S1.** Electronic access to confidential information will always be protected, at a minimum, by a unique user ID, and a password that is constructed and protected as required by section 4.2.4 Use and Construction of Passwords.
> > **S2.** Assigning duplicate user IDs or sharing user IDs is prohibited, except that generic user IDs with limited access privileges may be used for:
> > Maintenance, troubleshooting, or system monitoring;
> > Training;
> > Shared workstations in secured areas, where no classified data is accessible unless all users have identical access needs; or
> > Program batch runs.

S3. Users shall not be assigned or be allowed to use bogus user IDs (a user ID created under a fictitious name). This does not prohibit the use of test user IDs . . . .

4.2.4.1 General Password Requirements

Policy Statement 4.2.4.1

Users and system administrators must be informed of the importance of constructing safe passwords and protecting them from unauthorized disclosure; see DSHS IT Security References R4.2.2 Authentication Requirements.

Standards . . .

S4. Change passwords at least every 120 days or more often when required by the system. Where the feature is available, system administrators must configure systems to prompt users to change their passwords when they have expired. . . .

S11. Where possible, password rules must be systematically enforced, including configuring systems so that:

a. Entry of passwords on the screen is not viewable (i.e. a character such as the * is used to hide the actual keyed entry.)
b. Passwords are encrypted during storage and transmission using at least 128-bit encryption.
c. A "lock-out" mechanism is activated after a maximum of up to five unsuccessful authentication attempts.

The Washington State Department of Social and Health Services' *Information Technology Security Policy Manual*, Chapter 6: System Design, Development, Maintenance, and Operations, states in part:

6.2.1 SECURITY REQUIREMENTS DURING DESIGN AND DEVELOPMENT

Policy Statement 6.2.1

IT security must be an integral part of the system development or acquisition process. See DSHS IT Security Procedures P6.2.1 Internet Based Applications, for details.

NOTE: Failure to address and specify security requirements early in a project increases the likelihood that security will prove to be inadequate or that additional costs will be incurred.

Standards

S1. Staff will:

a. Identify the category of data (see Chapter 3, Classifying and Protecting Data and IT Resources) to be processed or accessed by the system.
b. Ensure that appropriate IT security measures are included in the design of the system from the beginning of the project, and
c. That plans for securing the system are included in the system's documentation.

S2. Where audit trails recording access to information are required, managers or developers must design applications such that the audit trails will be secure, and easily maintained and reconstructed.

6.2.3 APPLICATION ACCESS AND PRIVILEGES

Policy Statement 6.2.3

Access privileges for each employee must be controlled to ensure that the employee can only access those applications and processes needed in the performance of his or her duties.

Standards

S1. Operations Managers must require all applications on DSHS mainframe or client server systems to be regulated by standard access control systems software such as RACF, SIMAN and Security Option 1 for the UNISYS, or SAM for Windows.

NOTE: Access control systems software can be:

a. A feature of an operating system
b. An add-on access control package
c. A front-end or firewall that performs access control

S2. A user's session must initially be controlled by access control systems software, and, if defined permissions allow it, control will then be passed to separate application software.

S3. Managers of mainframe operations must ensure that operators are limited to only those system options for which they have privileges.

S4. Managers of mainframe operations must separate work duties and responsibilities of employees in the data control center, including input/output processing, production control, and operations.

S5. No modifications by operations staff to production data, production programs, or the operating system are permitted.

S6. Only authorized maintenance personnel may access the production library. Controls must be in place to prevent unauthorized use or removal of tape files, diskettes, and other media.

6.2.4 MODIFYING MAINFRAME PRODUCTION SYSTEMS

Policy Statement 6.2.4

Managers of operations must employ a formal change control procedure to ensure only authorized changes are made to computer production processing at DSHS.

Standards

S1. Establish and document a system change control procedure.

S2. Requests for changes to production programs or systems shall be in writing. This may be done by e-mail so long as the recipient of the request confirms its authenticity, e.g. by phone.

S3. Provide operations staff with adequate training and operating documentation before a system is moved into production processing.

Policy Statement 6.2.5

Managers of IT operations must require logs to be maintained for DSHS production application systems.

Standards

S1. All computer systems running DSHS production application systems must include logs which record:

a. Changes to critical application system files
b. Additions and changes to the privileges of users
c. System start-ups and shutdowns
d. Attempted system access violations

S2. It must be possible to reconstruct activities from operation logs . . . .

05-36 The Department of Social and Health Services, Economic Services Administration, should improve compliance with eligibility requirements for the Temporary Assistance for Needy Families Program.

Background

The Department of Social and Health Services, Economic Services Administration, administers the federal Temporary Assistance for Needy Families program (CFDA 93.558). Federal regulations require each state to fund a certain amount of this program each year or face financial penalties. For assistance payments to clients, the Program spent $135,281,998 in federal funds and $143,863,652 in state funds during fiscal year 2005.

The program is designed to provide time-limited assistance to needy families with children and to promote job preparation and work opportunities for the parents. As long as minimum requirements are met, states have flexibility in designing programs and determining eligibility requirements and may use grant funds to provide cash or non-cash assistance. To be eligible under federal requirements, a family generally includes a child under 18 living with the parent(s); in addition, the family must qualify as needy under a state's criteria. The state also has specified that, with certain exceptions, applicants must provide Social Security numbers in order to receive benefits.

During fiscal years 2002 through 2004 audits, we identified weaknesses related to compliance with eligibility requirements and reported them in the Statewide Accountability Reports and in the State of Washington Single Audit Reports.

Description of Condition

This year we found similar weaknesses, identifying 68 adult and 34 child clients receiving benefits with improper Social Security numbers. Departmental data for each of these clients included Social Security numbers belonging, according to Social Security records, to deceased individuals with different names and dates of birth.

Cause of Condition

In past audits, the Department identified several reasons that may cause these conditions, including data entry error and a client's use of a first or surname at the Department that was different from the one the client submitted to the Social Security Administration. The Department has been in the process of corrective action since our previous audit but was not able to complete additional controls over this system during fiscal year 2005. It will begin verifying all Social Security numbers to the federal source during fiscal year 2006 and will make necessary changes when the numbers do not match. We will review this area again during our fiscal year 2006 audit.

Effect of Condition

Clients who may not be eligible for the program are receiving both state and federal benefits. In addition, failure to use all resources available for verifying eligibility could leave the Department susceptible to fraud and could lead to a reduction in federal grant funds.

Recommendation

We recommend the Department:

a. Compare Social Security numbers provided by applicants to those contained in records maintained by other state or federal agencies and investigate any discrepancies.

b. Require employees to follow state regulations regarding Social Security numbers and investigate and resolve invalid numbers.

Department's Response

- *The Department currently requires staff to verify Social Security numbers (SSN) following State and Federal regulations and to review any Alerts created by discrepancies in the SSN.*

- *The Department will review the identified cases for errors and take the necessary action to ensure the SSN is correct.*

- *The Department will be implementing a change to the State On Line Query (SOLQ) system to assist staff with verifying the SSN at the time of application. The Information Technology Division / Automated Client Eligibility System will release this update in April 2006. The Department welcomes the 2006 audit review in this area and expects a significant reduction in errors with the implementation of this SOLQ upgrade.*

Auditor's Concluding Remarks

We appreciate the Department's efforts in addressing this finding and will review the Department's progress during our next regular audit.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states in part:

> The auditee shall . . .
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs . . . .

Washington Administrative Code 388-476-0005 states in part:

> (1) With certain exceptions, each person who applies for or receives cash, medical or food assistance benefits must provide to the department a Social Security Number (SSN), or numbers if more than one has been issued.
>
> (2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:
>
> > (a) Apply for the SSN;
> > (b) Provide proof that the SSN has been applied for; and
> > (c) Provide the SSN when it is received.
>
> (3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

05-37 The Department of Social and Health Services, Economic Services Administration, does not adequately monitor other state agencies to which it provides funds from the federal Temporary Assistance to Needy Families Program.

Background

The Department of Social and Health Services, Economic Services Administration, administers the federal Temporary Assistance to Needy Families Program (CFDA 93.558) for the U.S. Department of Health and Human Services. Through interagency agreements, the Administration shares some Program funds with three other state agencies: the Employment Security Department, the Department of Community, Trade and Economic Development, and the State Board for Community and Technical Colleges. In most cases, the Administration determines who is eligible for the Program; however, there are times when the other agencies also determine eligibility. During fiscal year 2005, the Administration spent $262,767,105 in federal Program funds, including distributions of $54,124,999 to these three agencies.

As the administering agency, the Department is responsible for ensuring Program funds are used according to federal regulations. During our fiscal year 2004 audit, we found the Administration was not adequately monitoring the use of Program funds by the other three agencies and could not be sure these funds were being used for allowable purposes.

Description of Condition

This year we found the Administration has not sufficiently addressed this control weakness. The Administration still does not receive adequate supporting documents or perform adequate monitoring of the agencies with which it shares Program funds. It has designed a monitoring plan for these contracts and performed some monitoring during the year, but this has not been sufficient to ensure funds are being used only for allowable purposes.

Specifically, we reviewed invoices totaling $22,225,754 sent to the Administration by the State Board for Community and Technical Colleges for services the colleges delivered to students during fiscal year 2005. Documents attached to the Board invoices included four categories of payments being claimed, including payments to the colleges for the education and training of students the colleges had determined to be eligible for Program funds. Payments to the Board for amounts in this category totaled $7,516,082. We found the following:

- The Administration did not evaluate the procedures colleges used to make these assessments or perform adequate reviews to determine whether applicable students were truly eligible.
    - Administration monitoring procedures rely on using data in its client eligibility and jobs systems. Data for students determined to be eligible by the colleges is not available in these systems, nor has the Administration requested it; therefore, the Administration cannot monitor this type of eligibility with this method.
    - The Administration's monitoring plan for the Board's activities included a procedure to select a sample of students to review for eligibility; however, the Administration relied on the Board to perform the selection. This nullified the validity of the sample and any conclusions drawn from the review.
- The Administration did not adequately review billings prior to payment.
    - The billings from the Board were not always supported with a record of the number of students being served, and the Administration did not follow-up on this omission.
    - The review the Administration performed when testing for eligibility did not include tracing the student clients in the sample to the billings to ensure support existed for those billings.

Cause of Condition

The Administration indicated there was no clear statement written in the agreement that required the other agencies to be monitored by the Administration for their performance. Further, the Administration's contract monitoring plan was not designed to ensure that billings were accurate and were for eligible students and allowable program purposes.

Effect of Condition

The Administration does not have assurance that Program funds were used for allowable purposes. We question the $7,516,082 in federal funds paid to the Board for students whose eligibility the Administration did not monitor.

Recommendation

We recommend the Administration design and follow a monitoring plan that will help ensure agencies receiving Program funds are using those funds for allowable purposes.

Department's Response

The Department agrees in part with the findings.

WorkFirst is a unique partnership of four state agencies working together, yet each agency has its own accountability process.

We acknowledge problems with the current techniques that are in place to monitor the partner agencies for assurance that program funds are used for allowable purposes. The current system is not adequate for monitoring agencies providing services under these contracts and systematically receiving adequate supporting documentation.

In response to the 2004 audit finding, the Department did initiate the following steps to improve the monitoring and documentation of WorkFirst partner's:

- *The Division of Employment and Assistance Programs (DEAP) monitored billings through a randomly selected sample of clients served.*
- *A DEAP Program Manager conducted on-site reviews at each Partner Agency.*
- *Verified services provided and documentation required in the E-JAS system.*

We acknowledge that additional steps are needed. The Department has met with the WorkFirst partners and it was agreed that the Statement of Work contained in the Interlocal agreements with the Employment Security Department, State Board of Community and Technical Colleges, and the Department of Community Trade and Economic Development will be amended by May 1, 2006 to include:

- *Regular monitoring of contracted programs and allowable services.*
- *Required submission and collection of the necessary supporting documentation.*

The Department has met with the State Board of Community and Technical Colleges on the questioned costs. They have assured us that they have the supporting documentation proving that all of the students were eligible for services billed. As part of its corrective action plan, the Department will collect the supporting documents to verify that the $7,516,082 cited by the state auditors was used for eligible students, consistent with state and federal laws, regulations, and rules. The Department will request this data from the SBCTC by March 1, 2006 with a due date of May 1, 2006. Review of returned verification will be completed by July 1, 2006.

Auditor's Concluding Remarks

We reaffirm our finding. We appreciate the Department's continuing efforts to resolve the issues identified in the finding and will review this area in our fiscal year 2006 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

Title 45 of the Code of Federal Regulations, Section 92.40, Monitoring and reporting program performance, states in part:

> (a) Monitoring by grantees. Grantees are responsible for managing the day-to-day operations of grant and subgrant supported activities. Grantees must monitor grant and subgrant supported activities to assure compliance with applicable Federal requirements and that performance goals are being achieved. Grantee monitoring must cover each program, function or activity.

05-38 The Department of Social and Health Services, Economic Services Administration, did not comply with state and federal regulations requiring a monthly inventory of electronic benefit transfer cards used by the Food Stamp Program.

Background

The Department of Social and Health Services, Economic Services Administration, administers the federal Food Stamp Program (CFDA 10.551/10.651) as the Washington Basic Food Program. The Program helps low-income people obtain a nutritious diet by supplementing their income with Basic Food benefits. In fiscal year 2005, approximately 7 percent of the state's population received total federal benefits of $518,739,108, with an average benefit per household of about $170 per month. The Department received federal funds of $43,217,908 for the costs of administering the Program.

The Department's Community Service Offices issue electronic benefit transfer cards to those families they have determined to be eligible. These households use the cards to purchase eligible food products.

Unissued cards are maintained at the Offices. Federal regulations require states to establish security measures to prevent the loss, damage or unauthorized transfer and use of the cards. The regulations specifically require secure card storage controls and the retention of applicable records. To help address this, the Department has established its own requirement that the cards be inventoried and discrepancies reconciled each month in each Office.

Description of Condition

We found the Offices are not always performing the required inventory counts and reconciliations. We reviewed records for the entire year at four Offices and found one provided no reconciliations at all, while another provided only a few months. We selected six more Offices and reviewed records for a six-month period. One of these Offices was able to provide documents for only four reconciliations during that time, while another provided documents for only two.

Cause of Condition

Office staff members indicated that staff changes and availability prevented them from following the inventory requirements.

Effect of Condition

Electronic benefit transfer cards are at increased risk of being removed and used inappropriately. Losses could occur and not be detected on a timely basis, if at all.

Recommendation

We recommend the Department comply with the requirements of federal law and agency procedures by completing and documenting a monthly electronic benefit transfer card inventory and reconciliation. We also recommend the Department ensure these records are maintained for the required period of time.

Department Response

The Department agrees with this finding.

The Community Services Division (CSD) will implement major changes with the electronic benefit transfer card (EBT) inventory and reconciliation process. The new requirements are as follows:

- *All Community Service Offices (CSO's) will be required to send a reconciliation report each month to their Region office. Region office staffs will be required to send a monthly report to Headquarters reporting all offices in the region have reconciled.*

- *Headquarters will monitor and follow up on any Region not reporting as required.*

- *A review of the reconciliation process will be sent to the field to ensure all CSO's understand and follow the required process.*

- *The new reporting requirements will be reviewed with the Regional Administrators with a follow up expectations letter to the field from the CSD Director.*

These changes will be implemented by April 1, 2006.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issue identified in the finding and will review the corrective action in our fiscal year 2006 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

The federal Office of Management and Budget's Circular A-133, *Audits of States, Local Governments, and Non-profit Organizations*, Compliance Supplement, Special Tests and Provisions for the Food Stamp Program states:

> 3. Issuance Document Security
>
> Compliance Requirement - The State is required to maintain adequate security over, and documentation/records for...EBT cards (7 CFR section 274.12(h)(3)....

7 CFR section 274.12(h)(3) states:

> (3) System security. As an addition to or component of the Security Program required of Automated Data Processing systems prescribed under Sec. 277.18(p) of this chapter, the State agency shall ensure that the following EBT security requirements are established:
>
> > (i) Storage and control measures to control blank unissued EBT cards....

7 CFR section 274.11 states:

> (a) Availability of records. The State agency shall maintain issuance, inventory, reconciliation, and other accountability records for a period of three years as specified in Sec. 272.1(f) of this chapter. This period may be extended at the written request of FNS.

Section 8.9 of the Department's training manual for the Program provides detailed instructions for a monthly reconciliation process, including a prohibition against issuing cards to staff or clients until all cards and card numbers have been reconciled

05-39 The Department of Social and Health Services, Division of Disability Determination Services, did not comply with state and federal regulations when contracting for services paid with Social Security Disability Insurance Program funds.

Background

The Department of Social and Health Services, Division of Disability Determination Services, administers the Social Security Disability Insurance Program (CFDA 96.001) with funds from the U.S. Social Security Administration. This Program pays monthly cash benefits to eligible claimants to replace earnings lost due to physical or mental impairments that prevent the individual from working. In general, State agencies make initial disability determinations for the federal government, which then pays them, either in advance or in reimbursement, for the costs of making such determinations. During fiscal year 2005, the Division spent $37,582,178 in federal funds to determine claimants' medical eligibility for disability benefits.

To assist in making proper determinations, the Division purchases medical examinations, X-ray services and laboratory tests to supplement evidence obtained from the claimants' physicians or other health care sources. These purchases are for personal services known as consultative evaluations and are obtained from two sources: individual medical professionals and companies that employ or subcontract with medical professionals. In state fiscal year 2005, the Division spent $5,225,989 for consultative evaluations by individual medical practitioners and $2,514,388 for consultative evaluations by companies that employ or subcontract with medical professionals.

Federal regulations applicable to the awarding of federal funds to states require the states to follow their own laws and regulations for contracting for services with these funds. Personal service contracts in this state must follow prescribed procurement regulations, including a formal competitive procurement process if the amount is more than $20,000.

Description of Condition

The Division did not comply with state regulations for contract procurement and therefore is not in compliance with federal regulations. During our review, we found:

- For consultative evaluations by individual medical practitioners:
    - No competitive procurement process was followed for these services. The Division learned of interested providers informally through word-of-mouth. Many practitioners were paid amounts that substantially exceeded the threshold of $20,000, requiring a formal competitive procurement process.
    - No contracts existed for any of these services.
- For consultative evaluations by companies that employ or subcontract with medical professionals:
    - The Division mailed a solicitation letter to four companies without establishing whether other companies might be interested in competing for the business. The Division did not have written documentation explaining why more firms were not contacted.
    - Of the four companies contacted, two responded. Division management stated that the other companies did not submit proposals because of insurance requirements. This is of particular concern because, after we discovered and reported to management that one of the two contractors did not meet the insurance requirements, the Division granted an exception from this requirement to the contractor. Since insurance was part of the contract procurement requirements, granting an exception may not have been in the best interests of the state.

Cause of Condition

The condition was caused by lack of knowledge regarding state procurement requirements.

Effect of Condition

The Department cannot ensure the state's resources were used in the most economical manner possible. In addition, the state may not be adequately protected when more than $5 million in services is purchased without written contracts and terms.

We question the $7,740,327 in federal funds paid for both types of consultative evaluation services in fiscal year 2005.

Recommendation

We recommend the Department:

- Properly classify consultative evaluation contracts as personal service contracts.
- Follow appropriate competitive procurement procedures.
- Prepare and maintain contract documentation for consultative evaluations by individual medical practitioner.

Department's Response

The Department of Social and Health Services, Division of Disability Determination Services (DDDS) does not agree with the auditor's assertion that medical providers who perform consultative examinations of claimants should be categorized as personal services and therefore these services must be competitively procured. The Division has been operating under the Office of Financial Management (OFM) classification of these contracts as client service. We recognize that there is a difference of opinion between the auditors and OFM. The Division will seek clarification of whether these services should be classified as personal service or client service from OFM.

Per our federal guidelines contained in the Social Security Administration's (SSA) Program Operational Manual Systems (POMS), DI 39545.260 #8 , "The Division ***may consider*** *conducting a study to determine the feasibility of using competitively awarded contracts for medical services with both large and small volume providers, including individual and group practices."*

The Division would like to correct the auditor's statement that "after we discovered and reported to management that one of the two contractors did not meet the insurance requirement; the Division granted an exception from this requirement to the contractor. Since insurance was part of the contract procurement requirements, granting an exception may not have been in the best interests of the state."

This contractor was a limited liability company (LLC) formed by a non-medical individual who had two psychiatrists who worked for the business entity. These medical providers perform the Division's medical evaluations. While the business entity was able to acquire liability insurance in the amounts the Department requires, the business entity could not acquire medical liability or omissions insurance. However, the two medical providers who worked for the entity each had the appropriate medical liability insurance in the amounts required by the Department and submitted certificates of insurance proving this to Central Contracting Services (CCS). CCS is the Department's contracting authority and CCS ***accepted*** *the insurance coverage as it pertained to this entity as meeting the Department's contractor insurance requirement. The insurance requirement was not waived for this entity.*

The Division agrees with the auditor's finding that no contracts exist with individual medical providers. The Division is given the responsibility of management and oversight of the Consultative Examination Process. One of the Policy Guidelines the Division must follow is to, "Maintain a good working relationship with the medical community in order to recruit sufficient physicians and other providers of medical services to ensure ready availability of Consultative Examination providers." (POMS DI 29545.230) On average, the Division sends 100-150 recruiting letters a year to professionals requesting their services in areas throughout the state. Our typical success rate is between 10-20%. The Division has difficulty recruiting because:

- *SSA documentation and report requirements are detailed and very specific*
- *Examinations take a considerable amount of time out of a doctor's practice*
- *Our client population has a risk of not showing for appointments which adds more burden of lost time and money for professionals*
- *DDDS fees are not commensurate with market rate for the detail we require*
- *Because of the malpractice insurance cost and doctors leaving WA state to practice elsewhere, resources are depleted, especially in rural areas and professionals are too busy with their own patients*
- *Specialists are already too busy with their own patients and do not have the necessary time to spend to do an exam and report*
- *Health Maintenance Organization's, Health Networks, etc. do not allow doctors to "moonlight" or work outside their company*

The Division has always used a fee for service voucher contract for individual doctors because of the difficulty we have in recruiting. As long as professionals meet the professional qualifications for doing consultative exams, we do not turn anyone away. We supply them with our rules, regulations, and guidelines and put them in the mix of scheduling. Our scheduling system is designed to create a fair and equitable process. Examination requests are pulled up on a queue based, on location of claimant, and type of exam. Corresponding available doctors meeting this criterion come up for scheduling. Doctors appear for scheduling in a rotational order. After an exam is scheduled with a doctor, he/she then moves to the bottom of the list and will not be scheduled again until we have scheduled with all other available, willing, and eligible doctors. In some areas, we may only have one doctor available and willing.

Due to the large number of psychiatric examinations (60 percent of our exams), and the lack of psychiatrists willing to do these examinations, we developed client service contracts to appeal to a provider or company by offering volume of exams in different counties. In an effort to ensure the state's resources were used economically and still obtain the necessary service, we set the client service contract fee lower than our published fee schedule. Even though client service contracts do not require a competitive bid process, we did send the contracts to five companies and one individual provider. One company did not respond, two responded stating our fees were too low, and the individual provider could not meet the insurance requirements. Of the two companies that bid the contract, both were awarded.

Because of the reasons associated with difficulty in recruiting, we often will attract semi-retired or retired providers who may not carry the amount of insurance required by Department contracts. The Division examinations are a one time medical or mental assessment of the claimant which considerably reduces the risk to the provider and the Department. Because of the extremely low risk to the state, the Division does not require the Department's insurance required amount, in order to maintain a sufficient amount of resources as directed by SSA.

The Division is in the process of drafting a Core Provider Agreement similar to those used by the Health and Recovery Services Administration/Medical Assistance Administration for all independent providers. We are working with the Attorney General's office to develop the appropriate language for the agreement and hope to have this ready for dissemination by the end of the calendar year.

Auditor's Concluding Remarks

We considered the Division's response and reaffirm our finding.

We relied on the Office of Financial Management contract guidelines to help determine if these contracts should properly be considered personal services contracts. Based on grant documentation, the federal government refers the disabled worker to the Division to assist it in making a disability determination and reimburses the Division for its costs; therefore, the federal government, not the applicant, is the Division's client.

Division management stated it was difficult to recruit providers for these services but did not provide evidence of a recruiting and evaluation process to support that statement. In addition, we remain concerned about the lack of contract documentation of insurance coverage that was part of the application requirement.

We appreciate the Department's efforts to resolve the issues identified in the finding and we will review the corrective action in the fiscal year 2006 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

The U.S. Office of Management and Budget's *Cost Principles for State, Local and Indian Tribal Governments*, Circular A-87, Attachment A, Section C states in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:

    c. Be authorized or not prohibited under State or local laws or regulations....

RCW 39.29.006 states in part:

> (3) "Competitive solicitation" means a documented formal process providing an equal and open opportunity to qualified parties and culminating in a selection based on criteria which may include such factors as the consultant's fees or costs, ability, capacity, experience, reputation, responsiveness to time limitations, responsiveness to solicitation requirements, quality of previous performance, and compliance with statutes and rules relating to contracts or services.
>
> (7) "Personal service" means professional or technical expertise provided by a consultant to accomplish a specific study, project, task, or other work statement....

RCW 39.29.011 states in part:

> All personal service contracts shall be entered into pursuant to competitive solicitations, except for...
>
> (1) Emergency contracts;
>
> (2) Sole source contracts;
>
> (3) Contract amendments;
>
> (4) Contracts between a consultant and an agency of less than twenty thousand dollars. However, contracts of five thousand dollars or greater but less than twenty thousand dollars shall have documented evidence of competition. Agencies shall not structure contracts to evade these requirements;...

The Office of Financial Management's *State Administrative and Accounting Manual,* states in Section 15.10.10:

> Personal services are to be procured and awarded by state agencies in accordance with the requirements of Chapter 39.29 RCW.

Section 15.20.30.a states:

> Competitive solicitation for contracts of $20,000 or greater requires a documented, formal solicitation process as described in the following subsections. *(Auditor's note: Following this section are detailed regulations for this process.)*

Section 20.20.20 states in part:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

The Office of Financial Management's *Guide to Personal Service Contracting*, Section 1.3, states in part:

> Personal services are professional or technical services providerd by a consultant to accomplish a specific study, project, task, or other work statement. Consultants, who provide personal services, serve state agencies as objective advisers by rendering professional opinions, judgments, or recommendations.

Section 1.6 of the *Guide* lists as an example of personal services:

> Medical and psychological services, including evaluation and consultative services

The Office of Financial Management's *Guide to Client Service Contracting*, Introduction, page 2, states in part:

> Clients are those <u>individuals</u> the agency has statutory responsibility to serve, protect, or oversee...

05-40 The Department of Social and Health Services, Division of Disability Determination Services, reported incorrect expenditures for the Social Security Disability Insurance Program on several reports, including the Schedule of Expenditures of Federal Awards.

Background

The Department of Social and Health Services, Division of Disability Determination Services, administers the Social Security Disability Insurance Program (CFDA 96.001) with funds from the U.S. Social Security Administration. This Program pays monthly cash benefits to eligible claimants to replace earnings lost due to physical or mental conditions that prevent the individual from working. In general, State agencies make initial disability determinations for the federal government, which then pays them, either in advance or through reimbursement, for the costs of making such determinations. During fiscal year 2005, the Division spent $37,582,178 in federal funds to determine claimants' medical eligibility for disability benefits.

As part of monitoring the Division and its performance, the Social Security Administration requires specific reports to be filed weekly, monthly, quarterly, and annually. The quarterly Report of Obligations for SSA Disability Programs helps the Administration to plan and authorize federal funding for the Division. In addition, as a condition of receiving federal funds, state agencies must report the total spent during the state fiscal year on the annual Schedule of Expenditures of Federal Awards

Description of Condition

When we attempted to reconcile reported Program data to accounting records, we found::

- The amount reported in the Schedule of Expenditures of Federal Awards was overstated by $2,218,301. June medical accruals, which are liabilities that have not been paid by the Division, were mistakenly entered twice into the state's Agency Financial Reporting System at fiscal year end.

- The yearly total of the payment amounts taken from the Division's in-house accounting system and reported in the quarterly Reports of Obligations was understated by $1,203,997. Division management had no explanation for this underreporting.

Cause of Condition

The Division does not reconcile among its various reports and two different accounting systems to ensure differences are identified, explained and corrected in a timely manner.

Effect of Condition

The federal grantor has not received accurate information to use for monitoring purposes. This could affect future federal funding.

Recommendations

We recommend the Division perform adequate reconciliations to ensure it is reporting correct Program financial data to the grantor.

Department's Response

The Division agrees with the finding that the Division's June medical accrual journal voucher was entered into the state accounting system twice in error. This breakdown in normal internal control procedures occurred as a direct result of being short staffed, with two of four staff gone on maternity leave. This is an isolated incident that should not occur in the future.

The Division along with the Office of Accounting Services (OAS) is attempting to reconcile the Division's Quarterly 4513 reports to the amounts that OAS reports on the Schedule of Expenditures of Federal Awards (SEFA) for state fiscal year 2005. OAS will report the conclusion of the reconciliation to the Auditors as soon as possible. However,

it is unknown, due to the complexity of the two different bases used, if a complete reconciliation will be possible. OAS reports grant expenditures on the SEFA with different bases than the Division reports expenditures and obligations to SSA. There is also the question of grant monies reported under the two Catalog of Federal Domestic Assistance (CFDA) numbers that SSA funds roll up to because they include grant funds expended by the Division of Vocational Rehabilitation. These expenditures are not included in the Division's official Quarterly 4513 reports.

The Division disagrees with the Auditor's "Cause of Condition." The Division uses the State's Agency Financial Reporting System (AFRS) for all expenditure processing and uses the State's Enterprise Reporting System to pull detailed reports of expenditures. The Division's in-house system, AS400, is used to collect medical obligation data only. The Division has internal controls in place to ensure all expenditure or disbursement data and all known obligations are reported to SSA in the period that they occur.

Auditor's Concluding Remarks

The Department was not able to provide us with appropriate reconciliations during our review. We reaffirm our finding that Program expenditures were reported incorrectly.

We appreciate the Department's commitment to resolving the issues identified in the finding and will review the corrective action in the fiscal year 2006 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

The U. S. Office of Management and Budget's Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, states in part:

Section .310 Auditee Responsibilities: Financial Statements

(b) Schedule of expenditures of Federal awards. The auditee shall also prepare a schedule of expenditures of Federal awards for the period covered by the auditee's financial statements. . . . At a minimum, the schedule shall:

(1) List individual Federal programs by Federal agency. For Federal programs included in a cluster of programs, list individual Federal programs within a cluster of programs.

(3) Provide total Federal awards expended for each individual Federal program and the CFDA number or other identifying number when the CFDA information is not available.

Title 20 of the Code of Federal Regulations, Part 437, *Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments*, states in part:

Section 437.20 Standards for financial management systems. Financial Administration:

(a) A State must expend and account for grant funds in accordance with State laws and procedures for expending and accounting for its own funds. Fiscal control and accounting procedures of the State, as well as its subgrantees and cost-type contractors, must be sufficient to—

(1) Permit preparation of reports required by this part and the statutes authorizing the grant, and

(2) Permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of applicable statutes.

(b) The financial management systems of other grantees and subgrantees must meet the following standards:

(1) Financial reporting. Accurate, current, and complete disclosure of the financial results of financially assisted activities must be made in accordance with the financial reporting requirements of the grant or subgrant.

(2) Accounting records. Grantees and subgrantees must maintain records that adequately identify the source and application of funds provided for financially-assisted activities. These records must contain information pertaining to grant or subgrant awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income.

(3) Internal control. Effective control and accountability must be maintained for all grant and subgrant cash, real and personal property, and other assets. Grantees and subgrantees must adequately safeguard all such property and must assure that it is used solely for authorized purposes.

The Office of Financial Management's *State Administrative and Accounting Manual* lists the following accounting and control requirements:

Section 50.30.45:

Responsibilities of state agencies/institutions administering or expending federal awards

1. Develop internal policies in accordance with this policy and the requirements of the Act and Circular.

2. Identify, account for, and report all expenditures of federal awards in accordance with laws, regulations, contract and grant agreements, and requirements included in this and other sections of the OFM, State Administrative and Accounting manual.

3. Provide year-end, certified, federal financial data per requirements included in Chapter 95.

05-41 The Department of Social and Health Services, Division of Disability Determination Services, received reimbursement for unallowable costs for the Social Security Disability Insurance Program.

Background

The Department of Social and Health Services, Division of Disability Determination Services, administers the Social Security Disability Insurance Program (CFDA 96.001) with funds from the U.S. Social Security Administration. This Program pays monthly cash benefits to eligible claimants to replace earnings lost due to physical or mental impairments that prevent the individual from working. In general, state agencies make initial disability determinations for the federal government, which then pays them, either in advance or in reimbursement, for costs in making such determinations. During fiscal year 2005, the Division spent $37,582,178 in federal funds to determine claimants' medical eligibility for disability benefits.

Federal regulations require states to follow their own laws and regulations when spending federal funds. The state of Washington requires all expenditures to be adequately supported and has described the minimum standards for payment support.

Description of Condition

The Division, the Social Security Administration, and the Washington State Patrol entered into a Memorandum of Understanding in October 2004 to create a Cooperative Disability Investigations Unit to investigate cases of possible disability fraud. The agreement names specific allowed costs for the Patrol and states that the Division will reimburse the Patrol only for those costs. The agreement does not include any provision for indirect costs.

We reviewed one 2005 quarterly billing from the Patrol for $76,021, consisting of $19,555 for unallowable indirect costs and $56,466 for other costs that were unallowable because they were not supported by documentation provided by the Patrol. We found the Division paid the total invoice and then requested reimbursement from the Administration.

Cause of Condition

The Division did not adequately review the transaction and the Memorandum of Understanding prior to payment and request for reimbursement to determine which costs were allowable.

Effect of Condition

The Division received funds from the federal grantor for payments that were unallowable under Memorandum terms and federal and state regulations. We question the $76,021 in unallowable costs we found in this one quarterly billing. Unallowable costs could be even higher if other billings had similar conditions.

Recommendations

We recommend the Division:

- Strengthen its review of documentation before making future payments and requesting reimbursement.
- Review prior billings to determine if it paid other unallowable costs, request reimbursement for any improper amounts from the Patrol, and then reimburse the federal grantor for these amounts.

Department's Response

The Department of Social and Health Services, Division of Disability Determination Services agrees with the Auditor's assessment that the Division may have paid indirect costs to the Washington State Patrol (WSP) that would be considered unallowable because there was no provision for these costs in the Memorandum of

Understanding (MOU) that was signed by representatives from the Social Security Administration (SSA), the Division and the WSP.

The Division has been in contact with SSA's Regional Office in Seattle. This office has federal oversight over the Division and wrote the original MOU between SSA, WSP and the Division. Currently, SSA's Regional Office is writing a new MOU between all parties involved. The new MOU will include a provision for indirect costs.

The Division agrees with the Auditor's finding that the Division paid $56,466 to the WSP that was not supported by adequate back-up documentation. However, the costs in question were payroll costs and these are allowable costs under the terms of the MOU. Since the audit, the Division reviewed all paid WSP billings from the inception of the Cooperative Disability Investigations Unit (January 2003) until current and did not find any instance where the Division over or underpaid the WSP.

The Division agrees that Fiscal Staff did not previously completely review the WSP billing documentation adequately. The Division has implemented internal controls that will ensure that every billing is reviewed for adequate documentation prior to payment.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review the corrective action in the fiscal year 2006 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

Title 20 of the Code of Federal Regulations, Section 437, *Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments*, states in part:

437.20 Standards for financial management systems. Financial Administration:

(a) A State must expend and account for grant funds in accordance with State laws and procedures for expending and accounting for its own funds.

(b) The financial management systems of other grantees and subgrantees must meet the following standards:

(5) Allowable cost. Applicable OMB cost principles, SSA program regulations, and the terms of grant and subgrant agreements will be followed in determining the reasonableness, allowability, and allocability of costs.

(6) Source documentation. Accounting records must be supported by such source documentation as cancelled checks, paid bills, payrolls, time and attendance records, contract and subgrant award documents, etc.

The Office of Financial Management's *State Administrative and Accounting Manual* lists the following accounting and control requirements:

Section 85.32.10: Agency Responsibilities

It is the responsibility of the agency head, or authorized designee, to certify that all expenditures/expenses and disbursements are proper and correct. Agencies are responsible for processing payments to authorized vendors, contractors, and others providing goods and services to the agency. Agencies are to establish and implement procedures following generally accepted accounting principles.

Section 85.32.20b: Payment Authorization

Prior to payment authorization, agencies are to verify that the goods and services received comply with the specifications indicated on the purchase documents. Authorized personnel receiving the goods and services are to indicate the actual quantities received.

Section 85.32.30a: Payment Processing Documentation

At a minimum, payment processing documentation should include evidence of authorization for purchase, receipt of goods or services, and approval for payment.

Section 85.32.40: Payment Processing related to accuracy of support states in part:

(b) Agencies are to establish procedures which verify the mathematical accuracy of all documents and ensure that charges are properly recorded to the appropriate accounts.

(c) Audit disbursement documents for the following:

- Quantities indicated on the invoice agree with those documented as received on the receiving report.
- Unit prices on the invoice agree with those indicated on the disbursement document.
- Extensions and footings are correct.
- Written approval by the agency head or authorized designee authorizing payment appears on the disbursement document.

The *Memorandum of Understanding for Cooperative Disability Investigations (CDI)* states in part:

Section IXB, fourth bullet: WSP Detectives and Office Assistant Senior (OAS)

SSA will provide additional funding to the Washington DDS (as discussed above) to reimburse the WSP for the personnel costs incurred for their detectives and OAS assigned to the CDI Unit, including salary, fringe benefits, and overtime (if needed), and other allowable expenses identified in this agreement.

Section IXC, first bullet: WSP Detective Vehicles

The WSP will provide two official vehicles to the WSP detectives assigned to the CDI Unit. SSA agrees to provide the Washington DDS with funds to reimburse the WSP's costs and all routine operational expenses of those vehicles exclusively identified for program utilization, with the use of such vehicles restricted to CDI Unit official use only. WSP acknowledges that its detectives will be covered by the State's self-insurance program when operating the two assigned vehicles in the course and scope of their official duties.

Section IXD, Other

The SSA will fund CDI-specific training and travel and all other costs necessary to maintain and operate the Seattle CDI Unit effectively, subject to the liability conditions set forth in Sections VIII and IX of the MOU and subject to the availability of funds.

05-42 The Department of Social and Health Services, Health and Recovery Services Administration, claimed costs for unallowable activities under the State Children's Health Insurance Program.

Background

The Department of Social and Health Services, Health and Recovery Services Administration, administers the federally-funded State Children's Health Insurance Program (CFDA 93.767). This Program provides health care to uninsured, low-income children not eligible for Medicaid, including children born in this country of undocumented alien parents. The latter are covered for prenatal care and associated health services from conception to birth. Total Program payments during fiscal year 2005 were $37, 238,638.

During federal fiscal years 2004 and 2005, qualifying states, including Washington, were permitted to use up to 20 percent of their federal fiscal year 1998-2001 Program awards to help pay for coverage for Medicaid-eligible children whose family income fell within certain limits. The expenditures transferred from Medicaid to the Program had to be for allowable activities as defined by federal requirements and could not be charged to the Program to avoid Medicaid restrictions. Such restrictions include a Medicaid prohibition against payments for medical services to undocumented aliens for anything except emergencies or labor and delivery. We have reported findings related to unallowable services provided with Medicaid funds to undocumented aliens for the past four years.

Description of Condition

Because of the risk associated with unallowable Medicaid payments for pregnant undocumented aliens *(See Findings M05-08 and M05-09 in our Medicaid Report for fiscal year 2005.)*, we reviewed such payments to determine if any costs for services other than labor and delivery had been transferred from Medicaid to the Program.

We found that $1,573,409 of unallowable Medicaid services for pregnant women, including dental procedures, eye care and durable medical equipment, had been transferred from Medicaid. These costs were also unallowable under the Program's requirements, as they were services for the benefit of the mothers rather than of the children.

Cause of Condition

We found:

- The Administration has no policies and procedures in place to identify allowable costs before they are transferred from Medicaid to the Program.

- According to management, the Administration does not have the staffing and expertise to review the potential 700,000 to 1 million claims for services related to births before transferring costs. Therefore, it simply included in the transfers all charges beginning at nine months before each birth, regardless of the actual length of pregnancy or allowability of the charges.

- Staff members believe that labor and delivery coverage includes all costs associated with the mother, regardless of the nature of those costs.

Effect of Condition

Costs that were unallowable for reimbursement in both the Program and Medicaid were transferred from Medicaid to the Program and federal reimbursements for those unallowable costs were obtained. We question the $1,573,409 of Program payments made for unallowable purposes.

Recommendation

We recommend the Administration:

- Establish adequate internal controls to ensure it transfers to this Program only those Medicaid expenditures that are allowable.

- Provide training and resources to help Program employees distinguish between allowable and unallowable costs.

- Work with the grantor to determine the amount it owes for the unallowable costs transferred to the Program and reimbursed by the federal government.

Department Response

The Department partially concurs with this finding for the following reasons:

- *The Administration does have policies and procedures in place to identify allowable costs for transfer from Medicaid to the State Children's Health Program (SCHIP). Our current process involves a quarterly matching of Department of Health (DOH) 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 & delivery, abortion, and sterilization are excluded.*

  Additionally, the Administration has been advised by CMS in an e-mail dated December 12, 2005 from Elizabeth Trias that they will "allow costs for such services as dental, vision care and physical therapy since Washington covers all services for women under the SCHIP unborn as they do under the pregnant women's program." As a result, the Administration will not isolate these costs from our current process.

- *The Administration would like additional detail information of the questioned costs of $1,573,409 in order to determine how these are related to labor & delivery, postpartum and family planning. This information will enable us to better refine our current process so that we can isolate the ineligible costs. We would not be able to review each individual claims but we can identify diagnosis and/or procedure codes for exclusion.*

- *As noted above, the Administration does exclude all inpatient hospital claims for labor & delivery in our current process.*

Auditor's Concluding Remarks

The Department's response confirms the use of a method that does not comply with the State plan because it does not filter for eligible procedure codes over the 271 day period. The CMS approval letter for the Program amendment for prenatal care states:

> Specifically, this amendment allows coverage for unborn children with family incomes up to, and including, 185 percent of the Federal poverty level and who are not eligible for Medicaid. Coverage will begin at conception and continue through birth. Benefits will include prenatal care and associated health services for children.

We have not received a copy of the e-mail cited in the Department's response and have not been able to review its origin, content or context. We affirm our finding that charges that would not reasonably be included in prenatal care and associated health care for children from conception until birth were transferred and paid by the Program.

Applicable Laws and Regulations

The U.S. Office of Management and Budget's Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Section C.3.c states in part:

> Any cost allocable to a particular Federal award or cost objective under the principles provided for in this Circular may not be charged to other Federal awards to overcome fund deficiencies, to avoid restrictions imposed by law or terms of the Federal award, or for other reasons....

Title 42 of the Code of Federal Regulations, Section 457.224 (a)(2), states for FFP *(Auditor's note: Federal Financial Participation)*: Conditions relating to cost sharing:

(a) No FFP is available for the following amounts, even when related to services or benefit coverage which is or could be provided under a State SCHIP program--

(2) Any amounts paid by the agency for health benefits coverage or services furnished to individuals who would not be eligible for that coverage or those services under the approved State child health plan, whether or not the individual paid any required premium or enrollment fee.

42 CFR 457.226 Fiscal policies and accountability.

A State plan must provide that the SCHIP agency and, where applicable, local agencies administering the plan will—

(a) Maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements;...

05-43 The Department of Social and Health Services, Mental Health Division, did not comply with state laws or the Department's policies and procedures for recovering a Community Mental Health Services Block Grant overpayment reported in the previous audit.

Background

The Department of Social and Health Services, Mental Health Division, administers the federal Community Mental Health Services Block Grant (CFDA 93.958), received from the U.S. Department of Health and Human Services. This Program provides funds to states and territories to help them provide comprehensive, community-based mental health services for adults with serious mental illness and children with serious emotional disturbances. These services may include direct services to clients or other professional/technical services. The Division contracts with service providers and professional and technical contractors to provide Program services. In fiscal year 2005, the Department spent $8,584,851 in this Program.

In our fiscal year 2004 State Accountability Report and State of Washington Single Audit Report, we described a Division contract with a vendor to provide training to Division clients. The amount of $112,000 was to be provided entirely by federal funds from this Block Grant. Federal regulations require states to follow their own laws and regulations when spending federal funds.

We found the Division paid the vendor an advance of $72,000, contrary to both state law and regulations. The contract was terminated after $88,900 had been paid; the services were never completed. We questioned the $72,000 in advance payments and recommended the Division comply with state and federal regulations. The Division responded it would develop policies and procedures, along with a mechanism for oversight, that would preclude further advance payments.

Description of Condition

While following-up on the resolution of the previous finding, we found:

- The Division has not yet begun developing policies and procedures to preclude advance payments.
- Department policy requires each of its divisions to establish written policies and procedures for identification and resolution of questionable bills from, or payments to, providers and vendors. The Division has not complied with this requirement.
- Department policy requires overpayment data to be forwarded to its Office of Financial Recovery for collection and provides that only the Office may forgive debt. The Division did not follow this policy. It did not:
    - Complete an analysis to determine how much of the $72,000 advance might have been earned by the contractor before the contract was terminated.
    - Advise Financial Recovery of the remainder to be collected and allow it to determine if the debt should be collected or forgiven.

Cause of Condition

Division management stated its recent restructuring and large staff turnover have prevented it from working on policies and procedures. The Division did not pursue repayment because management believed the contractor had gone out of business and the funds could not be collected.

Effect of Condition

No policies and procedures have been established to help prevent further advance payments and to assist in recovering future overpayments. In addition, the Office of Financial Recovery has no record that would allow it to pursue collection of this particular overpayment.

Recommendation

We recommend the Division establish and follow appropriate written policies and procedures. We also recommend the Division advise Financial Recovery of the amount the Office should attempt to recover from the contractor so that the federal funds can be reimbursed.

Department's Response

The Department partially agrees. The FY04 audit finding and State Auditor's Office recommendation were addressed through implementation of a corrective action plan. We recognize a need for further refinement of our policies and procedures to address a recovery process with the Office of Financial Recovery. The Mental Health Division (MHD) will assess and amend policies and procedures accordingly.

The finding and recommendation as cited above suggests that there was an overpayment. The MHD disagrees with this assumption based upon the following facts.

The contract in question had a pay point reimbursement methodology. The payment in question in the amount of $72,000 was for pay point #1. Pay point #1 provided for the payment of fixed administrative costs once the Consumer to Provider Training had commenced. Source documentation that accompanied the payment document validated that the training had commenced and that services were provided. This service was further validated by an on-site review conducted by a mental health program manager.

The Department of Health & Human Services (DHHS) notified the State of Washington Office of Financial Management (CIN A-10-05-8828) that they had reviewed the report (performed by the Washington State Auditor) and found it to have met Federal Audit Requirements. One of the items listed in this report (page 7 of 10) referenced Advanced Payments. DHHS recommended procedures be implemented to ensure prepayments are not charged to Federal Funds. In this report DHHS did not request return of funds to the federal government. The Department considers this issue resolved.

Auditor's Concluding Remarks

In the prior year's finding the Division concurred with the characterization of the payment as an advance and agreed the training was never completed. The Division did not follow state and agency requirements for collection of the advance as an overpayment. The Department agreed to develop and implement policies and procedures to preclude advance payment of administrative expenditures but the corrective action plan was not implemented.

With respect to the Health and Human Services Office of Inspector General notification (CIN A-10-05-82258) to the Office of Financial Management, this correspondence acknowledged completion of the initial review of the 2004 audit report and stated the audit work met federal audit requirements. This correspondence included an attachment summarizing the recommendations from the findings. The correspondence stated the final determination will be made by the Health and Human Services resolution official listed on the attachment and indicated responses should be sent to that official.

We reaffirm our finding and will review the corrective action plan for this area in the fiscal year 2006 audit. We appreciate the cooperation from Department staff during this audit.

Applicable Laws and Regulations

For certain grant programs, including the Mental Health Block Grant, federal regulations provide an exemption from federal cost principles, provided the state adopts its own cost principles consistent with federal requirements. The U.S. Department of Health and Human Services, Office of the Inspector General considers the U.S. Office of Management and Budget's Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments,* to be the benchmark for state cost principles. Because the state has not adopted its own cost principles in conformance with this Circular, the Circular's requirements apply.

Attachment A, Section C.4.a of the Circular states:

Applicable credits refer to those receipts or reduction of expenditure-type transactions that offset or reduce expense items allocable to Federal awards as direct or indirect costs. Examples of such transactions are: purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds or rebates, and adjustments of overpayments or erroneous charges. To the extent that such credits accruing to or received by the governmental unit relate to allowable costs, they shall be credited to the Federal award either as a cost reduction or cash refund, as appropriate.

Section C.1 states in part:

Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:

c. Be authorized or not prohibited under State or local laws or regulations....

Revised Code of Washington 43.88.160(4)e states in part:

The responsibility for recovery of erroneous or improper payments made under this section shall lie with the agency head or the agency head's designee in accordance with regulations issued pursuant to this chapter. Nothing in this section shall be construed to permit a public body to advance funds to a private service provider pursuant to a grant or loan before services have been rendered or material furnished.

The Department of Social and Health Services' Administrative Policy 10.02, "Overpayments and Debt for Providers and Vendors", states in part:

B. Each DSHS administration must have written policies and procedures regarding the identification and resolution of questionable bills from, or payments to, providers and vendors. OFR must receive a copy of these policies and procedures as they are developed or modified. These policies and procedures must:

1. Indicate that overpayments must be referred to OFR.
2. Comply with all relevant laws and administrative policies.

D. With the exception of the areas outlined in Administrative Policy 4.13:

1. All debts and overpayments must be referred to OFR for collection.
2. Only the OFR Chief may reduce or forgive overpayments or debts.
3. Only OFR may collect vendor and provider debt.

05-44 The Department of Social and Health Services, Mental Health Division, did not comply with state and federal regulations when contracting for services paid with federal Community Mental Health Services Block Grant funds.

Background

The Department of Social and Health Services, Mental Health Division, administers the federal Community Mental Health Services Block Grant (CFDA 93.958), received from the U.S. Department of Health and Human Services. This Program provides funds to states and territories to help them provide comprehensive, community-based mental health services for adults with serious mental illness and children with serious emotional disturbances. These services may include direct services to clients or other professional/technical services. The Division contracts with service providers and professional and technical contractors to provide Program services.

In fiscal year 2005, the Department spent $8,584,851 in this Program. Federal regulations regarding funds awarded to states require states to follow their own laws and regulations when spending this money.

In our fiscal year 2004 State Accountability Report and State of Washington Single Audit Report, we described a lack of Program compliance with state regulations for contract procurement. One of the issues we identified related to contracts not being properly executed or approved before the start of work, as state regulations require.

Description of Condition

The Division still is not in compliance with state regulations regarding contract procurement and therefore is not in compliance with federal regulations. During our review, we identified four Program personal and client service contracts that were not properly executed and approved prior to the start date of the contract or the performance of work Lag times between the start dates and the execution and approval dates ranged from a week to over three months. The total value of these four contracts is $3,467,000.

Cause of Condition

There is some discrepancy in instructions given to staff members. Division policies and procedures, effective June 1, 2005, allow for "after-the-fact" contracts in some cases, although an earlier e-mail notified staff members not to enter into after-the-fact contracts for this Program.

Effect of Condition

The Department has no accurate record of binding contract terms until after both parties sign the agreement. Relying on verbal agreements could place the Department in a situation in which the parties differ on the terms of the agreement, with a potential liability to the state.

Recommendation

We recommend the Department ensure contracts are properly executed and approved prior to the start date of the contract. We also recommend the Division update its policies and procedures to comply with state regulations.

Department's Response

The Department partially agrees with this finding.

The auditor asserts that four contracts were signed after work had started on the contract and/or the date the contract was signed was after the start date. Department staff reviewed the four contracts.

- *One contract (# 042-63038) was signed before the work began. This contract was executed properly and not after-the-fact.*

- *The other three contracts had text amendments signed after the contract work had begun. However, the amendments neither affect the consideration in the contracts nor changes in statement of work; they are*

viewed as administrative changes. We agree with after-the-fact dates on these amendments, but don't feel they are of any substance.

The Mental Health Division in responding to the FY04 audit issued an all staff email putting staff on notice that as of January 1, 2005, work in contracts could not start until there was proper execution of the contract. This verbal policy was later formally written and put into place June 1, 2005.

- *Two contracts (#0463-61089 and #04469) were signed after the execution date. However, these contracts were executed and signed in the period prior to January 1, 2005.*

Auditor's Concluding Remarks

We could not substantiate that work on the first contract discussed in the Department's response began only after the contract was executed because the contractor did not date the signature until three months later. We did not take issue with the three administrative amendments mentioned but rather with the lag time between the start of work and the dates the contracts were signed.

The guidance for this review comes from state laws and regulations that would not be overridden by an agency policy or directive in conflict with them. We reaffirm our finding and will review the corrective action in this area in the fiscal year 2006 audit. We appreciate the cooperation provided by the Department staff during this audit.

Applicable Laws and Regulations

For certain grant programs, including the Mental Health Block Grant, federal regulations provide an exemption from federal cost principles, provided the state adopts its own cost principles consistent with federal requirements. The U.S. Department of Health and Human Services, Office of the Inspector General considers the U.S. Office of Management and Budget's Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments,* to be the benchmark for state cost principles. Because the state has not adopted its own cost principles in conformance with this Circular, the Circular's requirements apply.

The Circular states in Attachment A, Section C:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:

    c. Be authorized or not prohibited under State or local laws or regulations....

The Office of Financial Management's *State Administrative and Accounting Manual*, Section 15.10.10, states:

> Personal services are to be procured and awarded by state agencies in accordance with the requirements of Chapter 39.29 RCW.

Revised Code of Washington 39.29.100 (1) states:

> The office of financial management shall adopt uniform guidelines for the effective and efficient management of personal service contracts and client service contracts by all state agencies....

RCW 39.29.110 (1) states:

> A state agency entering into or renewing personal service contracts or client service contracts shall follow the guidelines required by RCW 39.29.100.

The Office of Financial Management's *Guide to Personal Service Contracting*, Chapter 7, Section 13, states:

> The contract is executed when it is signed by all authorized parties....In most instances, service may begin immediately or may be scheduled for a predetermined date....

The Office's *Guide to Client Service Contracting*, Chapter 1, Section "Contract Manager 'Don'ts'", states:

> Among the multiplicity of responsibilities contract managers have, they need to be mindful of the following:
>
> > Don't instruct the contractor to begin work before the contract is executed and approved.

The Office's *State Administrative and Accounting Manual*, Section 20.20.20.a states:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

The Mental Health Division Policy Statement No. 6.02 states in part:

> ...Contracts must be submitted to the MHD Contract Manager at least thirty days prior to execution. No work is to commence prior to the approval and execution of a contract, unless staff have received prior written approval from the Director or his designee to move forward with an After-the-Fact Ratification....

05-45 The Department of Social and Health Services, Mental Health Division, did not comply with federal requirements for independent peer reviews of the Community Mental Health Services Block Grant.

Background

The Department of Social and Health Services, Mental Health Division, administers the federal Community Mental Health Services Block Grant (CFDA 93.958), received from the U.S. Department of Health and Human Services. This Program provides funds to states and territories to help them provide comprehensive, community-based mental health services for adults with serious mental illness and children with serious emotional disturbances.

In fiscal year 2005, the Division spent $8,584,851 in this Program. Approximately 95 percent of this amount was awarded to Regional Support Networks and other contractors to administer the Program throughout the state.

Federal regulations require the Division to provide independent peer reviews of entities providing Program services in order to assess the quality, appropriateness, and effectiveness of treatment services provided to individuals. At least five percent of the entities must be reviewed annually and they must be representative of the entities providing the services. No more than 25 percent of the individuals performing the review can be employees of the federal government, and all members of the group are to be individuals who, by virtue of their training or experience, are qualified to perform the review. In addition, the Division must develop procedures to put these requirements into operation.

In our fiscal year 2004 State Accountability Report and State of Washington Single Audit Report, we reported that the Division was not in compliance with these requirements. As part of the resolution of this finding, the Division submitted to the U.S. Department of Health and Human Services a monitoring report that reviewed two of the entities.
The federal Department's response to the Division stated: "Please ensure your Department has procedures for ensuring yearly reviews of Community Mental Health Services Block Grant Program service providers are conducted that meet the independent peer review requirements of 42 United States Code 300x-53a."

Description of Condition

The Division did not meet those requirements during 2005. We found the Division has no procedures to ensure yearly peer reviews are conducted. In addition, we found the following weaknesses related to the monitoring report the Division submitted as evidence of the completion of peer reviews:

- The monitoring report states it was prepared to meet the obligations of a different section of federal law, one which requires the federal government to conduct annual investigations of the grant expenditures received by at least 10 states. This is different from the section of the federal law that requires the states to provide peer reviews that evaluate patient/client records at the entities providing the services to determine the quality and appropriateness of treatment services.

- The Division could not provide assurance that the monitoring report was the result of a peer review structured to meet Program requirements. For instance, the Division provided no evidence that it had taken any steps to ensure the report was prepared by independent qualified reviewers.

- The two programs reviewed in the report may not have been sufficient to reach the required five percent coverage and may not have been representative of the entities providing services. The Division could not provide documentation of its total number of service providers and therefore could not provide assurance that these two programs met the coverage requirement.

- The scope of the monitoring review covered financial issues prior to fiscal year 2005 and did not address the quality, appropriateness, and efficacy of treatment services provided by the two entities. We saw no evidence in the report that the reviewers evaluated client case files to provide an assessment of the quality, appropriateness, and effectiveness of treatment services provided to individuals.

Cause of Condition

The Division did not prepare peer review policies and procedures because of other challenges, including staff changes and additional legislative requirements. In addition, the Division's federal Program staff contact advised the Division that the peer review requirement is not being enforced, even though it is still a part of the federal block grant statute, because the contact believes these reviews serve no purpose.

Recommendation

We recommend the Division develop and follow procedures to comply with federal regulations for the required independent peer reviews of this Program.

Department's Response

The MHD agrees with the SAO, that a formal peer review process needs to be implemented to comply with the federal requirements of community mental health block grants. The MHD will include specific actions steps to come into compliance as part of its corrective action plan.

Auditor's Concluding Remarks

We appreciate the Department's commitment in resolving the issues in the finding and will review this area in the fiscal year 2006 audit. We appreciate the cooperation from Department staff during this audit.

Applicable Laws and Regulations

Title V of the Public Health Service Act Section 1943, 42 U.S.C. 300x-53, states in part:

> (a) The State will –
>
> > (1) (A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved: and
> >
> > (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities); . . . .

Public Law 106-310, Title XXXIV, Section 3401, codified as 42 USC 290aa-3, PEER REVIEW states:

> `(a) IN GENERAL- The Secretary, after consultation with the Administrator, shall require appropriate peer review of grants, cooperative agreements, and contracts to be administered through the agency which exceed the simple acquisition threshold as defined in section 4(11) of the Office of Federal Procurement Policy Act.
>
> `(b) MEMBERS- The members of any peer review group established under subsection (a) shall be individuals who by virtue of their training or experience are eminently qualified to perform the review functions of the group. Not more than one-fourth of the members of any such peer review group shall be officers or employees of the United States.

The Mental Health Services Block Grant Core Monitoring report cites the Public Law 102-321, titled ADAMHA Reorganization Act, Section 203(g) [42 USC 300x-55] as the requirement for the report. This section describes federal investigations of grant expenditures related to mental health and substance abuse block grants.

> `(g) CERTAIN INVESTIGATIONS-
>
> > `(1) REQUIREMENT REGARDING SECRETARY- The Secretary shall in fiscal year 1994 and each subsequent fiscal year conduct in not less than 10 States investigations of the expenditure of

grants received by the States under section 1911 or 1921 in order to evaluate compliance with the agreements required under the program involved.

`(2) PROVISION OF RECORDS ETC. UPON REQUEST- Each State receiving a grant under section 1911 or 1921, and each entity receiving funds from the grant, shall make appropriate books, documents, papers, and records available to the Secretary or the Comptroller General, or any of their duly authorized representatives, for examination, copying, or mechanical reproduction on or off the premises of the appropriate entity upon a reasonable request therefor.

`(3) LIMITATIONS ON AUTHORITY- The Secretary may not institute proceedings under subsection (c) unless the Secretary has conducted an investigation concerning whether the State has expended payments under the program involved in accordance with the agreements required under the program. Any such investigation shall be conducted within the State by qualified investigators.

05-46 The Department of Social and Health Services, Mental Health Division, is not complying with subrecipient monitoring requirements for the Community Mental Health Services Block Grant.

Background

State agencies often award federal funds to organizations that provide services needed to accomplish federal program objectives. These organizations are known as subrecipients, while the state agencies are called pass-through agencies.

To help ensure funds are spent appropriately, the federal government requires pass-through agencies to monitor the activities of subrecipients to provide reasonable assurance they are complying with federal requirements. Monitoring includes reviewing documentation such as billings, subrecipient progress reports, and audits of subrecipients and performing on-site reviews of subrecipient financial, operational and program records. Federal regulations also require pass-through agencies to apply monetary sanctions to subrecipients who do not provide mandated independent audit reports.

The Department of Social and Health Services, Mental Health Division, administers the federal Community Mental Health Services Block Grant (CFDA 93.958). This Program provides funds to states and territories to help them provide comprehensive, community-based mental health services for adults with serious mental illness and children with serious emotional disturbances.

The Department contracts with Regional Support Networks and other contractors who administer the Program throughout the state. These subrecipients must submit plans to the Division documenting how they will use the funds. Subrecipients submit monthly reimbursement claims to the Division for services provided while following their plans. In fiscal year 2005, the Department spent Program funds, including grants to these subrecipients, of $8,584,851.

The federal grantor requires its grantees to report the amount of Program funds passed through to subrecipients on the state's annual Schedule of Expenditures of Federal Awards. The state's Office of Financial Management requires agencies to report this amount to it for inclusion in the Schedule.

In our fiscal year 2005 State Accountability Report and State of Washington Single Audit Report, we described weaknesses in the Division's monitoring of its subrecipient activity and recommended it establish and follow a monitoring process to improve this area. The Division responded that it would develop such a process.

Description and Effect of Condition

During this year's audit, we reviewed the Division's process for monitoring the activities of subrecipients and for payment of their claims and found the Division is still not complying with federal, state and Departmental regulations:

- To compensate for the fact that subrecipients are not required to submit supporting documentation of costs with reimbursement claims, the Division planned to include a review of payment support during its on-site reviews. The Division stated it had conducted on-site reviews of all 22 subrecipients; however we found no documentation of such a review for 13 of these. Without a review of supporting documentation at the time of payment or a review of such documentation on-site, the Division cannot be certain its subrecipients have spent grant funds in the proper amounts for allowable purposes.

- For the subrecipients with documented on-site reviews, several reviewers cited significant fiscal issues, such as insufficient support for costs or unavailable verification of deliverables. In these cases, there was no determination made as to whether costs should be reimbursed to the Division, and there was no corrective action plan to provide assurance that only allowable charges would be claimed in the future. Without proper follow-up, on-site reviews will not be effective.

- The Division is not receiving and reviewing all of the independent audits of subrecipient federal funds to help in planning for monitoring visits and to help ensure that any corrective action noted in the reports has been taken.

When the Division does not receive and review these audit reports, it may not have complete information about weaknesses identified by the independent auditors.

Cause of Condition

The Division made some progress in this area but noted that it had additional challenges this past year, including many staff changes and additional legislative requirements, which have not allowed it to complete its corrective action plan.

Recommendation

We recommend the Division complete its establishment of a process to:

- Require the submission of adequate payment support by all subrecipients or perform on-site reviews of fiscal records to establish claims are supported and then follow-up to ensure identified problems are resolved.

- Monitor subrecipients requiring an audit in accordance with federal regulations by:

    - Establishing a record of all such audits it needs to receive and ensuring it receives them.

    - Performing a timely review of these audit reports, followed by timely management decisions on audit findings.

    - Requiring timely corrective action on audit issues.

Department's Response

The Department partially agrees with this finding.

The Department agrees with the auditor's recommendation that monitoring activities could be strengthened. In addition to monitoring activities implemented after last year's finding, many additional improvements have been made during and after this year's audit period.

To compensate for the fact that subrecipients are not required to submit supporting documentation of costs with reimbursement claims, the Division planned to include a review of payment support during its on-site reviews.

MHD's subrecipient contracts contain a provision that the contractor must submit sufficient documentation, as determined by the Division, to support the payment of funds under the contract. Documentation was not always submitted with the payment request from the contractor. The documentation review referred to by the auditor was put in place to begin the process of educating contractors regarding the "sufficient documentation" requirement, and to make the contractor aware of what is "sufficient". During the past several months the MHD has worked with Contractors to clarify the documentation that needs to be submitted with, and in support of, their payment invoices. Invoices are reviewed for compliance with the requirements and contractors are asked to submit any missing support documents when a payment invoice is received without them. This review process began in early fiscal 2005.

The Division stated it had conducted on-site reviews of all 22 subrecipients; however [the auditor] we found no documentation of such a review for 13 of these.

MHD did not receive details of the review that SAO completed on subrecipient on-site reviews. The numbers, stated above, of subrecipients and reviews completed do not appear to be correct. MHD has a total of 44 subrecipient contracts. MHD conducted fifteen (15) on-site reviews during this period. Additionally, there were twenty-nine (29) other federal block grant contracts that received a desk review for the period 10/1/04-9/30/05. A schedule that showed which Contractors had received an on-site visit was provided to the SAO during their review – that schedule complies with the numbers of subrecipients and reviews stated above. Documentation and review protocols for these on-site reviews are generally maintained in Department files, although there are some contract reviews that

remain open and where documentation is not complete. The results of desk reviews, including review protocols are also maintained in the contract file for all other federal block grant contracts referenced above

For the subrecipients with documented on-site reviews, several reviewers cited significant fiscal issues, such as insufficient support for costs or unavailable verification of deliverables.

We agree that a few on-site review results and some desk reviews may have showed evidence of fiscal and other deliverable issues. However, the MHD review staff and program managers are still working with the Contractors to resolve open issues. The MHD has a goal to resolve and/or conclude the monitoring process for these by May 31, 2006.

The Division is not receiving and reviewing all of the independent audits of subrecipient federal funds to help in planning for monitoring visits and to help ensure that any corrective action noted in the reports has been taken.

The MHD has implemented a process to capture these audits. The process is two-fold. One – the MHD incorporated language into its current contracts (7/1/05) with the RSN's which require the Contractor to notify the MHD when an entity other than DSHS performs any audit contained in the Agreement. This requirement extended to sub-recipients of federal awards the Contractor may have subcontracted with. Two- since the prior year SAO review the Department collected and reviewed both A-133 audits and independent audits during the course of the on-site reviews. Both the RSN and its subcontractors were reviewed for the $500,000 threshold. The timing of the on-site reviews may have only allowed for the most recent A-133 audit available during the period of review but the new language added to the Department contracts would help assure notification to the MHD of other audits as they occurred. To date there were no finding and/or corrective action noted in the independent A-133 audits reviewed. We acknowledge lack of implementation of this requirement for mental health block grant contracts with Tribal entities.

Auditor's Concluding Remarks

We reaffirm our finding and look forward to reviewing the corrective action implemented in this area during our fiscal year 2006 audit. We appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

The U.S. Office of Management and Budget's Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, Section .400(d), states in part:

> Pass-through entity responsibilities. A pass-through entity shall perform the following for Federal awards it makes:...
>
> (3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.
>
> (4) Ensure that subrecipients expending $500,000 or more in Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.
>
> (5) Issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.
>
> (6) Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records....

Section .225 of the Circular states:

> No audit costs may be charged to Federal awards when audits required by this part have not been made or have been made but not in accordance with this part. In cases of continued inability or unwillingness to

have an audit conducted in accordance with this part, Federal agencies and pass-through entities shall take appropriate action using sanctions such as:

(a) Withholding a percentage of Federal awards until the audit is completed satisfactorily;

b) Withholding or disallowing overhead costs;

(c) Suspending Federal awards until the audit is conducted; or

(d) Terminating the Federal award.

The Department of Social and Health Services Administrative Policy 13.14, Identifying and Managing Federal Subrecipient Contracts and Agreements, states:

D. Administrations must monitor subrecipients for compliance with OMB Circular A-133 audit requirements. Subrecipients that expend $500,000, or more in direct and/or indirect federal awards during the subrecipient's fiscal year must meet OMB CircularA-133 audit requirements and provide appropriate documentation to the department.

4. Administrations must decide within six months after receipt of the subrecipient's audit report, whether audit findings are sustained, the reason for the decision, and the expected subrecipient's action to repay disallowed costs (if applicable). If the subrecipient has not completed corrective action, a timetable for follow-up must be included.

5. Administrations must promptly notify the Office of Accounting Services (OAS) of questioned costs requiring adjustment to department financial records.

   Administrations must monitor subrecipient activities to ensure the subrecipient takes appropriate and timely corrective action to resolve audit findings. Administrations must pursue collection of overdue audit reporting packages or written notification for all subrecipients that are not audited by the SAO.

6. ...Administrations must retain documentation to support monitoring audit compliance....Subrecipients' audit reports and corrective action plans must be retained for three years from date of receipt.

E. Administrations must perform monitoring of subrecipient contracts and agreements. In addition to monitoring compliance with OMB Circular A-133, described in Section D of this policy, monitoring activities must be performed as defined in DSHS Administrative Policy 13.11, Monitoring Contractor Performance. These actions are intended to ensure federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements.

05-47 The Department of Community, Trade, and Economic Development did not comply with state and federal regulations when contracting for services paid with federal Low Income Home Energy Assistance Program funds.

Background

The Department of Community, Trade, and Economic Development administers the Low Income Home Energy Assistance Program (CFDA 93.568), which provides funds for eligible low-income families and individuals to help pay home energy bills and weatherization projects. The Department funds local governmental and non-profit organizations that directly serve these low-income residents.

In fiscal year 2005, the Department spent grant funds of $38.9 million: $5.9 million through the Weatherization Section of the Department and $33 million through the Energy Assistance Section.

Federal regulations require states to follow their own policies and procedures when procuring services with federal funds. State contracting law and procedures require personal service contracts of $20,000 or greater to be procured through a competitive process and, in some cases, to be filed with the Office of Financial Management before any contract work begins. Using an information technology master contract for the state does not permit an agency to bypass the competitive procurement process.

Description of Condition

The Division did not comply with state law and regulations regarding competitive procurement for personal service contracts, and therefore was not in compliance with federal regulations, when it procured software consulting work totaling $60,000. The Department treated this as a purchased services contract when it more properly met the definition of personal services: professional or technical expertise provided by a consultant to accomplish a specific study, project, task, or other work statement.

The Department stated it selected a consultant from a list of pre-qualified contractors for a Master Contract maintained by the Department of General Administration. The Department then prepared a field order for $60,000 to the consultant for a study of database integration. We found the following issues with this process:

- According to General Administration contract specialists, this consultant has not been on the pre-qualified list cited by the Department for at least the past few years.

- The Department could not provide documentation to demonstrate it used a competitive process that allowed each consultant on the list an opportunity to bid for the contract.

- The contract, in the form of a field order, was not complete. It did not include signatures binding the parties, contract execution dates, due dates for the project, terms and conditions of the work required and budgeted amounts to be paid.

- The contract was never filed with the Office of Financial Management as a personal services contract.

- All payments were coded incorrectly to purchased services, rather than to personal services.

Cause of Condition

Staff members' lacked knowledge regarding state procurement regulations.

Effect of Condition

- The Department cannot ensure the state's resources were used in the most economical manner possible because the acquisition was not subject to competitive procurement procedures.

- Without proper documentation and signing of a contract, the Department has no accurate record of binding contract terms. This could place the Department in a situation in which the parties differ on the terms of the agreement, with a potential liability to the state.

- Purchased and personal service payments in the Department's accounting records are both misstated.

We question the $60,000 in federal funds paid for this software development in fiscal year 2005**.**

Recommendation

We recommend the Department:

- More carefully analyze services to be provided to determine whether rules for purchased services or for personal services should be followed.

- Follow state procurement policies and procedures set out by the Office of Financial Management for personal service contracts.

Department's Response

We agree with the finding that CTED did not comply with state law and regulations regarding the competitive procurement for personal service contracts. However, we made the initial determination that this was a purchased service and accessed the General Administration (GA) pre-qualified contractors listing to obtain a consultant. Based on our understanding at the time, we followed GA's competitive procurement process, which resulted in a Purchased Services Work Contract being executed. The Work Contract was for a survey of LIHEAP subrecipients with standalone data systems to create a common data dictionary and collect application schemas to facilitate integration with the Department's data system. The Work Contract contained a statement of work which included dates, terms and conditions, and a budget. The terms and conditions of the work contract were satisfactorily completed and the deliverables have benefited the LIHEAP program.

Subsequently the Department hired a Contracts Specialist to develop contracting policies and procedures. The Department's draft policies and procedures require a review of requests to issue a contract. The review includes a determination of contract type and classification.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review this area in our fiscal year 2006 audit. We also appreciate the cooperation extended to us throughout the audit by the Department staff.

Applicable Laws and Regulations

The U.S. Office of Management and Budget's *Cost Principles for State, Local and Indian Tribal Governments*, Circular A-87, Attachment A, Section C states in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:

    c. Be authorized or not prohibited under State or local laws or regulations..

RCW 39.29.006 states in part:

(3) "Competitive solicitation" means a documented formal process providing an equal and open opportunity to qualified parties and culminating in a selection based on criteria which may include such factors as the consultant's fees or costs, ability, capacity, experience, reputation, responsiveness to time limitations, responsiveness to solicitation requirements, quality of previous performance, and compliance with statutes and rules relating to contracts or services.

(4) "Consultant" means an independent individual or firm contracting with an agency to perform a service or render an opinion or recommendation according to the consultant's methods and without being subject to the control of the agency except as to the result of the work. The agency monitors progress under the contract and authorizes payment.

(7) "Personal service" means professional or technical expertise provided by a consultant to accomplish a specific study, project, task, or other work statement...

(8) "Personal service contract" means an agreement, or any amendment thereto, with a consultant for the rendering of personal services to the state which is consistent with RCW 41.06.142.

The Office of Financial Management's *State Administrative and Accounting Manual*, states in Section 15.10.10:

> Personal services are to be procured and awarded by state agencies in accordance with the requirements of Chapter 39.29 RCW.

Section 15.10.15 states in part:

> Personal Service – Professional or technical expertise provided by a consultant to accomplish a specific study, project, task, or other work statement.

Section 15.10.45 states in part:

> Agencies shall not structure contracts to avoid the competitive procurement or other requirements of this policy.

Section 15.20.10 states in part:

> ...a documented, formal, competitive process called "competitive solicitation" is required for contracts of $20,000 or greater.

Section 15.20.40 states in part:

> **Master Contracts.** The term "master" personal service contracts, as used in this policy, refers to competitively solicited personal service contracts awarded by the Department of General Administration and the Department of Personnel for use by other state agencies. The Department of General Administration (GA), Office of State Procurement (OSP), Professional Service Solutions (PS2) unit, uses two separate processes—one for personal service contracts that are not for information technology (IT) services and one for information technology personal service contracts.
>
>> ...For IT personal service contracts, GA conducts the initial competition and awards the master contracts (also referred to as primary agreements), but does NOT file them with OFM. To procure personal services under the IT master contracts, a second-tier competition is conducted. GA (or the agency) sends a Work Request to consultants/vendors for the applicable category. The agency evaluates responses, awards a Work Contract between the agency and the contractor, files the Work Contract with OFM, and provides a fully executed copy of the Work Contract to GA. GA's competitive processes for...IT personal services meet OFM's requirements for formal solicitation.
>>
>> Agencies are responsible to maintain adequate documentation of the second-tier competitive process when using GA's master personal service contracts to substantiate that all bidders were treated equally and fairly and that an equitable and impartial competition was conducted.
>>
>> Simply accessing names of firms from GA's list of master contractors in a particular category does not satisfy the requirement for second-tier competition. Also, just awarding a contract to a firm from GA's list does not satisfy the requirement for second-tier competition.

Section 20.20.20 states in part:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

05-48 The Department of Community, Trade, and Economic Development, Energy Assistance Section, is not complying with subrecipient monitoring requirements for the Low Income Home Energy Assistance Program.

Background

State agencies often award federal funds to organizations that provide services needed to accomplish federal program objectives. These organizations are known as subrecipients, while the state agencies are called pass-through agencies.

To help ensure funds are spent appropriately, the federal government requires pass-through agencies to monitor the activities of subrecipients to provide reasonable assurance that they are complying with federal requirements. Monitoring should be based upon the risk at the subrecipient level and may take various forms, such as reviewing reports submitted by subrecipients, maintaining regular contact with subrecipients, and performing on-site reviews of subrecipient financial, operations and program records.

Risk factors that may affect the degree of monitoring include program complexity, amount of the award, and risks directly related to the subrecipient. Pass-through entities must also ensure they receive and review applicable audit reports from subrecipients and follow-up on any problems identified in those reports.

In the Program's current Washington State Plan, the Department provides assurances related to its subrecipient monitoring and describes the methods it uses for this activity. In fiscal year 2004, we suggested improvements to the Department's subrecipient monitoring documentation.

In fiscal year 2005, the Department spent $38.9 million from the Low Income Home Energy Assistance Program; the Energy Assistance Section spent $33 million of this amount. Of the $38.9 million in payments, 91.5 percent was passed through to subrecipients.

Description of Condition

For 2005, we reviewed Program subrecipient monitoring activities and found the Energy Assistance Section does not perform adequate subrecipient monitoring. We found:

- Risk assessments were not adequately and consistently performed and did not always include a review of:
    - Subrecipient single audit reports to identify weaknesses that could affect the Program.
    - Subrecipient cost allocation plans and indirect cost classifications to determine if these areas required review during on-site visits.
    - Staff correspondence to evaluate observations of potential weaknesses with subrecipient operations.
- Monitoring plans were not always adjusted to include the effect of issues such as those above.
- Documentation was not always sufficiently complete to establish that on-site visits were adequately performed.

We also found the Program and fiscal office subsidiary records that track advance payments to subrecipients did not always reconcile with each other or with the state's accounting records.

Cause of Condition

The Energy Assistance Section has not established and put into place adequate policies and procedures for monitoring subrecipient activities and payments.

Effect of Condition

The Department cannot ensure its subrecipients are complying with federal requirements and using the funding for allowable purposes. This could jeopardize future federal funding for the Program.

Recommendations

We recommend the Department develop subrecipient monitoring policies and procedures that include requirements that:

- Risk assessments address significant risk areas.
- Monitoring plans address risk assessments and change as conditions change.
- Desk monitoring and site visits be sufficiently documented
- Employees receive adequate training as to what constitutes sufficient monitoring documentation to be retained.
- Proper reconciliations are made between Department records and the state's accounting system for payments made in advance to subrecipients.

Department's Response

We partially agree with the finding. The LIHEAP block grant has policies and procedures in place for monitoring subrecipient activities and payments. These policies and procedures apply to LIHEAP and are coordinated with other federal and state programs administered by CTED. In some cases, documentation was not totally completed because the program has a 25 year on-going relationship with the network of Community Action Agencies, who are the subrecipients. This statewide network of subrecipients is assessed, reviewed and monitored by a variety of programs within CTED and the information is shared among all the programs. This sharing of information was not always fully documented, but did contribute to adequately managing risk of all of the Community Action Agencies in our contracting portfolio.

In response to auditor concerns, the LIHEAP program has consolidated several policies, procedures and protocols into one comprehensive document. This will ensure better and more complete documentation of risk assessment and monitoring activities. Additionally, the risk assessment of all of the Community Action Agencies in the closely aligned Community Services Block Grant will be enhanced.

Payments and advances to contractors are reconciled monthly and any concerns noted by the auditors were explained. All contractor payments were verified before draws of federal funds were made.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review these areas in our fiscal year 2006 audit. We also appreciate the cooperation extended to us throughout the audit by the Department staff.

Applicable Laws and Regulations

The U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section .400(d) states in part:

> (d) Pass-through entity responsibilities. A pass-through entity shall perform the following for the Federal awards it makes: ...

(3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

(4) Ensure that subrecipients expending $300,000 *($500,000 for fiscal years ending after December 31, 2003)* or more in Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.

The Washington State Plan in effect for the Program during fiscal year 2005 states in part:

Assurances:

The Department of Community, Trade and Economic Development agrees to:

(10) provide that such fiscal control and fund accounting procedures will be established as may be necessary to assure the proper disbursal of and accounting for Federal funds paid to the State under this title, including procedures for monitoring the assistance provided under this title, and provide that the State will comply with the provisions of chapter 75 of title 31, United States Code (commonly known as the "Single Audit Act");....

The Plan continues in question-and-answer format:

Statutory Reference: 2605(b)(10) **PROGRAM, FISCAL MONITORING, AND AUDIT**

How do you ensure good fiscal accounting and tracking of LIHEAP funds? (Please describe. Include a description of how you monitor fiscal activities.)

CTED internal control systems include: annual contractor financial and compliance audits, monthly budget-to-expenditure controls, and periodic monitoring of contractors by CTED staff.

An initial advance payment will be issued if: sufficient funds are available from HHS; CTED has received from a contractor the signed contract and a payment request for the first half of October; and the previous Program Year contract has been adequately reconciled. If funds from HHS are delayed or awarded incrementally, CTED will impose a spending limit. Payments made under the contract will be limited until complete funding is awarded and the spending limit is eliminated.

Advance and reimbursement payment systems will be used after the initial advance payment. The Policies and Procedures for EAP specify the payment systems to be used by CTED and its contractors. Upon final reconciliation at the end of the program year, unspent funds will be recovered by CTED and a plan for their use developed and submitted to HHS.

CTED maintains a system that ensures fiscal control internally and with its local contractors.

How do you monitor program activities? (Please be sure to include a description of how you monitor eligibility and benefit determination.)

CTED representatives periodically monitor each local program contractor on site to ensure that LIHEAP is managed effectively, and complies with federal and state statutes and regulations and the program policies and procedures. This includes reviewing financial management systems, reporting practices, outreach activities, eligibility determination and documentation, and other service delivery activities. A corrective action plan may be required to address issues raised during the review. A monitoring review report sent to the contractor's Executive Director includes findings and correction

action plan items to be addressed. A statewide computerized screening system which includes data taken from the client intake form prevents duplication of service. A summary of the demographic data compiled from the client intake forms will be submitted to CTED.

05-49 The Department of Community, Trade, and Economic Development did not comply with earmarking requirements for the Low Income Home Energy Assistance Program.

Background

The Department of Community, Trade, and Economic Development administers funds from the Low Income Home Energy Assistance Program (CFDA 93.568) and disburses these funds to local governmental and non-profit organizations that directly serve low-income residents. The Program provides funds to help eligible low-income families and individuals in paying for their home energy bills and weatherizing their homes.

In fiscal year 2005, the Department spent Program funds of $38.9 million: $5.9 million through the Weatherization Section of the Department and $33 million through the Energy Assistance Section.

State agencies receiving federal funds often must agree to federally-specified funding limits, either minimum or maximum dollar amounts or percentages, for certain types of activities. This is known as earmarking and helps ensure funds are spent in a manner consistent with program requirements. The earmarking computation for this Program can only be made at the end of each two-year grant period.

The federal government specifies that payments for weatherization activities in this Program may not exceed 15 percent of the award, less any adjustment for leveraging incentive awards, unless the Department applies for, and is granted, a waiver. The leveraging incentive awards are incentive payments that the state receives for obtaining funds from other sources that contribute to home energy resources. Examples of such sources include contributions from utility companies or individuals.

Description of Condition

We used the 2003 Program grant to review earmarking, since it was the only two-year grant that ended during the audit period. The 2003 grant covered October 1, 2002 through September 30, 2004.

The earmarking calculation for the 2003 grant, which included the adjustment for leveraging incentive awards, resulted in $5,705,493 as the maximum the Department could spend on weatherization. The Department spent $6,182,102 for weatherization, exceeding the earmarking requirement by $476,609.

Cause of Condition

Since 1988, the Department has interpreted “the State”, in the Low-Income Home Energy Assistance Act of 1981, Public Law 97-35, to mean the State of Washington and all Indian tribes in the State, even though the tribes receive separate awards. Based on this interpretation, the Department has included both the funds for the state and the funds for the tribes in Washington to calculate its earmarking amount.

Effect of Condition

This method of calculating the earmarking amount increases the maximum beyond the amount allowed by federal regulations. The calculation resulted in expenditures of $476,609 more than were allowed; we are questioning these costs.

Recommendations

We recommend the Department:

- Calculate the weatherization earmarking requirement in compliance with Program laws and regulations.
- Contact the grantor, the U.S. Department of Health and Human Services, to determine if repayment of the federal funds is required.

Department's Response

We disagree with the finding. The Department of Health and Human Services (HHS), by national formula, allocates LIHEAP funds to each state, which includes an allocation to the state and a tribal set-aside. For at least the past eighteen years, CTED has used the total amount allocated to all Washington recipients as the basis for computing the maximum amount to be spent on the Weatherization Program. The calculation has been a part of the Annual Plan submitted to and approved by HHS each year.
No Indian tribe in the state provides Weatherization activities because the start-up costs are too expensive. Tribes use their allotment of LIHEAP funds solely for heating assistance. Tribal members receive Weatherization assistance from the funds distributed to CTED's subrecipients for that purpose.

The 15 percent limitation pertains to Weatherization Assistance Benefits only, not total program expenditures. Total expenditures include administrative costs, which are calculated separately. Administrative costs are limited to 10 percent of total available funds. For the 2003 grant period, total Weatherization program expenditures (including administration) exceeded 15 percent of total available funds, but Weatherization Assistance Benefits expenditures, as calculated by HHS, did not exceed 15 percent of total available funds, therefore there are no questioned costs.

Auditor's Concluding Remarks

As part of our review, we re-performed the earmarking calculation according to the federal criterion and compared the result to the amount actually spent for weatherization. We concluded that the Department was not in compliance with that criterion.

After re-evaluating our calculations based upon the Department's response and other information it provided at the exit conference, we reaffirm our conclusion. We appreciate the cooperation extended to us throughout the audit by Department staff and will review this issue in our fiscal year 2006 audit.

Applicable Laws and Regulations

The U.S. Office of Management and Budget's Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment A, Section C, states in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:

    d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.

The Low-Income Home Energy Assistance Act of 1981 (Title XXVI Of The Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, as amended) states in part:

Section 2603 [42 USC section 8622] Definitions

Paragraph (10)

The term "State" means each of the several States and the District of Columbia.

Section 2605 [42 USC section 8624] Applications and Requirements

Paragraph (k)

(2)(B)...the Secretary may grant a waiver to a State for a fiscal year if the State submits a written request to the Secretary after March 31 of such fiscal year....

Paragraph (k) (1) states:

> Except as provided in paragraph (2), not more than 15 percent of the greater of—
>
> (A) the funds allotted to a State under this subchapter for any fiscal year; or
>
> (B) the funds available to such State under this subchapter for such fiscal year;
>
> may be used by the State for low-cost residential weatherization or other energy-related home repair for low-income households, particularly those low-income households with the lowest incomes that pay a high proportion of household income for home energy.

The 2003 Detailed Washington State Plan, in effect during 2004 and 2005, states in part:

> Statutory Reference: 2605(c)(l)(C)
>
> Please estimate what amount of available LIHEAP funds will be used for each component that you will operate: (The total of all percentages must add up to 100%.)
>
> 70.83 % heating assistance
> 2605(k)(1) 14.04 % weatherization assistance
> 2605(b)(9) 10 % administrative and planning costs
> 2605(b)(16) 5 % services to reduce home energy needs including needs assessment (assurance 16)
> 0.13 % ($35,000) used to develop and implement leveraging activities (limited to the greater of 0.08% or $35,000 for States, the greater of 2% or $100 for territories, tribes and tribal organizations).
> 100 % TOTAL

The Washington State Abbreviated Plans for 2004 and 2005 state in part:

> 2004 Use of Funds: Please estimate what amount of available LIHEAP funds will be used for each component that you will operate:
>
> 2605(c)(1)(C) 70 % heating assistance
> 2605(k)(1) 15 % weatherization assistance
>
> 2005 Use of Funds: Please estimate what amount of available LIHEAP funds will be used for each component that you will operate:
>
> 2605(c)(1)(C) 70.83 % heating assistance
> 2605(k)(1) 14.04% weatherization assistance

05-50 Certain University of Washington departments' controls are not working effectively to ensure Time And Effort Certification forms are completed in a timely manner and to ensure monthly certification of salaries and wages paid for federal programs are completed as required.

Description of Condition

The University of Washington has approximately 500 organizational units that receive federal assistance for research and development programs. The Regional Primate Center also receives other federal assistance. Organizational units are used to account for financial information for the University. From July 1, 2004, through June 30, 2005, the University spent approximately $621 million in federal funds for research and development programs and $14 million in federal funds for the Regional Primate Center (CFDA 93.389).

Federal regulations require universities to establish a system that demonstrates allowable and allocable payroll costs charged to federal grants and sponsored agreements. To that end, the University distributes Faculty Effort Certification (FEC) forms and Grant and Contract Certification Reports (GCCR) to campus departments for faculty, staff and hourly employees whose compensation is charged to each grant and contract budget.

To comply with federal regulations, University policy requires faculty to verify the information on the FEC form, to certify and return the form to Management Accounting and Analysis (MA&A) within five weeks. University policy requires principle investigators to verify and certify GCCR forms within 60 days after receiving them. This is noted on the form.

During our 2004 audit, we communicated to management that the University was not complying with this requirement. For the 2005 audit, we reviewed 13 federal awards, which included 30 payroll transactions subject to FEC certification and 149 payroll transactions subject to GCCR certification. We found six awards with FEC noncompliance and five awards with GCCR noncompliance as follows:

FEC Certifications

CFDA 93.389 National Center for Research Resources and Infrastructure:

- Three forms were certified by the faculty member and received by MA&A after the return due date.
- Three forms were certified by the faculty member by the due date, but were received by MA&A after the return due date.

CFDA 93.866 Aging Research:

- One form was certified by the faculty member by the due date, but we found no evidence as to when MA&A received it.

CFDA 93.846 Arthritis, Musculoskeletal and Skin Diseases Research:

- One form was certified by the faculty member and received by MA&A after the return due date.
- Two forms were certified by the faculty member by the due date, but were received by MA&A after the return due date.

CFDA 93.837 Heart and Vascular Diseases Research:

- One form was certified by the faculty member and received by MA&A after the return due date.

CFDA 93.864 Male Contraception Research Center:

- Three forms were certified by the faculty member and received by MA&A after the return due date.
- One form was certified by the faculty member by the due date, but received by MA&A after the return due date.
- One form was certified, but not dated by the faculty member, and submitted to MA&A after the due date.

CFDA 93.866 Aging Research:

- One of four forms was certified by the faculty member and received by MA&A after the return due date.
- Two forms were certified by the faculty member by the due date, but were received by MA&A after the return due date.

For all federal awards reviewed, 63 percent of FECs tested were submitted after the five-week deadline.

GCCR Certifications:

CFDA 93.389 National Center for Research Resources and Infrastructure:

- Four reports associated with 12 of 30 payroll transactions examined were either not dated or not signed within 60 days.

CFDA 93.837 Heart and Vascular Diseases Research:

- Three of four reports reviewed for internal control testing were not signed.
- Five reports associated with six of nine payroll transactions tested for compliance were not signed. Of the six instances, four transactions were the same reports reviewed during the testing of controls.

CFDA 93.856 Microbiology and Infectious Diseases Research:

- One report associated with four of 11 payroll transactions examined was not signed within 60 days.

CFDA 93.859 Biomedical Research and Research Training:

- Four reports associated with six of eight payroll transactions examined were reviewed and signed by the principle investigator but not dated. We found no evidence that the report was signed within 60 days.
- One report associated with one of eight payroll transactions examined was not signed within 60 days.

CFDA 93.864 Male Contraception Research Center:

- One report associated with one of 18 payroll transactions examined was reviewed and signed by the principle investigator but not dated. We found no evidence that the report was signed within 60 days.

Cause of Condition

The departments did not follow procedures to ensure time and effort records were reviewed and approved in accordance with University policy over federal grants.

Effect of Condition

Without proper time and effort records, the University cannot demonstrate allowable and allocable payroll costs charged to federal programs. Because the FECs were eventually submitted for certification, we are not questioning payroll costs charged to the federal programs.

Recommendation

We recommend the University take steps to ensure monthly certifications of salaries and wages paid for federal programs are completed in accordance with University policy to ensure compliance with federal regulations.

University's Response

FEC Certifications:

The University concurs that some faculty effort was certified after the University's deadline. However, we note that federal guidelines have no defined deadline for effort certifications. The University of Washington established internal dates to encourage efficiency and establish a follow-up process. We believe that federal compliance is achieved when the PI signs the faculty effort certification (FEC) by the University's internal due date. We do not agree that those signed by the University's due date but received after the central office's due date are out of compliance with federal guidelines. Of the 30 payroll transactions tested, 20 were certified by the faculty member consistent with the University's internal due date.

We are engaged in a variety of projects that will improve the timeliness of faculty effort certification. Those projects include mandatory training of all faculty receiving effort reports (concluded 11/30/05). In addition, we are enhancing our follow up process to ensure FECs are certified and submitted in a timely manner. Also, individual departments cited in this finding will strengthen their monitoring and follow-up processes.

Finally, we are beginning a process to replace our manual system with an electronic effort reporting and certification system. Later this spring, we will begin an analysis that is expected to result in a decision to build or buy a new electronic effort reporting system. The new system will include enhanced tracking and follow-up capabilities.

GCCR Certifications:

The University concurs that some Grant and Contract Certification Reports (GCCRs) were signed after the University's deadline. The University is working with departments on a campus wide basis and specifically with those cited in this finding to strengthen controls that ensure GCCRs are signed in a timely manner.

Auditor's Remarks

We thank University officials for the assistance we received during the audit.

Applicable Laws and Regulations

Office of Management and Budget Circular A-21, *Cost Principles for Educational Institutions*, Section J, subsection 2.e states:

> For professorial and professional staff, the reports will be prepared each academic term, but no less frequently than every six months. For other employees, unless alternate arrangements are agreed to, the reports will be prepared no less frequently than monthly and will coincide with one or more pay periods.

Office of Management and Budget Circular A-21, *Cost Principles for Educational Institutions*, Section J, subsection 3 and 3.f states:

> (3) Multiple Confirmation Records: Under this system, the distribution of salaries and wages of professorial and professional staff will be supported by records which certify separately for direct and F&A cost activities as prescribed below . . .
>
> . . . (f) The reports will be prepared each academic term, but no less frequently than every six months.

Office of Management and Budget Circular A-21, *Cost Principles for Educational Institutions*, Section J, subsection 10, b.2.b states:

> The method must recognize the principle of after-the-fact confirmation or determination so that costs distributed represent actual costs, unless a mutually satisfactory alternative agreement is reached. Direct cost activities and F&A cost activities may be confirmed by responsible persons with suitable means of verification that the work was performed. Confirmation by the employee is not a requirement for either direct or F&A cost activities if other responsible persons make appropriate confirmations.

05-51 The University of Washington did not submit financial status reports in a timely manner.

Description of Condition

Federal regulations and the University's grant contracts require financial status reports to be submitted to the granting agency within 90 days of the expiration date of the budget period.

During our 2001 audit of federal programs, we communicated instances in which the University did not comply with this reporting requirement.

In our current audit, we reviewed 13 awards and identified five awards that had financial reporting requirements. Based on our testing, we determined that, for three of the five awards, the University did not submit a financial status report to the sponsor within 90 days after the budget ended as follows:

- The National Center for Research Resources and Infrastructure program (CFDA 93.389) status report was submitted six months late.

- The Biomedical Research and Research Training program (CFDA 93.859) status report was submitted eight months late.

- The Male Contraception Research Center Grant (CFDA 93.864) status report was submitted two months late.

Cause of Condition

The Grants and Contract Accounting Office did not ensure financial status reports were submitted with the 90-day deadline due to significant turnover.

Effect of Condition

Federal grantors rely on the information submitted in these reports to assess program operations and to make decisions about future awards. Untimely submission of the financial status reports could result in the University losing federal funding for continued programs.

Recommendation

We recommend the University take steps to ensure fiancial status reports are sumbitted in accordance with federal regulations.

University's Response

The University concurs that 3 financial status reports (FSRs) were not submitted in a timely manner. Grant and Contract Accounting (GCA) experienced a 50% rate of turnover in the fiscal positions responsible for preparing FSRs in 2005. GCA is working aggressively to hire and train new staff so that FSRs can be submitted in a timely manner.

Auditor's Remarks

We thank University officials for the assistance we received during the audit.

Applicable Laws and Regulations

Office of Management and Budget Circular A-110, *Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations,* Section __.51(b) states:

> Except as provided in paragraph ___.51(f), performance reports shall not be required more frequently than quarterly or, less frequently than annually. Annual reports shall be due 90 calendar days after the grant year; quarterly or semi-annual reports shall be due 30 days after the reporting period. The Federal awarding agency may require annual reports before the anniversary dates of multiple year awards in lieu of these requirements. The final performance reports are due 90 calendar days after the expiration or termination of the award.

Office of Management and Budget Circular A-110, *Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations,* Section __.52(a.1.iv) states:

> The Federal awarding agency shall require recipients to submit the SF-269 or SF-269A (original and no more than two copies) no later than 30 days after the end of each specified reporting period for quarterly and semi-annual reports, and 90 calendar days for annual and final reports. Extensions of reporting due dates may be approved by the Federal awarding agency upon request of the recipient.

05-52 The Department of Community, Trade, and Economic Development did not comply with federal requirements for suspension and debarment for the Home Investment Partnership Program.

Background

The Department of Community, Trade and Economic Development administers the federal Home Investment Partnership Program (CFDA 14.239), also referred to as the HOME program. The objectives of the HOME program are to:

- Expand the supply of decent and affordable housing, particularly to low- and very-low-income residents.
- Strengthen the abilities of state and local governments to provide adequate supplies of affordable housing.
- Provide financial and technical assistance to states.
- Strengthen partnerships among governments involved with providing affordable housing.

The Department reported total HOME expenditures of $13,412,319 for fiscal year 2005. Approximately 91 percent of these expenditures were awards passed through to subgrantees, such as local governments and non-profit organizations.

Federal grantors prohibit recipients of federal awards from contracting with entities that have been suspended or debarred from receiving federal funds. The federal government can debar a party for convictions for fraud, anti-trust violations, forgery, or other offenses indicating a lack of business integrity or honesty; a history of failure to perform agreements; or a failure to pay a substantial debt. Suspension is usually a preliminary step that may lead to debarment.

New federal regulations effective in November 2003 offer three options for grant recipients to verify that proposed contractors are not suspended or debarred. In addition, grant recipients must inform their subgrantees that they are responsible for following the same suspension and debarment requirements.

Description of Condition

The Department is not in compliance with federal suspension and debarment requirements. The Department included a descriptive clause or condition in the contracts for two sections of the HOME program: Tenant Based Rental Assistance and Housing Repairs and Rehabilitation Program. However, the Department failed to include a notification that the subgrantees also have responsibilities regarding suspension and debarment when they make further awards or vendor payments. We estimate the payments related to these two sections of HOME during fiscal year 2005 totaled $4.9 million. This condition was previously reported in the fiscal years 2003 and 2004 State Accountability Reports and State of Washington Single Audit Reports.

Cause of Condition

Department management stated the Tenant Based Rental Assistance Section did not believe its contracts required this prescribed language regarding suspension and debarment. The Housing Repairs and Rehabilitation Program contracts did not have the correct version of the language because the Program Manager was not told about the revised language requirement in time to insert it into the contracts. The Department stated the next round of contracts will have the correct suspension/debarment language.

Effect of Condition

Subgrantees' lack of knowledge could make them susceptible to receiving their own audit findings if they also fail to follow suspension and debarment requirements. The Department may be liable for any amounts paid by the subgrantees to contractors who have been suspended or debarred from receiving federal funds.

Recommendation

We recommend the Department review its contracts for the HOME program to ensure they comply with the new suspension and debarment requirements

Department's Response

We partially agree with the finding. The Housing Division's Housing Repairs and Rehabilitation program (HRRP) believed they were in compliance and did not update contract language to include the specific lower tier notification requirements. All HRRP contractors have now signed certifications acknowledging the suspension and debarment requirements, including the lower tier notifications. This was completed on February 28, 2006.

The Housing Division's contractors for the Tenant Based Rental Assistance program (TBRA) are responsible for the determination of low-income family eligibility to receive rental assistance and pay for the family's rent with vouchers directly to landlords. They do not deal with lower tier contractors, so notification is not warranted. However, in response to auditor concerns, as of February 10, 2006 the notification language has been included in all existing contracts.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issue identified in the finding and will review this area in our fiscal year 2006 audit.

Applicable Laws and Regulations

Title 24 of the Code of Federal Regulations, Section 24.220, regarding procurement contracts included as covered transactions, states in part:

(b) Specifically, a contract for goods or services is a covered transaction if any of the following applies:

(1) The contract is awarded by a participant in a nonprocurement transaction that is covered under Sec. 24.210, and the amount of the contract is expected to equal or exceed $25,000.

24 CFR 24.300 states:

When you enter into a covered transaction with another person at the next lower tier, you must verify that the person with whom you intend to do business is not excluded or disqualified. You do this by:

a) Checking the EPLS (Excluded Parties List System)

b) Collecting a certification from that person if allowed by this rule

c) Adding a clause or condition to the covered transaction with that person.

24 CFR 24.330, subpart C states:

Before entering into a covered transaction with a participant at the next lower tier, you must require that participant to -

a) Comply with this subpart as a condition of participation in the transaction. You may do so using any method unless section 24.440 requires a specific method be used.

b) Pass the requirement to comply with this subpart to each person with whom the participant enters into a covered transaction at the next lower tier."

24 CFR 24.440 states:

To communicate the requirements to participants, you must include a term or condition in the transaction requiring the participant's compliance with subpart C of this part and requiring them to include a similar term or condition in lower tier covered transactions.

05-53 The Department of Employment Security has inadequate internal controls over payments to claimants for unemployment insurance benefits.

Background

The Agency pays more than $1.4 billion a year in benefits to unemployed workers through the Unemployment Insurance Program (CFDA 17.225). In the fiscal year 2004 and 2003 audits, we reported findings involving unemployment insurance benefits. The Agency has made improvements in certain areas such as payments to claimants with invalid Social Security numbers and duplicate payments.

Description of Condition

The following was reported to the Agency as a finding in the prior two audits:

- We reviewed unemployment insurance benefit payments totaling $504,593 and found that at least $42,054 in benefits was paid to ineligible claimants. Eleven claimants received unemployment and either workers' compensation benefits or pension benefits from Department of Labor and Industries for the same time period. Subsequent to notifying the Agency of these overpayments, the Agency collected $1,121.

- We identified claimants whose benefits were not properly reduced by their retirement pension benefits as required by state law. The seven claimants were overpaid by $9,412 due to adjudicators making calculation errors or using incorrect pension amounts as the base for the calculation or claimants not disclosing to the Agency that they were receiving a state pension.

- The Agency did not make changes to the benefit payment system that would prevent claimants from being paid during their first week of unemployment, which is prohibited by state law. However, the Agency asserts the changes were completed by June 30, 2005. We were not able to review those program changes during this audit, but plan to review this area in our next audit.

  We produced a report that compared the weeks of unemployment to the benefit payment weeks and found 1,132 claimants who received a payment within one week of their effective date of claim, totaling $501,647. We selected 75 of the 1,132 claimants and found the waiting week payment was waived in error by the system for 13 claimants. These overpayments totaled $3,057.

Cause of Condition

Overpayments made as the result of inaccurate pension deductions were due to staff calculation errors or use of an inaccurate pension rate. Due to lack of available resources during the audit period, the Agency had not yet made system programming changes to eliminate overpayments caused by concurrent payment of unemployment insurance and workers compensation. These changes were completed after the end of the audit period. Although the Agency made changes to eliminate overpayments due to payment of the waiting week, these changes were not made until late in the audit period.

Effect of Condition

Without adequate internal controls over the disbursement of unemployment insurance benefits, the Agency cannot ensure that benefits are being paid to eligible claimants for the correct amounts. Office of Management and Budget Circular No. A-133, Subpart E, Section 510, requires the auditor to question and report unallowable costs greater than $10,000.

Recommendation

We recommend the Agency:

- Perform a weekly cross-match with the Department of Labor and Industries to identify and investigate claimants receiving industrial insurance benefits.

- Establish and follow procedures to ensure that all pension benefit reductions are accurately calculated and that accounts with estimated pension amounts are properly monitored.

- Ensure that the benefit payment system properly prohibits payments during the claimant's first week of unemployment.

Agency's Response

We agree with the auditor's recommendation to identify and investigate overpayments resulting from concurrent payment of workers compensation and UI benefits. ESD implemented the changes to GUIDE to address this condition in July of 2005. However, seven of the eleven individuals identified for this condition had "back pay awards". These seven claims represented a total of $33,077 in overpayments. A back pay award occurs when someone is denied time loss compensation by Labor and Industries, appeals the denial, wins the appeal and is granted a back pay award for the time between when the time loss compensation is denied and the back pay is awarded. While someone appeals the time loss compensation denial, he/she can be eligible for Unemployment Insurance. We get information from the cross match with Labor and Industries that shows that a payment has been made. We then go into the Labor and Industries Industrial Insurance System (LINIIS) to get the detail about the back pay award payments. Currently there is no way to prevent overpayments caused by back pay awards. We have proposed legislation in the past that would allow us to deduct overpaid UI from back pay awards, but have not been successful.

We agree with the auditor's recommendations to ensure that all pension benefit reductions are accurately calculated and that estimated pensions would be properly monitored. We have published information on pension calculations and updated the pension desk aides, including a pension calculator. We will develop a report using information in the data warehouse that will allow us to monitor estimated pensions. Also, we will assess the cost effectiveness of implementing a cross match with the Department of Retirement Systems. The audit findings listed seven claimants with a total overpayment amount of $9,412. All seven cases have been forwarded to TeleCenter management for action and resolution. We anticipate overpayments due to improper pension calculations to diminish significantly during the next year due to the corrective steps described above.

We agree with the auditor's recommendation that the benefit payment system (GUIDE) should properly prohibit payments during the claimant's first week of unemployment. ESD implemented changes to GUIDE to address this condition in April of 2005. System changes were made that "locked" the first week of the claim so it could not be incorrectly paid if the claim was later "recalculated. We believe these changes have fixed this condition.

Auditor's Remarks

We appreciate the Agency's commitment to resolving issues identified in the finding. We will review these areas in our fiscal year 2006 audit.

Applicable Laws and Regulations

RCW 50.04.323 (1), states in part:

> The amount of benefits payable to an individual for any week which begins . . . in a period with respect to which such individual is receiving a governmental or other pension, retirement or retired pay, annuity, or any other similar periodic payment which is based on the previous work of such individual shall be reduced (but not below zero) by an amount equal to the amount of such pension, retirement or retired pay, annuity, or other payment, which is reasonably attributable to such week.

RCW 50.04.323 (1)(b), states:

> The amount of such a reduction shall take into account contributions made by the individual for the pension, retirement or retired pay, annuity, or other similar periodic payment, in accordance with regulations prescribed by the commissioner.

RCW 50.20.010 (1), states in part:

> An unemployed individual shall be eligible to receive waiting period credit or benefits with respect to any week in his or her eligibility period only if the commissioner finds that: . . . (c) He or she is able to work, and is available for work in any trade, occupation, profession, or business for which he or she is reasonably fitted [and] (d) He or she has been unemployed for a waiting period of one week.

RCW 50.20.085, states:

> An individual is disqualified from benefits with respect to any day or days for which he or she is receiving, has received, or will receive compensation under RCW 51.32.060 or 51.32.090.

RCW 51.32.060 is the state law providing compensation for permanent total disability in the case of an industrial accident, which is referred to as workers' compensation pensions.

RCW 51.32.090 is the state law providing compensation for temporary total disability in the case of an industrial accident, which is referred to as workers' compensation time loss.

WAC 192-110-005 (3), states in part:

> The first week you are eligible for benefits is your waiting week. You will not be paid for this week . . . .

WAC 192-16-030, states in part:

> The deductible pension amount shall be determined as of the last pay period in the individual's base year for which contributions were made.

Section 20.20.20.a of the Office of Financial Management's *State Administrative and Accounting Manual*, states in part:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

05-54 The Employment Security Department did not comply with federal requirements for suspension and debarment for the Workforce Investment Act and Unemployment Insurance programs.

Background

The Agency administers the federal Workforce Investment Act (CFDA 17.258-17.260) and the Unemployment Insurance Program (CFDA 17.225).

The Workforce Investment Act helps workers improve or learn new job skills and helps U.S. companies find skilled workers. One-stop service delivery unifies numerous training, education and employment programs into a single system in each community. The Act has programs serving adults, youth and dislocated workers. Total expenditures in fiscal year 2005 for this cluster of programs were approximately $107 million.

The Unemployment Insurance Program provides partial income replacement for those who become unemployed through no fault of their own. These benefits are temporary while the unemployed individual is seeking work or, in authorized cases, attending training. Total expenditures in fiscal year 2005 for this program were $927 million.

Federal grantors prohibit recipients of federal awards from contracting with entities that have been suspended or debarred from receiving federal funds. The federal government can debar a party for fraud convictions, anti-trust violations, forgery or other offenses indicating a lack of business integrity or honesty, a history of failure to perform agreements or a failure to pay a substantial debt. Suspension is usually a preliminary step that may lead to debarment.

New federal regulations, effective November 2003, offer three options for grant recipients to verify that proposed contractors are not suspended or debarred. In addition, grant recipients must inform their subgrantees that they are responsible for following the same suspension and debarment requirements.

Description of Condition

The Agency did not comply with federal suspension and debarment requirements. It failed to include a notification in grant agreements that subgrantees also have responsibilities regarding suspension and debarment when they make further awards. In addition, grant agreements did not include the proper dollar amounts applicable to subgrantees and their subcontracts.

For the Workforce Investment Act, we estimate payments related to such subrecipient awards to be approximately 80 percent of total program payments, or $85.6 million. For the Unemployment Insurance Program, we identified four contracts, totaling an estimated $1.3 million, that did not comply with suspension and debarment requirements.

Cause of Condition

The Agency was unaware of the changes to suspension and debarment requirements that occurred in November 2003.

Effect of Condition

Subgrantees' lack of knowledge could result in them receiving their own audit findings if they also fail to follow suspension and debarment requirements. The Agency may be liable for any amounts paid by the subgrantees to contractors who have been suspended or debarred from receiving federal funds.

Recommendation

We recommend the Agency review its grant agreements for both programs to ensure they comply with the new suspension and debarment requirements.

Agency's Response

The Employment Security Department is revising their Grant and Contract General Terms and Conditions to include revised language on Debarment and Suspension and a separate Debarment and Suspension Certification for each agreement requiring an authorized signature. This certification is part of the Department's Grant General Terms and Conditions and the Department's Contract General Terms and Conditions. For the existing agreements, each grantee (Workforce Development Area) has been asked to sign one Debarment and Suspension Certification. These Debarment and Suspension Certifications include a specific reference to all grants and contracts the Workforce Development Council has with the Department. All new grants and contract will include the appropriate revised General Terms and Conditions.

Auditor's Remarks

We appreciate the Agency's commitment to resolving issues identified in the finding. We will review these areas in our fiscal year 2006 audit.

Applicable Laws and Regulations

Title 29 of the Code of Federal Regulations, Section 98.200 states:

> What is a covered transaction?
>
> > A covered transaction is a nonprocurement or procurement transaction that is subject to the prohibitions of this part. It may be a transaction at—
> >
> > (a) The primary tier, between a Federal agency and a person...; or
> >
> > (b) A lower tier, between a participant in a covered transaction and another person

Section 98.205 states:

> Why is it important if a particular transaction is a covered transaction?
>
> > The importance of a covered transaction depends upon who you are.
> >
> > > (a) As a participant in the transaction, you have the responsibilities laid out in Subpart C of this part. Those include responsibilities to the person or Federal agency at the next higher tier from whom you received the transaction, if any. They also include responsibilities if you subsequently enter into other covered transactions with persons at the next lower tier.

Section 98.220 states:

> Are any procurement contracts included as covered transactions?
>
> > (a) Covered transactions under this part—
> >
> > > (1) Do not include any procurement contracts awarded directly by a Federal agency; but
> > >
> > > (2) Do include some procurement contracts awarded by non-Federal participants in nonprocurement covered transactions...
> >
> > (b) Specifically, a contract for goods or services is a covered transaction if any of the following applies:
> >
> > > (1) The contract is awarded by a participant in a nonprocurement transaction that is covered under Sec. 98.210, and the amount of the contract is expected to equal or exceed $25,000.

(2) The contract requires the consent of a(n) Department of Labor official. In that case, the contract, regardless of the amount, always is a covered transaction, and it does not matter who awarded it. For example, it could be a subcontract awarded by a contractor at a tier below a nonprocurement transaction, as shown in the appendix to this part.

(3) The contract is for federally-required audit services.

Section 98.300 states:

What must I do before I enter into a covered transaction with another person at the next lower tier?

Doing Business With Other Persons

When you enter into a covered transaction with another person at the next lower tier, you must verify that the person with whom you intend to do business is not excluded or disqualified. You do this by:

(a) Checking the EPLS (Excluded Parties List System); or

(b) Collecting a certification from that person if allowed by this rule; or

(c) Adding a clause or condition to the covered transaction with that person.

Section 98.330 states:

What requirements must I pass down to persons at lower tiers with whom I intend to do business?

Before entering into a covered transaction with a participant at the next lower tier, you must require that participant to—

(a) Comply with this subpart as a condition of participation in the transaction. You may do so using any method(s), unless Sec. 98.440 requires you to use specific methods.

(b) Pass the requirement to comply with this subpart to each person with whom the participant enters into a covered transaction at the next lower tier.

Section 98.970 states:

Nonprocurement transaction.

(a) Nonprocurement transaction means any transaction, regardless of type (except procurement contracts), including, but not limited to the following:

(1) Grants.
(2) Cooperative agreements.
(3) Scholarships.
(4) Fellowships.
(5) Contracts of assistance.
(6) Loans.
(7) Loan guarantees.
(8) Subsidies.
(9) Insurances.
(10) Payments for specified uses.
(11) Donation agreements.

05-55 The Military Department is not properly accounting for and safeguarding assets purchased by the National Guard Military Operations and Maintenance Projects Program.

Background

The state Military Department administers the U.S. Department of Defense's National Guard Military Operations and Maintenance Projects Program (CFDA 12.401). This Program supports the operations and training of the state Army and Air National Guards. The Department spent $14,919,960 for this Program in fiscal year 2005. Approximately 30 percent of this amount was spent for furnishings, equipment, software, land and buildings. The federal government requires states to use, manage, and dispose of equipment purchased with federal funds in accordance with state laws and procedures.

In Washington, agencies are responsible for developing internal policies and procedures to protect and control the use of all capital assets, in compliance with the standards in the *State Administrative & Accounting Manual*. These standards are minimum requirements; agencies may develop more restrictive standards. The Military Department has adopted its own generally more restrictive policy and procedures to meet this responsibility.

The state requires physical inventories to be conducted at least once every other fiscal year for all assets with a unit cost of $5,000 or more and assets with a unit cost of less than $5,000 if they have been identified as small and attractive assets.

In order to ensure objective reporting of inventory items, the state also requires that a physical inventory be performed by personnel who do not have any direct responsibility for assets included in the inventory count.

Description of Condition

We found the following weaknesses in the Department's equipment inventory procedures and asset records:

- The Department did not finish a physical inventory in fiscal year 2005, as required. The physical inventory and inventory records had not been reconciled seven months after the due date; therefore, the Department cannot be sure its records are accurate.

- The Department allowed 24,000 rounds of its ammunition purchases, worth $4000, to be shipped directly to a retail establishment and stored there for at least seven months without adequate control over the inventory. The ammunition was to be used for security guard training and practice at the store's indoor target range. The Department has no evidence that anyone at the store signed to acknowledge receipt of the ammunition at the time of delivery or that the ammunition was segregated from the store's stock. In addition, the Department maintained no concurrent record of how much ammunition was used for approved purposes and how much should remain.

- Department's inventory procedures are not adequate because they assign responsibility to conduct the physical inventory of equipment to the same division responsible for custody of the equipment. This does not meet the requirement for an adequate separation of duties.

- The Department did not always issue asset tags to identify ownership and/or create adequate asset records. We reviewed 10 transactions totaling $212,000 for adherence to asset record requirements. Within these 10 transactions, 55 items with serial numbers should have been recorded; however 24 of these, worth a total of $104,000, were not. Two items worth a total of $46,000 had not been tagged.

- During the fiscal year, the Department changed its procedure for recording small and attractive assets; this new procedure does not comply with the minimum standard required by the state.

Cause of Condition

The Department stated the inventory was not finished due to the absence of a key employee after the close of the fiscal year. Lack of knowledge appears to be the cause of the rest of the conditions. For instance, during discussions with us, the statements of the Department's inventory staff indicated knowledge of requirements in state policies and procedures but little knowledge of requirements in the Department's more restrictive policy and procedures.

Effect of Condition

The Department cannot ensure that federal property and equipment is recorded and safeguarded properly. A loss of assets could occur and not be discovered on a timely basis, if at all.

Recommendations

We recommend the Department:

- Complete the fiscal year 2005 inventory and all future physical inventories timely and in compliance with requirements.
.
- Revise its inventory procedure to fully comply with state policies and procedures.
- Record the missing serial numbers and ensure future assets are properly recorded.
- Establish inventory control procedures for assets stored offsite.

Department's Response

The Department agrees with the finding.

The 2005 inventory is now complete and documented. All future inventories will be completed in accordance with state requirements.

Ammunition will no longer be shipped directly to or stored at a vendor's location.

Paragraph 4e of the Military Department's procedure states, "The inventory will be reconciled by an individual with no direct responsibility for the assets subject to inventory." The Department will ensure this process is always followed in all future inventories.

The two items that were not tagged have been tagged and added to CAMS. The missing serial numbers were added to the records in CAMS. Our policy and procedure will be reviewed and updated as necessary to ensure they meet the minimum requirements in the SAAM manual for asset tracking.

The Department will return to using CAMS for tracking small and attractive items.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review the corrective action in fiscal year 2006 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

Title 32 Code of Federal Regulations Part 33, *Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments*, states in part:

Sec33.32 Equipment.

(b) States. A State will use, manage, and dispose of equipment acquired under a grant by the State in accordance with State laws and procedures.

The Office of Financial Management's *State Administrative and Accounting Manual* lists the following accounting and control requirements for fixed assets:

Section 30.30.10:

Mark all inventoriable fixed assets upon receipt and acceptance to identify that the property belongs to the state of Washington.

Section 30.40.40:

Upon receipt and acceptance of an inventoriable fixed asset, the agency inventory officer is responsible for supervising the addition of the asset to the inventory system. This includes assigning tagging responsibilities to specific individuals as well as developing and implementing procedures to ensure that the necessary information is entered into the fixed asset inventory records.

Section 30.40.55:

Conduct physical inventories at least once every other fiscal year for all inventoriable fixed assets.

Section 30.40.60:

In order to ensure objective reporting of inventory items, physical inventories should be performed by personnel having no direct responsibility (custody and receipt/issue authority) for assets subject to the inventory count. If it is not feasible to use such personnel for any part of the inventory, then those portions are, at least, to be tested and verified by a person with neither direct responsibility for that portion of the inventory nor supervised by the person directly responsible.

Section 30.40.70:

After the physical inventory count is completed, the agency inventory officer is to conduct the reconciliation process. Reconciliation is defined as the process of identifying, explaining, and correcting the differences occurring between the physical count and the inventory records. When all differences have been identified and explained the inventory is considered reconciled.

After the inventory is reconciled, the agency inventory officer is to certify the reconciliation with a statement and signature that it is correct and report this to the supervisor. If the certification cannot be made, the inventory officer is to disclose that fact and the supervisor is to determine the appropriate course of action.

Section 85.60.60:

Quarterly, all agencies are to reconcile their authorized capital asset management system with the balances in GL Code Series 2XXX "Capital Assets" to ensure the accuracy of the balances in the general ledger.

05-56 The Military Department is not in compliance with subrecipient monitoring requirements for the State Domestic Preparedness Equipment Support Program.

Background

State agencies often award federal funds to organizations that provide services needed to accomplish federal program objectives. These organizations are known as subrecipients, while the state agencies are called pass-through agencies.

To help ensure funds are spent appropriately, the federal government requires pass-through agencies to monitor subrecipient activities for compliance with federal requirements. Monitoring may take various forms, such as reviewing billings and reports submitted by subrecipients; contacting subrecipients regularly for discussions; and performing on-site reviews of subrecipients' financial and program records and operations.

Factors that may affect the degree of monitoring include program complexity, amount of the award, and risks directly related to the subrecipient. Pass-through agencies must ensure they receive and review audit reports from subrecipients and follow-up on any issues identified in those reports.

The Military Department administers the State Domestic Preparedness Equipment Support Program (CFDA 16.007 and CFDA 97.004). The U.S. Department of Homeland Security provides funds to enhance the capacity of state and local first responders to respond to terrorism, such as the release of chemical and biological agents or the use of radiological, nuclear, and explosive devices. Program expenditures for fiscal year 2005 were $8,938,896.

In addition to its own activities, the Department contracts with all 39 counties in the state to provide funds for the purchase of specialized equipment and for training exercises, planning and administration. These counties are subrecipients of the Department and together received $8,378,813 of the Department's federal equipment grant during fiscal year 2005. The Department is required to monitor whether the Program equipment is being used appropriately by the counties.

We reported in our fiscal year 2004 State Accountability Report and State of Washington Single Audit Report that the Department did not have adequate internal controls for this Program to ensure compliance with federal regulations regarding purchases for, contracting with, and monitoring of its subrecipients. In its response, the Department stated it would complete a comprehensive written policy and procedures for subrecipient monitoring by March 31, 2005.

Description of Condition

The Department is still not in compliance with subrecipient monitoring requirements.

- We reviewed five of the 39 county contracts for evidence of subrecipient monitoring but were informed by management that the Department did not perform any monitoring of these contracts during fiscal year 2005. Payments for the five contracts totaled $1,486,473 during the fiscal year.

- The Department developed a policy in 2005 requiring its programs to perform subrecipient monitoring but passed the responsibility on to the programs to develop the procedures in support of the policy. The State Domestic Preparedness Equipment Support Program has not developed the procedures necessary to assess the risks at individual subrecipients; to perform periodic on-site visits of subrecipients; or to collect, review, and follow-up on subrecipient audit reports.

Cause of Condition

Department management stated it did not have time to establish adequate internal controls, conduct the necessary training and perform any monitoring during the 2005 state fiscal year. They stated training was provided in November, 2005.

Effect of Condition

Inadequate subrecipient monitoring increases the risk of loss of public funds. In addition, these conditions impair the Department's ability to prevent or detect errors and irregularities in a timely manner and could affect the level of future federal funding for this Program in this state. We question the $1,486,473 that was provided for the five selected contracts that were not monitored.

Recommendation

We recommend the Department devote the resources necessary to ensure it properly monitors its subrecipients. At a minimum, the Department should:

- Ensure adequate Program subrecipient monitoring procedures are in place and followed.
- Communicate the federal equipment management requirements to all subrecipients**.**
- Periodically check that all subrecipients have an adequate system for equipment recording, usage, inventorying and disposition.
- Check annually to see if subrecipients received an audit of the Program, when required.

We also recommend the Department work with the federal grantor to determine if it must repay any of the questioned costs.

Department's Response

The Department agrees with the finding.

A workgroup within Emergency Management Division (EMD) has been meeting bi-weekly/monthly since the results of the 2004 single audit were released in 2005. This workgroup has identified basic procedures that can be applied across the various programs. The workgroup initiated a request to SAO to provide sub-recipient monitoring training to EMD staff and that training was held in November 2005. In December 2005, the workgroup met again to discuss the results of the training and refine the draft procedures.

The Office of Financial Management (OFM) is reviewing the draft procedures and they expect to have the draft returned to us by the first week in April. The workgroup will meet to incorporate any OFM recommendations and the procedures are expected to be finalized and released by May 1, 2006.

Once the procedures are in place, it will be the responsibility of each Program to monitor their respective subrecipients. Within the Homeland Security Section, a master subrecipient tracking database will be created to identify sub-recipients that need monitoring or have been monitored, as well as to follow-up on outstanding issues resulting from the monitoring visits.

In all contracts, federal equipment management requirements are identified via reference to the applicable OMB Circulars and the Department of Justice Financial Guide. In order to meet this recommendation, additional language will be incorporated into all contracts by July 1, through amendment or new contract initiation, to clearly explain that any equipment purchased with federal funds must be recorded on an equipment/asset system with CFDA numbers associated with the equipment items. Also, subrecipients will have instructions about the recording, usage, inventorying and disposition of equipment, per OMB regulations. Lastly, it will be stated that this applies to any sub-grantees or sub-sub grantees that may receive federally funded equipment through any of these programs and that these instructions need to be passed on in any sub-grants.

As part of the subrecipient monitoring procedures, one monitoring requirement will be to ensure that subrecipients have such a system in place, whether that is an electronic or paper based system, and to ensure that the CFDA number is appropriately listed and that any disposition has been in accordance with the regulations.

The Department has developed a grants management application. One of the tools in the application is to record the receipt of audits. The Department has started to enter the received audits into the application. On completion of entering all received audits on hand the Department will review state and federal resources to determine if any other audits have been completed.

The action items related to this audit finding will be reviewed and reported on in the Department's Government Management Accountability and Performance (GMAP) quarterly meetings.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review the corrective action in fiscal year 2006 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Section .400(d), states in part:

> A pass-through entity shall perform the following:
>
> > Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved . . .
> >
> > Ensure that subrecipients expending $500,000 or more in Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.
> >
> > Issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.
> >
> > Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.

The Department of Homeland Security has established the Office of Justice Programs' *Financial Guide* as the fiscal and oversight requirements for this grant program. Part II, Chapter 3 of this guide states in part:

> 1. Reviewing Financial Operations. Direct recipients should be familiar with, and periodically monitor, their subrecipients' financial operations, records, system, and procedures. Particular attention should be directed to the maintenance of current financial data . . .
>
> 5. Audit Requirements. Recipients must ensure that subrecipients have met the necessary audit requirements contained in this Guide (see Part III, Chapter 19: Audit Requirements).
>
> Where the conduct of a program or one of its components is delegated to a subrecipient, the direct recipient is responsible for all aspects of the program including proper accounting and financial recordkeeping by the subrecipient. Responsibilities include the accounting of receipts and expenditures, cash management, the maintaining of adequate financial records, and the refunding of expenditures disallowed by audits.

Part III, Chapter 19 of the Guide states in part:

> When subawards are made to another organization or organizations, the recipient shall require that subrecipients comply with the audit requirements set forth in this chapter.

> Recipients are responsible for ensuring that subrecipient audit reports are received and for resolving any audit findings. Known or suspected violations of any law encountered during audits, including fraud, theft, embezzlement, forgery, or other serious irregularities, must be communicated to the recipient.
>
> For subrecipients who are not required to have an audit as stipulated in OMB Circular A-133, the recipient is still responsible for monitoring the subrecipients' activities to provide reasonable assurance that the subrecipient administered Federal awards in compliance with Federal requirements

Part III, Chapter 6 of the Guide states in part:

> Records for equipment, non-expendable personal property, and real property shall be retained for a period of three years from the date of the disposition or replacement or transfer at the discretion of the awarding agency. If any litigation, claim, or audit is started before the expiration of the three year period, the records shall be retained until all litigations, claims, or audit findings involving the records have been resolved.

05-57 The Military Department was reimbursed for unallowable charges for the National Guard Military Operations and Maintenance Projects Program.

Background

The state Military Department administers the U.S. Department of Defense's National Guard Military Operations and Maintenance Projects Program (CFDA 12.401). This Program provides funds to support the operations and training of the state Army and Air National Guards. The Department spent $14,919,960 for this Program in fiscal year 2005. The Master Cooperative Agreement between the Military Department and the grantor specifies that indirect costs are not allowable for reimbursement from the grantor.

Federal regulations require states to spend and account for grant funds in accordance with state laws and procedures. This state requires that all expenditures be adequately supported and has defined the minimum standards for payment transaction support. State regulations also require specific acquisition methods for certain types of expenditures such as travel. For instance, in general, state agencies must use pre-qualified travel providers when making air travel arrangements. One valid exception occurs if an emergency situation has been approved by the agency's designated travel coordinator.

Description of Condition

Based upon our review of transactions, we have determined that the following expenditures were not allowable under this grant.

- When the Department contracted with another state agency for services, the other agency included in its billings $7,523 in indirect costs. The invoice support documentation identified these costs only as overhead. The Department did not deduct these costs from the total of the invoice before payment.

- The Department paid $36,694 to a utility company without adequate support for the payment. The utility company sent a statement in October 2003 for work performed early in 2000 by a company the utility company had now acquired. Despite the unusual circumstances, the Department did not require evidence that the billing was accurate and for a valid debt before paying it in August 2004. After the end of our field work, the Department did locate a federally-approved field order for $20,796 of the total, but provided no support for the remaining $15,898.

- The Department paid $1,518 in staff training travel costs that were either unsupported or did not comply with state travel regulations. The travel costs related to:

  - The purchase of $515 in airfare by an employee using a personal credit card. The purchase was made at a high price at the last minute and was not approved by the travel coordinator as an emergency. The department reimbursed the employee without adequate supporting documentation.

  - Personal vehicle mileage, airport parking and rental car use totaling $1,003 for another employee. The mileage reimbursement and airport parking costs of $531 and the rental car costs of $472 indicate conflicting travel methods. The Department had insufficient support to resolve this conflict. In addition, the mileage reimbursement was made without proper Program approval.

Cause of Condition

The Department did not review the transactions adequately prior to payment and prior to request for reimbursement from the grantor.

Effect of Condition

The Department requested and received reimbursement from the grantor for costs that were unallowable due to their nature or to the lack of adequate support. We question the total $24,939 charged to this Program.

Recommendations

We recommend the Department:

- Improve the payment review process to ensure:
  - Sufficient support exists for the payment.
  - The payment is allowable for reimbursement under the terms of the grant.
- Consult with the federal grantor to determine whether any questioned costs should be repaid.

Department's Response

The Department partially agrees with the finding.

The Department will not make another payment on an existing contract or execute another contract with a government entity for payment with CFDA 12.401 funding in the future that allows the ability to apply an indirect rate without first consulting with the National Guard Bureau.

Puget Sound Energy (PSE) does not send out invoices, all billing is done on a statement. This bill appeared several years after the work was performed. Appearing as a standard PSE statement; the lack of detail was not questioned. The Department did question whether or not the bill was valid, and if so would the federal government still reimburse. After discussions between program, accounting, and federal staff it was determined that the bill was valid and reimbursable.

A receipt was obtained for the questioned airfare regarding an employee's travel. The employee requested reimbursement for an incorrect amount, and has paid back the difference to the Department. The federal government is being refunded $236.

The $1,003 of questionable cost for another employee is not correct. The parking cost of $90 was valid. Only $210 for the rental car cost was billed to the federal government, and that was valid. The reminder of $262 was recovered from the employee in the reimbursement of the original travel voucher. This leaves an amount of $441 as questionable for the this employee's travel. The employee will be required to pay back any amount that is ultimately found to have been paid in error.

The mandatory travel training is currently being provided to all staff in the program area where the travel concerns originated. More diligence will be given to travel voucher reviews. The Department is phasing implementation of the Office of FinancialManagement's (OFM) Travel Voucher System (TVS) through 6/30/2006. This system will provide built in edits, and allows a more convenient and cleaner ability to send back travel vouchers for correction.

Auditor's Concluding Remarks

One of the basic criteria for the allowability of costs charged to a federal grant is that they be adequately documented to support the charges. Each of these issues lacked that support and therefore we reaffirm our finding.

We appreciate the Department's commitment to resolving the issues identified in the finding and will review the corrective action in the fiscal year 2006 audit. We also appreciate the cooperation extended to us throughout the audit by the Department staff.

Applicable Laws and Regulations

The *Master Cooperative Agreement* No. DAHA45-01-2-1000, issued by the National Guard Bureau to the State of Washington, states in part:

Section 305. Advance Agreements on the Allowability of Costs

b. Indirect costs, as such costs are defined in OMB Circular A-87, shall be unallowable, unless the costs are listed in subsection c.

c. The costs of compensation for personnel services, including the cost of fringe benefits, including, but not limited to, the costs of workmen's compensation, unemployment compensation, State sponsored life and health insurance, and retirement benefits shall be allowable in the amount determined in accordance with the procedures set forth in NGR 5-1/ANGI 63-101.

Title 32 Code of Federal Regulations, Part 33, *Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments*, states in part:

Section 33.20 Standards for financial management systems. Financial Administration:

(a) A State must expend and account for grant funds in accordance with State laws and procedures for expending and accounting for its own funds.

(b) The financial management systems of other grantees and subgrantees must meet the following standards:

(5) Allowable cost. Applicable OMB cost principles, agency program regulations, and the terms of grant and subgrant agreements will be followed in determining the reasonableness, allowability, and allocability of costs.

(6) Source documentation. Accounting records must be supported by such source documentation as cancelled checks, paid bills, payrolls, time and attendance records, contract and subgrant award documents, etc.

The Office of Financial Management's *State Administrative and Accounting Manual* lists the following accounting and control requirements:

Section 85.32.10: Agency Responsibilities

It is the responsibility of the agency head, or authorized designee, to certify that all expenditures/expenses and disbursements are proper and correct. Agencies are responsible for processing payments to authorized vendors, contractors, and others providing goods and services to the agency. Agencies are to establish and implement procedures following generally accepted accounting principles.

Section 85.32.20b: Payment Authorization

Prior to payment authorization, agencies are to verify that the goods and services received comply with the specifications indicated on the purchase documents. Authorized personnel receiving the goods and services are to indicate the actual quantities received.

Section 85.32.30a: Payment Processing Documentation

At a minimum, payment processing documentation should include evidence of authorization for purchase, receipt of goods or services, and approval for payment.

Section 85.32.40(a): Payment Processing

The following information, at a minimum, is to be indicated either on the disbursement documentation or in an automated system for compliance with federal regulatory agencies and internal control policies:...

- Receipt dates for goods and services;
- Signature of receiver;
- Receipt date of invoice;
- Invoice number, if available;
- Total amount of invoice;
- Invoice date;
- Discount or other terms; and
- Date of payment.

Section 85.32.40(b)

Agencies are to establish procedures which verify the mathematical accuracy of all documents and ensure that charges are properly recorded to the appropriate accounts.

Section 85.32.40(c) Audit disbursement documents for the following:

Quantities indicated on the invoice agree with those documented as received on the receiving report.

Unit prices on the invoice agree with those indicated on the disbursement document.

Extensions and footings are correct.

Written approval by the agency head or authorized designee authorizing payment appears on the disbursement document.

Interest for late payment, upon billing, is properly documented and computed.

Section 10.50.35: Restrictions and requirements on rental motor vehicle use

The state contract for rental of motor vehicles does not authorize vehicles to be used for other than official state business. Therefore, when a traveler couples a personal vacation with official state business, the traveler is expected to execute a personal contract to rent a motor vehicle for the vacation portion of the trip.

Since the use of rental motor vehicles makes it difficult to segregate charges between official use and occasional incidental personal use, the agency head or authorized designee is to establish written internal policies in accordance with Subsection 10.10.10 to guard against abuse and require the traveler to pay for all personal miles driven.

Section 10.50.45: How to make air travel arrangements

Absent agency specific purchasing requirements, state agencies **must use** an OSP qualified travel provider when making air travel arrangements. The only exceptions are for:

Conditions stated in OSP contract documents. Agencies are to contact OSP if they have questions regarding the exception conditions.

Emergency situations that have been approved by the agency designated travel coordinator

05-58 The Department of Ecology is not complying with subrecipient monitoring requirements for the Clean Water State Revolving Funds Program.

Background

State agencies often award federal funds to organizations that provide services needed to accomplish federal program objectives. These organizations are known as subrecipients, while the state agencies are called pass-through agencies.

The federal Clean Water State Revolving Loan Fund Program (CFDA 66.458), which the Department administers, provides low-interest loans to subrecipient state agencies, local governments, and Indian tribes for wastewater treatment facilities and related activities and for reduction of water pollution sources. Typical Program projects are site-specific facilities planning, design and construction; land acquisition; and collection and side sewer installations. In fiscal year 2005, the Department spent Program funds totaling $22,179,915; of this, 96 percent was in the form of loans to subrecipients.

To help ensure funds are spent appropriately, the federal government requires pass-through agencies to monitor the activities of subrecipients to provide reasonable assurance they are in compliance with federal requirements. Monitoring includes reviewing documentation such as billings, subrecipient progress reports, and audits of subrecipients and performing on-site reviews of subrecipient financial, operational and program records.

To help comply with this requirement, the Department has established policies and procedures to identify conditions that could increase risk for loan recipients and warrant the consideration of increased subrecipient oversight. This process requires:

- Selected loan recipients to provide the Department with copies of invoices and receipts to verify costs submitted on payment requests.

- The establishment of requirements for site visits and related documentation.

Description of Condition

The Department could not demonstrate that it was complying with its policy and the subrecipient monitoring requirements for this grant.

We noted the following:

- The active workload spreadsheet, which is used to track projects, did not include time frames identified as appropriate for oversight.

- Staff members could not clearly identify why projects were placed on increased oversight or when and why they were removed from the active workload spreadsheet.

- Documentation in the file of the extent and frequency of monitoring was not sufficient to determine if the increased oversight requirement was met.

Cause of Condition

Program staff members believed that keeping a current list of projects to be monitored was sufficient to document the monitoring process. They also believed project files were adequately documented to support the increased oversight process.

Effect of Condition

The Department cannot ensure its subrecipients are complying with federal requirements and using the funding for allowable purposes. This could jeopardize future federal funding for the Program.

Recommendation

We recommend the Department provide adequate documentation to support monitoring of subrecipients through reports and site visits as identified in the policy on increased oversight.

Department's Response

The Department takes its grant and loan tracking and subrecipient monitoring responsibility very seriously and has developed a number of procedures to implement its Risk Based Determination Policy. The Department does agree that more can be done to improve how the tracking and reporting aspects of the policy are being documented in the files and is actively taking steps to address more thoroughly the subrecipient monitoring condition noted in this audit.

- *The active workload spreadsheet is being updated to handle dates and time frames for projects identified for increased oversight.*

- *Staff are currently developing a new project tracking form for increased oversight and payment request processing. The form will include the reason/determination, effective dates, increased oversight conditions and requirements (payment backup and site visit schedule), payment request processing dates, check boxes for meeting requirements, and the method in which the Financial Manager verified costs.*

The Department looks forward to working with staff from the Office of the State Auditor to ensure that the improvements being made are adequate to address the outstanding issues.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review this area in our fiscal year 2006 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

The U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section .400(d), states in part:

> Pass-through entity responsibilities. A pass-through entity shall perform the following for the Federal awards it makes:...
>
> > (3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

Title 40 Code of Federal Regulations, Section 30.51, "Monitoring and reporting program performance", states:

> (a) Recipients are responsible for managing and monitoring each project, program, subaward, function or activity supported by the award. Recipients shall monitor subawards to ensure subrecipients have met the audit requirements as delineated in Sec. 30.26.

The Department's Water Quality Program Project Management WQP Policy 2-07 provides procedures for risk-based determination for increased oversight process of these loans.

05-59 The State of Washington is not complying with federal requirements for time and effort reporting for some of the programs it administers.

Baclground

Federal requirements are specific as to the standards expected of payroll documentation for compensation of employee salaries and wages claimed for Federal awards. Requirements state that documentation will be approved payrolls plus, for employees who work on multiple activities or cost objectives, payroll costs charged directly to federal awards require support by personnel activity reports or equivalent documentation. Usually the personnel activity reports are monthly employee time records. The time records should reflect the actual distribution of the employee's activities between two or more programs and are used as a basis for requesting federal funds.

If an employee works solely on only one federal activity, semi-annual certifications signed by the employee or a supervisor meet federal requirements. Budget estimates as a basis for requesting funds are allowable on an interim basis only if adjustments to actual costs are made at least quarterly.

The Office of Financial Management has delegated to each applicable agency the responsibility for determining the best method for fulfilling these requirements.

Description and Cause of Condition

In reviewing compliance with federal requirements, we identified the following agencies and programs that have time and effort compliance weaknesses.

Department of Social and Health Services

- *Juvenile Accountability Block Grant..... CFDA 16.523*

In our fiscal year 2004 State Accountability Report and State of Washington Single Audit Report, we reported that the Juvenile Rehabilitation Administration was not requiring nine employees working solely on the Juvenile Accountability Incentive Block Grant Program (CFDA 16.523) to prepare semi-annual certifications of their time. Two full-time employees working part-time on the Program were charging time based on budgeted rather than actual amounts.

For fiscal year 2005, we found the Administration charged salaries and benefits for 10 employees whose time was allocated to the Program based on a budgeted percentage rather than on actual time spent on grant activities. The Administration provided several groups of time certifications for these 10 employees, but certifications are acceptable only if employees work for a program 100 percent of the time. The time for these employees was charged to multiple activities; however, the Administration could not provide time records to support the payroll charges. We question the $24,849 charged to the Program for the 10 employees.

- *Rehabilitation Services Vocational Rehabilitation Grants to States.....CFDA 84.126*

In our fiscal year 2004 State Accountability Report and State of Washington Single Audit Report, we reported the Department was not complying with time and effort requirements for the Rehabilitation Services Vocational Rehabilitation Grants to States (CFDA 84.126). In some cases, time charged to Program funds was based on budgeted percentages rather than actual amounts.

The Department is still not in compliance with these requirements because it chose not to change the process of charging payroll costs for certain employees who work in areas other than the Program. Salaries and benefits totaling $101,618 for 10 Department employees were automatically allocated to the Program based upon budgeted percentages rather than on actual time spent on Program activities. We question the $101,617.80 for these 10 employees charged to the Program.

Department of Community, Trade and Economic Development

- *Low Income Home Energy Assistance Program..... CFDA 93.568*

In our fiscal years 2003 and 2004 State Accountability Reports and State of Washington Single Audit Reports, we reported the Department was not complying with time and effort requirements for this Program. Time charged to Program funds was based on budgeted rather than actual amounts.

During our audit of the corrective action plan for the previous findings, we found the Department had corrected time and effort problems in this Program. We reported this result to the Department. Then, in an adjustment made at the end of the fiscal year to correct charges to the indirect cost plan, the Department moved payroll charges for three employees from state funds to these federal Program funds. The adjustment for the payroll charges was not supported by the employee time records.

We question the $16,843 in federal funds charged to this Program as a result of the adjustment.

Department of Veteran's Affairs

- *Grants to States for Construction of State Home Facilities..... CFDA 64.005*

The Department of Veteran's Affairs spent $30 million of the Grants to State Construction State Home Facilities to construct a 240- bed skilled nursing facility for veterans. Two Department employees who worked on multiple activities were charged to this grant based on budgeted hours rather than on actual hours. Department management was not aware of the requirement to charge based only on actual time worked or to perform a quarterly analysis and adjustment process if charges are based originally on budget.

We reviewed informal time records the Department later provided us in support of the payroll charges for these two employees. We found they substantiated the charges and their benefit to the grant; therefore, we are not questioning the related costs.

Department of Health

In reviewing compliance with federal requirements, we identified the following programs that have time and effort compliance weaknesses.

- *Special Supplemental Nutrition Program for Women, Infants, and Children.....CFDA 10.557*
- *Immunization Grants..... CFDA 93.268*
- *Centers for Disease Control and Prevention Investigations and Technical Assistance (Public Health Preparedness and Response for Bioterrorism Project).....CFDA 93.283*

None of the 58 full-time staff members who charged 100 percent of their time to one of these programs during fiscal year 2005 had signed certifications stating they worked only on that one. This occurred because no office within the Department was responsible for ensuring the certifications were completed. Because we were able to determine by other methods that these staff members did work full-time on their assigned programs, we are not questioning these costs.

Military Department

- *National Guard Military Operations and Maintenance Projects.....CFDA 12.401*

We found exceptions in the time and effort records for 69 employees in the National Guard Military Operations and Maintenance Projects. Twelve split their time between this grant and state funding but had not prepared time and effort records to verify the charges were for actual time worked. We question the $217,630 in unallowable charges for these salaries and benefits. The other 57 employees were charged 100 percent to the grant but did not prepare proper certifications to support the charges. Because we were able to satisfy ourselves through other records that the 57 employees did work full-time on the grant, we are not questioning these costs.

- *State Domestic Preparedness Equipment Support Program..... CFDA 16.007 and 97.004*

In our fiscal year 2004 State Accountability Report and State of Washington Single Audit Report, we reported the Department was charging some employees to the State Domestic Preparedness Equipment Support Program based on budgeted rather than actual amounts. We questioned $150,000 charged to the Program for these employees. The Department concurred and described the controls it planned to establish to ensure actual time worked would be charged.

This year we found unallowable salary and benefit costs charged due to the following:

- Budgeted amounts were used for 26 employees.

- Inadequate, untimely certifications were prepared by seven employees, including some for whom certifications were not appropriate because they worked on more than one grant. These certifications were prepared anywhere from 30 days to six months late or were not completed at all until we requested them.

- Payroll costs for two employees who did prepare time sheets were adjusted without adequate support. The adjustments were made in 2005 based upon transactions that spanned the entire 2004 fiscal period.

These errors occurred because the Department's policies and procedures for reporting employees' time and effort do not meet federal requirements. For instance, the Department authorized employees to use periodic certifications when working on multiple funding sources, rather than only when working 100 percent on one program.

We question the $353,000 in unallowable charges for salaries and benefits.

Effect of Condition

Without adequate time and effort documentation to include time records and certifications, federal grantors cannot be assured that salaries and wages charged to their programs are accurate and valid. This could jeopardize future federal funding to the state. We are questioning a total of $713,940 as unallowable charges for salaries and benefits for the state as a whole.

Recommendations

We recommend state agencies receiving federal funds maintain time and effort records that comply with federal regulations and consult with the federal grantor to determine whether any questioned costs should be repaid. We also recommend the Office of Financial Management improve and emphasize training for agencies in this area.

Department Responses (in italics) and Auditor's Concluding Remarks

<u>Department of Social and Health Services</u>

- *Juvenile Accountability Block Grant..... CFDA 16.523*

The Juvenile Rehabilitation Administration (JRA) does not concur with this finding. JRA implemented the requirement of the Department's Fiscal Policy 50.01, Federal Compliance with Time Allocation/Certification in February 2005. Semi-annual certifications were completed for salaried and part-time employees for both the current period and the audit review period. JRA employees who work on multiple activities keep daily timesheets on their activities. JRA staff that work on single activities but with multiple funding sources also complete the semi-annual certifications. JRA believes that staff working on single federal grant activity 100 percent of the time, such as those meeting the purpose areas of the federal Juvenile Accountability Block Grant, should only need to complete the semi-annual certifications even though there may be multiple funding sources – due to the lidded federal funds available.

We reaffirm our finding that the time and effort documentation provided by the Administration for the 10 employees did not meet the requirements of federal cost principles for payroll charges to this grant. We will review the Department's corrective action during the fiscal year 2006 audit. We appreciate the cooperation extended to us throughout the audit by Department staff.

- *Rehabilitation Services Vocational Rehabilitation Grants to States.....CFDA 84.126*

The Division of Vocational Rehabilitation partially concurs with this finding. When DVR first received this finding for fiscal year 2003, a corrective action plan was immediately developed and implemented. In addition, the DSHS Accounting Policy Management Board issued Fiscal Policy 50.01, Federal Compliance With Time Allocation/Certification, on July 1, 2004. Policy 50.01 states 'For P4s (positions) split between multiple programs, the program that owns the P4 shall complete the certification'. The 10 positions charged to DVR during FY05 were positions that did not belong to DVR. At the current time three of the 10 individuals have left the agency, two are no longer charged to DVR, and the Office of Accounting Services confirms that the required Semi-Annual Certifications are on file for the remaining five staff for the period April 2005-September 2005. DVR will establish additional steps to monitor positions partially coded to their program and the Office of Accounting Services will work with the administrations to raise awareness of the policy requirements for split-coded positions. In addition the Office of Accounting Services will be submitting Fiscal Policy 50.01 with the associated Semi-Annual Certification form to the federal Health and Human Services's Division of Cost Allocation as an amendment to the department's cost allocation plan by April 30, 2006.

During our review, we included the Office of Accounting Services when we requested support documentation for the time and effort charges for these positions; however, the Office did not provide any documentation. We affirm our finding that the Department was not in compliance for time and effort requirements for this grant. We appreciate the Department's commitment to resolving the issues identified in the finding and will review the Department's corrective action during the fiscal year 2006 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Department of Community, Trade and Economic Development

- *Low Income Home Energy Assistance Program..... CFDA 93.568*

We agree with the finding. At the end of the fiscal year, five journal voucher entries were made to transfer salary and benefit expenditures between programs. The affected employee's timesheets were not corrected. The adjustments were not to correct charges to the indirect cost plan. Immediately upon being notified of the issue, the Department enhanced procedures by (1) re-focusing resources to implement tighter controls over the review and approval of journal voucher entries and (2) identifying procedures to ensure all corrections of salaries and benefits include the necessary corrections to employee timesheets.

We appreciate the Department's efforts to address this issue. We look forward in our audit in 2006 to reviewing procedures that ensure time and effort charges are maintained on an actual basis, that corrections to reflect actual are adequately documented, and that approved adjustments are prepared for those corrections. We also appreciate the cooperation extended to us throughout the audit by the Department staff.

Department of Veteran's Affairs

- *Grants to States for Construction of State Home Facilities..... CFDA 64.005*

The department concurs with the finding. The charges for the two positions were included as administrative costs in the project budget approved by the grantor, but not listed as specific line items with a schedule driven spending plan. However, as acknowledged by the auditor, the total charges to the grant did not exceed the approved budget totals and are supported by calendar records.

DVA will implement the necessary administrative procedures to ensure documentation of time and effort charged to any future federal grants complies with the applicable federal accounting requirements.

We thank the Agency for their assistance and cooperation during the audit. We will follow up on the Agency's corrective action during our next audit.

Department of Health

- *Special Supplemental Nutrition Program for Women, Infants, and Children.....CFDA 10.557*
- *Immunization Grants..... CFDA 93.268*
- *Centers for Disease Control and Prevention Investigations and Technical Assistance (Public Health Preparedness and Response for Bioterrorism Project).....CFDA 93.283*

We concur with the State Auditors Office and agree that appropriate certification or timesheets be included in employee payroll files where salaries are charged to Federal awards or grants. We will work closely with our program managers and payroll office to implement a certification and/or a time keeping documentation process that is consistent with the requirements of A-87 Cost Principles for State, Local and Indian Tribal Governments.

We appreciate the Department's commitment to resolving the issue identified in the finding and will review this area in our fiscal year 2006 audit.

Military Department

- *National Guard Military Operations and Maintenance Projects.....CFDA 12.401*
- *State Domestic Preparedness Equipment Support Program.....CFDA 16.007 and 97.004*

The Department agrees with the finding.
The Departments Time and Effort Policy and Procedures will be corrected and reissued by 6/30/2006.
All employees that are incorrectly using certificates will be required to submit time sheets starting 4/1/2006.
Certificates for employees that are only charged to a single federal grant will be attained in a timely manner.
The action items related to this audit finding will be reviewed and reported on in the Department's Government Management Accountability and Performance (GMAP) quarterly meetings.

We appreciate the Department's commitment to resolving the issues identified in the finding and will review the corrective action in fiscal year 2006 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

The Federal criteria for the determination of costs for states is U.S. Office of Management and Budget's Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments.* For certain block grant programs, like LIHEAP, federal regulations give an exemption from federal cost principles, provided the state adopts its own cost principles consistent with federal requirements. The federal Department of Health and Human Services, Office of the Inspector General has provided us with guidance that it considers the U.S. Office of Management and Budget's Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments* to be the benchmark for state cost principles since the State of Washington has not adopted its own cost principles in conformance with this Circular.

Attachment A, Section C.3 of the Circular requires allocable costs to be chargeable or assignable in accordance with the relative benefits received.

Attachment B, Section 8(h) of the Circular states in part:

a. Support of salaries and wages. These standards regarding time distribution are in addition to the standards for payroll documentation.

   (1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a responsible official(s) of the governmental unit.

(2) No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.

(3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi annually and will be signed by the employee or supervisory official having first hand knowledge of the work performed by the employee.

(4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection (5) unless a statistical sampling system (see subsection (6)) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:

(a) More than one Federal award,
(b) A Federal award and a non Federal award,
(c) An indirect cost activity and a direct cost activity,
(d) Two or more indirect activities which are allocated using different allocation bases, or
(e) An unallowable activity and a direct or indirect cost activity.

(5) Personnel activity reports or equivalent documentation must meet the following standards:

(a) They must reflect an after the fact distribution of the actual activity of each employee,
(b) They must account for the total activity for which each employee is compensated,
(c) They must be prepared at least monthly and must coincide with one or more pay periods, and
(d) They must be signed by the employee.
(e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:

(i) The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;

(ii) At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and

(iii) The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

(6) Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort.

(a) Substitute systems which use sampling methods (primarily for Temporary Assistance to Needy Families (TANF), Medicaid, and other public assistance programs) must meet acceptable statistical sampling standards including:

(i) The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results except as provided in subsection (c);

(ii) The entire time period involved must be covered by the sample; and

(iii) The results must be statistically valid and applied to the period being sampled.

(b) Allocating charges for the sampled employees' supervisors, clerical and support staffs, based on the results of the sampled employees, will be acceptable.

(c) Less than full compliance with the statistical sampling standards noted in subsection (a) may be accepted by the cognizant agency if it concludes that the amounts to be allocated to Federal awards will be minimal, or if it concludes that the system proposed by the governmental unit will result in lower costs to Federal awards than a system which complies with the standards.

(7) Salaries and wages of employees used in meeting cost sharing or matching requirements of Federal awards must be supported in the same manner as those claimed as allowable costs under Federal awards.