Federal Findings and Questioned Costs

06-01 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.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Activities Allowed or Unallowed & Special Tests and Provisions: Provider Eligibility
Questioned Cost Amount:	$5,117,085

Background

Home health care includes a broad range of services offered in clients' homes including 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 waivers give states the flexibility to use alternatives to institutionalized care such as hospitals and nursing homes. The 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.

The waivers stipulate the qualifications a home health provider must meet in order to give care to Medicaid clients. They indicate credentials 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 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.

In our fiscal year 2005 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.

Federal Findings and Questioned Costs - continued

Description of Condition

In its corrective action plan for conditions noted in the past audit, the Administration reported it would request approval from the Centers for Medicare and Medicaid Services for two amendments to the State Plan. These amendments would stipulate Medicare certification is not required of a home health agency when it provides skilled nursing services and home health aide services or services performed by licensed registered nurses or licensed professional nurses.

We found both these amendments were submitted. At the time of our audit only one had been approved by the Centers. As of April 19, 2006, home health agencies are not required to obtain Medicare certification to provide private duty nursing services. Within the home health agency, private duty nursing services must be performed by a licensed and appropriately trained registered nurse and/or licensed practical nurse.

The Administration made no other changes to resolve this condition. As a result, we found non-certified providers were performing services that according to federal regulations and waivers only Medicare certified providers should have supplied.

Cause of Condition

The Administration states it expects the Centers will approve the request for home health agencies that provide home health aide services need not be Medicare certified.

The Administration also stated it believes all non-skilled 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 and Questioned Costs

We do not have reasonable assurance that those 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 have rendered to Medicaid clients. We are questioning costs of $10,234,170, of which $5,117,085 was paid with federal 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 has worked diligently on the State Plan Amendments (SPA) identified in the Department's 2005 response to the audit findings. SPA 06-008 was approved effective April 1, 2006 exempting home health agencies that provide Private Duty Nursing from the Medicare certification requirement. SPA 06-008 originally also included language to clarify that home health agencies providing personal care did not require Medicare certification. At the request of the Centers for Medicare and Medicaid Services (CMS), that language was removed from SPA 06-008 and a new SPA 06-012 was submitted to CMS on June 28, 2006 with that clarifying language. SPA 06-012 is still under CMS review.

Federal Findings and Questioned Costs - continued

The State Auditor's Office (SAO) correctly noted that states may request waivers of certain federal requirements to provide Home and Community-Based Services (HCBS) as an alternative to institutional care provided in nursing homes or Intermediate Care Facilities for the Mentally Retarded. Aging and Disability Services Administration (ADSA) manages three HCBS waivers under its Home and Community Services Division and four HCBS waivers under its Division of Developmental Disabilities. Each waiver establishes provider qualifications and requirements by service type. Under those waivers there is no requirement under any service type that home health agencies be Medicare certified to provide personal care, assisted living, adult family home, personal emergency response system, environmental modifications, transportation, adult day care, client training, home delivered meals, specialized medical equipment & supplies, respite care or community transition services. (Copied below is the Community Options Program Entry System (COPES) Appendix B-2 - Provider Qualifications.) The Department disagrees with the SAO interpretation that the Code of Federal Regulations requiring Medicaid home health agencies to be Medicare certified applies to any waiver service.

None of these services require a plan that is established and periodically reviewed by a physician as is required for home health services in federal statute (42 USC sec. 1395x(m)). This is a fundamental difference between home health care and in-home care services under home and community based waivers. Medicare does not pay for, and moreover does not recognize, these as medical services. Provider qualifications are specified in approved waivers and do not include Medicare certification as a qualification.

The Department agreed with last year's findings that in addition to Registered Nurses or Licensed Practical Nurses as qualified to provide skilled nursing services under its waivers that it would amend the waivers to include licensed home care agencies under WAC 335-246. ADSA is amending the waivers as they are renewed. The renewal for the Medically Needy In-Home Waiver is due to CMS in January 2007 and the COPES waiver is due December 2008.

Regarding the specific State Auditor's Office recommendations:

- *Develop controls to ensure all home health providers meet the criteria for participating in the Medicaid program.*

The Department assures that all providers meet criteria for participation in the Medicaid program. This is confirmed by repeated approval from CMS of the Medicaid State Plan, Home and Community Based Waivers and related collection of federal financial participation. The Department will continue to work with CMS to obtain approval of SPA 06-012. The Department will amend waivers on the renewal schedule to clarify providers of skilled nursing.

- *Work with the U.S. Department of Health and Human Services (DHHS) to determine if any unallowable costs charged to federal Medicaid funds should be returned.*

The Department will work with DHHS should any unallowable costs be identified.

In summary, the Department does not agree with the auditor that agencies which perform in-home care must be Medicare certified. The Department followed up on the previous SAO audit by submitting SPA 06-008 and 06-012. The Department agreed to amend the Medically Needy In Home and COPES waivers to include licensed home care agencies as providers of skilled nursing. The Department's original intent was to amend the waivers as each came up for renewal. Given the auditor's concerns, the Department is currently submitting the Medically Needy In Home Waiver with agreed amendments and will move to amend COPES as soon as possible.

(For reference, following is COPES Appendix B-2, Provider Qualifications):

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached as Attachment B-2.

Service	Provider	License	Certification	Other Standard
1 Personal Care	Individual Providers		Must be a registered or certified nursing assistant in the state of WA to provide delegated nursing tasks	Meet the requirements of WAC 388-71-0500 through 399-71-05952
	Agency Providers	Home Care Agency License under Chapter 70.127 RCW and Chapter 246-336 WAC: or Home Health Agency License under Chapter 70.127 RCW		
2 Assisted Living/ Enhanced Adult Residential Care	Boarding Home	BH License under Chapter 18.20 RCW, Chapter 388-110 WAC		
3 Adult Family Home Care	Adult Family Home	AFH License under Chapter 70.128 RCW and 388-76 WAC		
4 Personal Emergency Response	Electronic Communication Equipment and Monitoring Agency			See attachment B-2a
5 Environmental Modifications	Contractor Volunteer			Meet the requirements of Chapter 18.27 RCW
6 Skilled Nursing	Licensed Practical Nurse (LPN)	LPN License under Chapter 18.79 RCW and Chapter246-840 WAC RN License under Chapter 18.79 RCW and Chapter 246-840		
7 Transportation	Taxicab Public Transit Volunteer			Standards are the same as those applied to vendors who provide access to state plan medical services.
8 Home Health	Nursing Assistant Certified		Nursing Assistant Certified (and registered) under Chapter 18.88A RCW and WAC 246-841	

Federal Findings and Questioned Costs - continued

9 Adult Day Care	Adult Day Care Center		Certified as Title XIX Provider	Meet the requirements of WAC 388-71-0702 through WAC 388-71-0776
10 Caregiver/ Recipient Training/ Support	Licensed Practical Nurse (LPN) and Registered Nurse (RN) Certified Dietician/Nutritionist Physical Therapist (PT) Licensed Occupational Therapist (OT) Home Health Agencies Home Care Agencies Community Colleges	LPN license under RCW 18.79 and WAC 246-840 RN license under RCW 18.79 and WAC 246-840 PT license under Chapter 18.74 RCW OT license under Chapter 18.59 RCW Home Health Agency license under Chapter70.127 RCW and WAC 246-327 Home Care Agency license under Chapter 70.127 RCW and Chapter 246-336 WAC	Dietician and Nutritionist Certificate under 18.138 RCW	Higher education institutions conducting programs under RCW 28B.50.020
	Independent Living Providers			A Bachelor's degree in social work or psychology with two years experience in the coordination or provision of Independent Living Services; or, Two years experience in the coordination or provision of Independent Living Services (e.g. housing, personal assistance services recruitment and/or management, IL skills training) in a social service setting under qualified supervision; or, Four years personal experience with a disability, two years experience in the coordination or provision of IL services in a social service setting under qualified supervision.

Federal Findings and Questioned Costs - continued

11 Home Delivered Meals	Food Service Vendor			Title III: Home Delivered Nutrition Program Standards Chapter 246-215 WAC: Food Service Vendor
12 Specialized Medical Equipment and Supplies	Contractor, RN			Have a state contract as a Title XIX Vendor
13 In home Nurse Delegation	RN Registered Nurse	RN licensed under Chapter RCW 18.79.040		
14 Community Transition Services	Any waiver provider listed above and any community provider that is appropriate such as stores, landlords, utilities, exterminators.			Meet all the state licensure and contract standards as required by service

Attachment B-2

Minimum Standards for PERS Equipment Vendors and Monitoring Agencies

1. All PERS equipment vendors must provide equipment approved by the Federal Communications Commission and the equipment must meet the Underwriters Laboratories, Inc., (UL) standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard.

2. The emergency response activator must be able to be activated by breath, by touch, or some other means and must be usable by persons who are visually or hearing impaired or physically disabled.

3. The emergency response communicator must be attached to the PERS client's telephone line and must not interfere with normal telephone use. The communicator must be capable of operating without external power during a power failure at the recipient's home in accordance with UL requirements for home health care signaling equipment with stand-by capability.

4. The monitoring agency must be capable of simultaneously responding to multiple signals for help from clients' PERS equipment. The monitoring agency's equipment must include a primary receiver, a stand-by information retrieval system and a separate telephone service, a stand-by receiver, a stand-by back up power supply, and a telephone line monitor. The primary receiver and back-up receiver must be independent and interchangeable. The clock printer must print out the time and date of the emergency signal, the PERS client's Medical identification code (PIC) and the emergency code that indicates whether the signal is active, passive, or a responder test. The telephone line monitor must give visual and audible signals when an incoming telephone line is disconnected for more than 10 seconds. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements including PERS equipment installation, functioning and testing; emergency response protocols; and record keeping and reporting procedures.

Auditor's Concluding Remarks

We thank the Department for its response. We will follow up in this area during our next audit.

Applicable Laws and Regulations

Certification

State Medicaid Plan, approved July 11, 2003.

WAC 388-551-2200, states in part:

> 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 . . . .

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 . . . .

Department of Health In Home Service License

RCW 70.127.080, states:

> Licenses -- Application procedure and requirements
>
> > (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, states:

Licenses required after July 1, 1990 -- Penalties.

(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.

06-02 The Department of Social and Health Services is not complying with federal regulations that require people receiving Medicaid benefits to have valid Social Security numbers.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	$903,821

Background

The Department of Social and Health Services must require, as a condition of eligibility, each individual, including children, applying for Medicaid services furnish his or her Social Security number. Federal regulations also require the Department to verify with the Social Security Administration the number given 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 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 Medicaid Management Information System (MMIS), which the Department's Health and Recovery Services Administration uses to process claims and initiate payments. The Administration stated all Medicaid clients, except those admitted through the Involuntary Treatment Act, are entered into ACES upon enrollment.

During our audits for fiscal years 2004 and 2005, 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 a number and other cases in which MMIS made payments for medical services for clients not listed in ACES.

Description of Condition

For our current audit, we sought to determine what improvements the Department had made to address the condition. We found continued weaknesses in internal controls intended to ensure all Medicaid applicants have, or have applied for, a valid Social Security number:

- Current procedures to ensure that staff obtain client Social Security numbers or assist those without a number in obtaining one upon application are not effective or consistently applied at all of the Department's field offices.

- Staff does not consistently validate Social Security numbers prior to admitting clients into the Medicaid program or verify that the individual is the actual owner of the Social Security number.

- Applications without Social Security numbers are being processed.

Federal Findings and Questioned Costs - continued

Cause of Condition

Department headquarters does not have effective monitoring procedures to make certain all field offices are adhering to policies and procedures related to ensuring that staff is obtaining, upon application, client Social Security numbers or assisting those who do not have one in obtaining one.

Effect of Condition and Questioned Costs

We performed audit procedures to determine the effect of the control weaknesses that we found. Our testing showed $31,276,404 in payments for medical care was made on behalf of 23,782 clients from July 1, 2005, through December 31, 2005. This amount did not include payments made for clients that would not need a Social Security number under Medicaid regulations. The following were eliminated from our testing:

- Clients the Department identified as being in the Alien Emergency Medical program.
- Clients whose procedures were paid only with state funds.
- Children born of a mother who was eligible for Medicaid and on the program at the time of the baby's birth.

We selected 281 clients for review. The payments attributed to their care totaled $4,594,546. We found 65 clients (23 percent) had received medical care paid for by the Medicaid program and were not listed in the Department's eligibility system or had been admitted into the program without Social Security numbers. In other instances, the Department was aware that the Social Security numbers provided by the client were invalid or erroneous:

- For 19 clients, the Department could not give us evidence that the client had been recorded in any of the Department's eligibility databases. This included databases for highly confidential clients such as adopted children, those in foster care or clients receiving services under the Take Charge Program of Medicaid.
- Three clients were listed in the Department's eligibility databases, but without a Social Security number.
- Forty-three clients were listed in the Department's eligibility databases with a designation of "Invalid SSN" in the Social Security number field.

The payments associated with the care for these clients resulted in actual questioned costs of $1,807,642. Of this, $903,821 (50 percent) was paid with federal matching funds.

When projected to the entire population of Medicaid clients that we found to be without Social Security numbers in the Department's payment system, the costs were $7,587,438. Fifty percent of these costs were paid with federal funds.

Recommendation

We recommend the Department:

- Require staff members to obtain client Social Security numbers or assist those without a number in obtaining 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.

- 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 the findings:

The 65 cases have been reviewed by the Department, they have been corrected or pended and letters have gone out requesting verification of information.

To ensure the field is adhering to policies and procedures related to obtaining the correct social security number for clients at application and reviews the Department has implemented the following requirements:

- *Developed and required State On-line Query (SOLQ) on-line training for field staff. All six regions have reported all appropriate staffs have completed this training.*

- *Required supervisors add medical cases to their monthly case audits and focus on Social Security number (SSN) mismatched alerts and check for consistent use of SOLQ for SSN verification.*

- *Community Services Division (CSD) Headquarters will be conducting quarterly random audits on medical cases and checking for consistent use of SOLQ at application and reviews.*

- *CSD supports the Health and Recovery Services Administration's change request for an Automated Client Eligibility System hard edit at the time of medical recertification for individuals who have a SSN application pending more than 60 days.*

The Department does not concur with the questioned costs as the cases in error were reviewed and corrected and still determined eligible for benefits during the audit time frame.

Auditor's Concluding Remarks

We appreciate the actions taken by the Department to correct the conditions identified. We will follow up during our next audit.

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.

Federal Findings and Questioned Costs - continued

06-03 The Department of Social and Health Services, Health and Recovery Services 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.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	$681,508

Background

We began reviewing the Department's controls related to Social Security numbers as a condition of eligibility for the Medicaid program in 2002. We found reportable conditions for that year and in state fiscal years 2003, 2004 and 2005. During those years we saw little improvement in the control structure.

For those audits and in the current year, the Social Security Administration will not permit our independent access to the State On-line Query, a system that would allow us to verify Social Security numbers. Because of this condition, we must rely on the Department of Social and Health Services to perform Social Security number verifications for all our testing. For the past two audit cycles, however, we have been able to obtain independent access to death certificate information from the Health Department through the Department of Social and Health Services' systems. This has greatly improved audit efficiency.

Description of Condition

For state fiscal year 2006, we found conditions seen during previous audits. Specifically:

- Department staff at Community Service offices does not consistently use the computer system's capability to verify the validity of a Social Security number at the time of application. Thus, 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.

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

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

Federal Findings and Questioned Costs - continued

Our current audit also found some improvements:

- Although not yet consistent among all the field offices, we saw more supervisory oversight with respect to responding to alerts.
- Better communication between headquarters and the field offices.
- The Department has completed modifications to its computer system that, if used by field staff, would greatly facilitate the verification of Social Security numbers at the time of application. These modifications were completed toward the end of the audit period.
- The Department has taken steps to recoup some of the payments we identified that were made on behalf of clients after their date of death.

Cause of Condition

- The number of alerts would substantially decrease for invalid Social Security numbers if staff would verify them at the time of application. The volume of alerts coming in daily precludes correction in a timely manner.
- The Administration is largely dependent on the provider or family members to report a client's death.
- Except for a few instances, we saw no evidence that the Department is assisting clients who are using Social Security numbers of deceased spouses and other relatives in obtaining their own numbers as the law provides.

Effect of Condition and Questioned Costs

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 and state laws.

The Medicaid program is unnecessarily susceptible to loss or misappropriation when it does not address unresolved control weaknesses.

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

For the six-month period, July 1, 2005, through December 31, 2005, questioned costs related to medical services for deceased persons or persons using the Social Security numbers of persons, both living and deceased, totaled $1,363,015. Fifty percent ($681,508) was matched by federal funds. When projected to the entire population of Medicaid clients that we found in the Department's system having a Social Security number that matched a deceased person's Social Security number in the federal government's system, the costs were $1,684,194. Fifty percent of these expenditures were paid with 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 the State On-line Query.
- Assist applicants in completing an application for a Social Security number for those who cannot recall their Social Security numbers or who have not been issued one as the law requires.
- 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.
- Establish procedures with the Department of Health that will provide notification of clients' deaths in a timely manner.
- Forward the instances of apparent identity theft and provider fraud to its own Post-Payment Review Office or to appropriate legal authorities.
- Work with the U.S. Department of Health and Human Services to determine if any unallowable costs must be reimbursed.

Department's Response

The Department partially concurs with this finding.

To ensure the field is adhering to policies and procedures related to obtaining the correct social security number for clients at application and reviews the Department has implemented the following requirements:

- *The Department's Community Services Division (CSD) has developed and requires State On-line Query (SOLQ) on-line training for field staff. All six regions have reported all appropriate staffs have completed this training.*
- *Required supervisors add medical cases to their monthly case audits and focus on Social Security number (SSN) mismatched alerts and check for consistent use of SOLQ for SSN verification.*
- *CSD headquarters will be conducting quarterly random audits on medical cases and checking for consistent use of SOLQ at application and reviews.*
- *CSD supports the Health and Recovery Services Administration's (HRSA) change request for an the Department's Automated Client Eligibility System (ACES) hard edit at the time of medical recertification for individuals who have a SSN application pending more than 60 days.*

Currently CSD field staff acts on notification from HRSA Medicaid Management Information System (MMIS) staff when date of death (DOD) is reported. Field staff then work the 271 ACES alert when issued from the Social Security DOD interface. At this time the system issues hundreds of alerts for various reasons, requiring supervisor approval for all alerts would not be feasible for day to day work requirements.

Federal Findings and Questioned Costs - continued

HRSA has been, and 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 (DSHS). 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, DSHS will continue its successful post-pay review activities by using the quarterly DOH death data file to identify and recoup claims paid for deceased clients.

When provider fraud or abuse is suspected, HRSA refers these cases to the Medicaid Fraud Control Unit of the Attorney General's Office for investigation and possible prosecution.

The auditor supplied HRSA with claims totaling $1,315,155.49 to research and respond. HRSA analyzed the 93 client records/SSNs attributed to these claims and verified that these clients were not deceased. The Department agrees that the SSN in the MMIS should be the client's correct SSN and has corrected them in the ACES and MMIS systems.

The Department disagrees that the $1,315,155.49 are unallowable claims.

HRSA validation found:

- *Correct SSNs for 27 clients were researched, validated and corrected in ACES;*
- *27 clients were using the SSN of a deceased spouse. HRSA staff researched, verified and corrected the SSN in ACES;*
- *28 undocumented persons had incorrect SSNs and were corrected in ACES;*
- *6 ACES keying errors for clients and were corrected in ACES;*
- *4 clients where the SSNs had already been corrected in ACES; and*
- *1 client was deceased, the correct SSN and Date of Death was corrected in ACES. The claim attributable to this SSN was not for this deceased client.*

Auditor's Concluding Remarks

We thank the Department for its response. We will follow up on this area during our next audit.

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 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.

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 . . . .

Federal Findings and Questioned Costs - continued

42 CFR 435.920 (a-b) 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.

Federal Findings and Questioned Costs - continued

06-04 The Department of Social and Health Services, Health and Recovery Services Administration, does not have adequate controls to ensure compliance with Medicaid requirements to identify third parties responsible for payments for pharmaceutical services.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Activities Allowed or Unallowed
Questioned Cost Amount:	$70,980

Background

Third-party liability refers to the legal obligation of third-party resources, usually insurance companies, to pay medical and pharmaceutical claims of Medicaid recipients prior to Medicaid coverage. The function of third-party liability within the Medicaid program is to ensure non-Medicaid resources are the primary source of payment. Federal regulations require states to have processes to identify third parties liable for payment for services before Medicaid dollars are used.

Pharmacies submit claims for payment electronically through the Point of Sale system. This is a real-time system that interfaces with the Medicaid Management Information System (MMIS), which processes requests for payment through a series of edits. Claims are paid if they successfully pass all edits.

When pharmacies submit claims for payment through the Medicaid program, they also must enter any third-party payers that may be liable for paying a portion of the claim. If a provider submits a claim on behalf of a client who has other insurance without accurately entering the third-party resource, MMIS will deny the claim. However, edits in MMIS can be rendered inoperative by manual override codes.

The Department of Social and Health Services paid more than $343 million in claims for pharmaceutical services from July 1, 2005, through December 31, 2005. We selected Somatropin, an anabolic steroid for review for our current audit. The Department spent more than $3.3 million for this drug in the same time period.

Description of Condition

Our audit testing showed that the accuracy of information entered into the Point of Sale system is totally dependent on the provider. We found that providers can enter either the accurate third-party payer information or alternatively, at their discretion, enter the override codes to bypass the edits in the system that would deny payment on the claim should the information be inaccurate.

The Department reported it reviewed more than 50 percent of the third-party liability payments related to pharmacy expenditures after the payments were made. Despite this effort, however, claims that could have been paid, at least in part, by third-party payers were still paid by the Medicaid program. We found that given the volume of drug claims that pass through the system, the Department's post-payment efforts are not sufficient to identify all overpayments. We found no controls over the providers' use of override codes to ensure third-party information is accurate prior to paying the claims.

Cause of Condition

Pharmacy providers are misusing override codes. The Department has no controls over the use of override codes when claims are entered into the system.

Effect of Condition and Questioned Costs

Inaccurate third-party liability coverage information is being entered into the system causing Medicaid dollars to be spent on pharmacy services that could have been paid by other third party resources. We reviewed $190,019 for 16 clients to determine whether Medicaid was the payor of last resort. We found claims for nine clients (56 percent of those we looked at) had other resources to pay for at least a portion of their claims. For these clients, we found questioned costs of $97,657 and $44,303 were paid for fiscal years 2005 and 2006, respectively. Half of these expenditures, or $70,980 was paid with federal funds.

Recommendation

We recommend the Department:

- Strengthen controls over the entry of claims into its payment system to ensure third-party payers are properly billed as the primary source of payment, as federal regulations require.

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

Department's Response

The Department disagrees with this finding. The finding asserts inadequate internal controls over the providers' use of override codes without consideration and understanding of why override codes are allowed to bypass existing Point of Sale (POS) edits. The Department has compensating internal controls in place to provide sufficient internal control and reasonable assurance that third party resources will be identified and overpayments recovered.

Pursuant to 42 CFR 433 sections 138 and 139, the Department has taken "reasonable measures to determine the legal liability of third parties . . . ." Specifically, the Department: requires clients to report third-party coverage when applying for Medical Assistance; conducts health insurance data cross-matches e.g. Employment Security, Department of Labor and Industries and Department of Personnel, to determine if any other coverage benefits exist; and denies pharmacy claims if third-party coverage exists. Department staff assists pharmacists, by making billing information available through toll-free lines, the Health and Recovery Service Administration's (HRSA) provider website, clients' medical identification cards, and as explanations of benefits on weekly remittance advices sent to providers.

The Department requires pharmacy providers seek timely reimbursement from a third party when a client has available third-party resources (see WAC 388-501-0200 and Title XIX State Plan). When claims are submitted through the POS system and the Medicaid Management Information System (MMIS) client eligibility file reflects a client having insurance coverage, an edit denies the claim. The onus is then placed on the pharmacy provider to verify the availability of third-party benefits and then bill the third party and Medicaid appropriately. When the pharmacy providers bill Medicaid they may need to use override codes to ensure they receive timely reimbursement for services provided. If the pharmacy provider uses an override code and later determines that third party insurance was available, the pharmacy provider is required to verify and pursue clients' third party benefits and refund to HRSA any Medicaid payments also paid by a liable third party.

The override codes, part of the National Council for Prescription Drugs Programs electronic claims submission standard, are recognized nationally as electronic claims processing standards used throughout the pharmacy community. Disallowing pharmacy providers from using these codes would result in significant delays in claims processing, severely affecting service delivery. Claims processing and prior authorization backlogs would ensue, potentially preventing clients from obtaining life sustaining prescription drugs. Additionally, pharmacy providers would assume increased administrative burdens in order to obtain payment for services rendered to Medicaid clients.

In addition to the compensating pre-payment controls, the Department actively conducts post-payment audits of pharmacy override code usage. Thirty-four pharmacy third party liability audits were performed in 2005; twenty-five in 2006. All of these audits were identified and prioritized by risk exposure i.e. dollars by override code. Identified overpayments for these fifty-nine audits total $3,314,056. In addition, HRSA will examine the nine clients identified by the auditor who have other insurance. If appropriate, expenditures will be recovered.

All of the internal controls, including pre-payment and post-payment compensating controls, provide sufficient internal control and reasonable assurance that third party resources are identified and overpayments recovered.

Auditor's Concluding Remarks

We thank the Department for its response. We will follow up in this area during our next audit.

Applicable Laws and Regulations

When probable liability is established at the time a claim is filed 42CFR433.139 (b) (1) requires:

> If the agency has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third party liability takes place when the agency receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

42CFR 433.140 (a) stipulates the following regarding a state's claim for federal financial participation:

> (a) FFP is not available in Medicaid payments if—
>
> > (1) The agency failed to fulfill the requirements of §§433.138 and 433.139 with regard to establishing liability and seeking reimbursement from a third party;
> >
> > (2) The agency received reimbursement from a liable third party; or
> >
> > (3) A private insurer would have been obligated to pay for the service except that its insurance contract limits or excludes payments if the individual is eligible for Medicaid.
>
> (b) FFP is available at the 50 percent rate for the agency's expenditures in carrying out the requirements of this subpart.

Federal Findings and Questioned Costs - continued

06-05 The Department of Social and Health Services, Health and Recovery Services Administration, has not established sufficient internal controls to support decisions on the eligibility of clients enrolled in Medicaid's Basic Health Plus program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Activities Allowed or Unallowed &Eligibility
Questioned Cost Amount:	$53,126

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 eligible Washington residents 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, a Medicaid program for children in qualified households. With Basic Health Plus, children receive additional health care coverage such as dental care, vision care and physical therapy. The Health Care Authority provides the insurance coverage under Basic Health Plus, while the Health and Recovery Services Administration pays the premiums.

In our audits for fiscal years 2001 through 2005, we reported findings relating to weaknesses in the internal control structure in the Administration's management of the Basic Health Plus program as well as noncompliance with federal regulations. The Department did not concur with our findings and has not made any significant changes in its administration of the program.

Description of Condition

During our current audit, we found the Department does not consistently:

- Follow its own policies and procedures for determining income eligibility. For example, a full month of payroll documents for wage earners and sufficient documentation supporting a self-employed client's declaration of income were not always obtained.

- Document its method of calculating an estimate of a household's income clearly and completely.

- Determine if adults other than the head-of-household are employed and all household income is accounted for. This is especially notable in self-employed households.

Cause of Condition

The Department believes it follows policies and procedures, obtains sufficient supporting documentation and correctly determines income eligibility of its clients.

Effect of Condition and Questioned Costs

We performed audit procedures to determine the effect of the weaknesses we found in the cases of 90 clients who received services from July 1, 2005, through December 31, 2005.

For 57 out of the 90 (63 percent), we found the Department could not support its determination of income eligibility.

- For 38 of all clients tested (42 percent) the Department did not have adequate documents on file supporting its estimate of a household's income.

- For 19 of all clients tested (21 percent), the Department did not calculate a household's income according to its policies or did not account for all household income.

For these clients, questioned costs for payments made on their behalf totaled $106,251. Fifty percent of this or $53,126 was paid with federal funds.

Due to the continuing weaknesses we have identified and the pervasiveness of the condition in our test selection, we have little assurance the Department would be able to support its determination of income eligibility for all the clients currently enrolled in the program. Total claims that were paid for medical services from July 1, 2005, through December 31, 2005 to Basic Health Plus clients were $14,554,443. Of this, approximately 50 percent was paid with federal funds. We are reporting these as costs at risk.

Recommendation

We recommend the Department:

- Follow its policies and procedures and require staff to corroborate the client's representations with adequate documents 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 agrees with this finding. This findings concerns children receiving Medicaid (whose parents receive coverage under the Basic Health Program); which is administered by Medical Eligibility Determination Services (MEDS).

The Department is committed to ensuring accurate determinations of income eligibility. In order to assure the highest possible level of accuracy, the Eligibility Policy and Community Education office will develop and present a new two-part training module. One component will focus on regular earned and unearned income and the verification and documentation of that income. The second component will concern self-employed income, also including the methodology of verification and documentation of that income.

This training will be mandatory for all eligibility staff at MEDS. All supervisory staff, the three trainers/internal auditors will attend a separate session that will include both of the income components described above as well as focus on accurate and consistent audit practices. The goal of the mandatory training is improved accuracy of eligibility determinations and development of consistent internal auditing practices.

The MEDS current audit process was developed in April 2006 and is expected to be updated annually. MEDS expects to update the audit policy and procedures document by January 31, 2007. The current audit standard for MEDS will be increased and findings will continue to be reported to the MEDS Office Chief monthly as described in the audit policy and procedures. The revised audit plan will reflect an additional staff person, responsible for fair hearings and increased auditing, assigned effective November 2006. This staff person is expected to audit a minimum of 120 cases per month.

HRSA will work with CMS to ensure agreement on eligibility determination policies and procedures.

Auditor's Concluding Remarks

We appreciate the actions taken by the Department to correct the conditions identified. We will follow up during our next regularly scheduled audit.

Applicable Laws and Regulations

With respect to Income Budgeting per the Department's A-Z Manual, regulations from the Washington Administrative Code are cited as guidance for staff:

> WAC 388-450-0215
>
> > The department uses prospective budgeting to determine if your Assistance Unit (AU) is eligible and to calculate your benefits.
> >
> > > 1. We determine if your AU is eligible for benefits and calculate your monthly benefits based on an estimate of your AU's income and expenses for that month. This is known as prospective budgeting.
> > >
> > > 2. We base this estimate on what can be reasonably expected based on your current, past and future circumstances.
> > >
> > > 3. We determine if our estimate is reasonable by looking at documents, statements and other verification.

Basic Health Plus Application under the DSHS Programs' Self-Employment or Rental Income Worksheet instructs self-employed clients as follows:

> You must provide proof of all your gross receipts and expenses for the last complete calendar month.

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) Except as provided in paragraphs (d), (e), and (f) of this section, 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--
>
> > (1) State wage information maintained by the SWICA during the application period and at least on a quarterly basis;
> >
> > (2) Information about net earnings from self-employment, wage and payment of retirement income, maintained by SSA and available under Section 6103(l)(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;
> >
> > (3) 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;
> >
> > (4) 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;

(5) 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:

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

(ii) 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.

(iii) 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.

(6) 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:

(i) AFDC;

(ii) Medicaid;

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

(iv) SWICA;

(v) Unemployment compensation;

(vi) Food stamps; and

(vii) 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 (a) 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 2006 A-133 compliance supplement page 4-93.778-13 through 15 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. States 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.

06-06 The Department of Social and Health Services, Health and Recovery Services Administration, does not have adequate controls to ensure claims for wheelchairs and wheelchair accessories are properly authorized as required by law.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Special Tests and Provisions: Provider Eligibility
Questioned Cost Amount:	$45,795

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.

Medicaid claims for wheelchairs are paid in one of two ways:

1. As a payment for a benefit covered solely by the Medicaid program.

2. As a co-payment with Medicare for clients who are eligible for benefits under Medicaid and Medicare. Claims made on behalf of these dual eligible clients are called crossover claims.

Washington state regulations require prior authorization or expedited prior authorization before claims for wheelchairs, wheelchair accessories, wheelchair modifications, air/foam/gel cushions and repairs may be paid. Federal regulations state that in order for costs to be paid with federal money, they must be authorized or not prohibited under state or local laws or regulations.

For prior authorization requests, the Department requires specific documentation before payment is approved. This documentation includes patient-specific justification for base equipment, a prescription signed by a physician or other licensed health practitioner and proof of medical necessity.

Expedited prior authorization is a form of prior authorization. This process is allowed for selected medical procedures and for durable medical equipment. For wheelchair claims, this authorization is valid for a period of need that does not exceed two months in a 12-month period. If it is later determined that the length of need will exceed two months, the provider must obtain prior authorization through a written request or a phone request.

Description of Condition

We reported concerns in this area in our last audit. While we found improvements during the current audit, the Health and Recovery Services Administration continues to have inadequate controls to ensure payments for wheelchairs and wheelchair accessories are allowable and adequately supported.

Specifically we found:

- A lack of adequate controls over expedited prior authorization procedures that would ensure providers have obtained a written or verbal authorization from the Department if the length of need exceeds two months.

- The authorization process is bypassed for all claims for wheelchairs and wheelchair accessories on behalf of managed care and Medicare clients.

Cause of Condition

The Department does not monitor transactions requiring expedited prior authorization adequately.

The Department incorrectly adjusted the Medicaid Management Information System to allow managed care payments for wheelchairs to be made without authorization.

The Department states prior authorization for Medicare clients would be an unnecessary burden on the Department, providers and clients.

Effect of Condition and Questioned Costs

Our testing showed that the control weaknesses in the expedited prior authorization process allowed 12 claims out of 14 to be submitted past the two month period. We found $4,530 in questioned costs. Fifty percent of this amount was paid in federal funds.

We also found the Department paid $87,059 in claims for wheelchairs and wheelchair accessories for managed care clients during the second half of 2005 without any authorization. We question these costs. Fifty percent of this amount was paid in federal funds.

Due to the control weaknesses we do not have reasonable assurance that all claims the Department paid for dual eligible clients are allowable and supported with adequate documents, placing approximately $1,787,369 at risk for calendar year 2005.

Fifty percent of all claims for wheelchairs and wheelchair accessories were paid with federal funds.

Recommendation

We recommend the Department:

- Establish and follow controls to ensure providers submit a written request or a phone request if a length of need for an expedited prior authorization exceeds two months in a 12-month period.

- Ensure claims for wheelchairs and wheelchair accessories made on behalf of both managed care and Medicare clients are authorized in compliance with state and federal regulations.

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

Department's Response

The Department recognizes that expedited prior authorization for wheelchair claims exceeding two months in a 12 month period of time is a control weakness. The expedited prior authorization process was corrected through a completed change request implemented on July 6, 2006, to prevent payment beyond authorized time periods without authorization.

The Department recognizes that claims paid on behalf of managed care clients should be subject to the same authorization requirements as other claims. Incorrect coding in the Medicaid Management Information System had been put in place for managed care clients in the disease management program; this has been corrected as of July 6, 2006, Department staffs are now required to perform authorization.

Claims paid on behalf of clients who are eligible for Medicare are authorized by Medicare before payment is made by the Department. The Department accepts Medicare authorization for payment of these claims. A second authorization on these claims is not necessary. The Department is implementing a Washington Administrative Code (WAC) governing authorization of wheelchair payments to clearly state that for Medicare clients, no further authorization beyond Medicare is necessary. Projected date for implementation of the new WAC is March 2007.

Auditor's Concluding Remarks

We appreciate the actions taken by the Department to correct the conditions identified. We will follow up during our next audit.

Applicable Laws and Regulations

The March 2006 Federal Office of Management and Budget Circular A-133 Compliance Supplement, part 3, page 3-B-10, page 3-B-1 and page 3-B-3, states in part:

1. Compliance Requirements - State/Local Department or Agency Costs - Direct and Indirect

    a. Basic Guidelines - Refer to the previous section, "Allowable Costs – State/Local-Wide Central Service Costs, 1.a - Compliance Requirements-Basic Guidelines," for the guidelines affecting the allowability of costs (direct and indirect) under Federal awards.

OMB Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments" (2 CFR part 225) cost principles circulars prescribe the cost accounting policies associated with the administration of Federal awards by States, local governments, and Indian tribal governments. The circular describes selected cost items, allowable and unallowable costs, and standard methodologies for calculating indirect costs rates (e.g., methodologies used to recover facilities and administrative costs (F&A) at institutions of higher education).

1. Compliance Requirements - State/Local-Wide Central Service Costs

    a. Basic Guidelines

        (1) The basic guidelines affecting allowability of costs (direct and indirect) are identified in A-87, Attachment A, paragraph C.

        (2) To be allowable under Federal awards, costs must meet the following general criteria (A-87, Attachment A, paragraph C.1):

(a) Be necessary and reasonable for the performance and administration of Federal awards. (Refer to A-87, Attachment A, paragraph C.2 for additional information on reasonableness of costs.)
(b) Be allocable to Federal awards under the provisions of A-87. (Refer to A-87, Attachment A, paragraph C.3 for additional information on allocable costs.)
(c) Be authorized or not prohibited under State or local laws or regulations.
(d) Conform to any limitations or exclusions set forth in A-87, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
(e) Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
(f) Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.
(g) Be determined in accordance with generally accepted accounting principles, except as otherwise provided in A-87.
(h) Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award, except as specifically provided by Federal law or regulation.

(i) Be net of all applicable credits. (Refer to A-87, Attachment A, paragraph C.4 for additional information on applicable credits.)
(j) Be adequately documented.
(Emphasis added.)

WAC 388-502-0100 states:

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 388-543-1600 states:

Items and services which require prior authorization.

(1) MAA bases its determination about which DME and related supplies, prosthetics, orthotics, medical supplies and related services require **prior authorization (PA)** or **expedited prior authorization (EPA)** on utilization criteria. (See WAC 388-543-1000

for PA and WAC 388-543-1800 for EPA.) MAA considers all of the following when establishing utilization criteria:

(a) High cost;
(b) Potential for utilization abuse;
(c) Narrow therapeutic indication; and
(d) Safety.

(2) MAA requires providers to obtain prior authorization for certain items and services. This includes, but is not limited to, the following:

(a) Augmentative communication devices (ACDs);

(b) Certain by report (BR) DME and supplies as specified in MAA's published issuances, including billing instructions and numbered memoranda;

(c) Blood glucose monitors requiring special features;

(d) Certain equipment rentals and certain prosthetic limbs, as specified in MAA's published issuances, including billing instructions and numbered memoranda;

(e) Decubitus care products and supplies;

(g) Decubitus care mattresses, including flotation or gel mattress, if the provider fails to meet the criteria in WAC 388-543-1900;

(g) Equipment parts and labor charges for repairs or modifications and related services;

(h) Hospital beds, if the provider fails to meet the requirements in WAC 388-543-1900;

(i) Low air loss flotation system, if the provider fails to meet the requirements in WAC 388-543-1900;

(j) Orthopedic shoes and selected orthotics;

(k) Osteogenic stimulator, noninvasive, if the provider fails to meet the requirements in WAC 388-543-1900;

(l) Positioning car seats for children under five years of age;

(m) Transcutaneous electrical nerve stimulators, if the provider fails to meet the requirements in WAC 388-543-1900;

(n) Wheelchairs, wheelchair accessories, wheelchair modifications, air, foam, and gel cushions, and repairs;

(o) Wheelchair-style shower/commode chairs;

(p) Other DME not specifically listed in MAA's published issuances, including billing instructions and numbered memoranda, and submitted as a miscellaneous procedure code; and

(q) Limitation extensions.

(Emphasis added.)

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:

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:

> 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 . . . .

06-07 The Department of Social and Health Services, Health and Recovery Services Administration, is not complying with federal requirements to defer Medicaid expenditures related to undocumented aliens as instructed by the Centers for Medicare and Medicaid Services.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Reporting & Activities Allowed and Unallowed
Questioned Cost Amount:	$40,564

Background

The federal government requires states to report expenditures for medical assistance and administrative costs quarterly. 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 this claim form. Line 6, item 27, which is entitled *Emergency Services Undocumented Aliens* on the claim, is to be used to report allowable emergency expenditures for undocumented aliens.

In our audits of state fiscal years 2003 and 2004, we found the Administration was not reporting payments for alien emergency medical services on the claim form as required. Instead, it combined payments for both allowable emergency medical and unallowable non-emergency services and reported that amount in other categories of the form as allowable expenditures.

On May 6, 2005, the Centers for Medicare and Medicaid Services 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 Administration. However, in our audit of state fiscal year 2005, we found funds were still being drawn and expenditures for undocumented aliens were being commingled with the expenditures of eligible clients on the claim. The state reported in its response to our finding that it had received clarification from the Centers that labor and delivery charges are excluded from the deferral.

During that audit, we also found the Department had no coding in its accounting records to differentiate emergency services from non-emergency services for undocumented aliens.

Description of Condition

During our audit of fiscal year 2005, the Department reported it had improved its reporting and monitoring procedures of expenditures related to the weaknesses we found in our previous audit for both non-pregnant and pregnant undocumented aliens. We reviewed these controls for our current audit and found:

For the non-pregnant group:

Every week, the Department draws federal funds based on its Medicaid expenditures for that week. These funds include expenditures for the non-pregnant group. Once a quarter, the Department transfers that portion of the weekly draws attributable to this group's expenditures to state-only funds, effectively repaying the federal

government at the end of a quarter. The Department reported this process will continue until the outcome of the deferral set by the Centers is resolved. A record of these expenditures is kept in a separate account.

An improvement that we have seen is that the Department has taken steps to establish coding in its accounting records to differentiate between services to non-pregnant undocumented aliens and non-citizen pregnant women. However, weaknesses continue:

- The account coding still does not differentiate between emergent and non-emergent services.
- No monitoring functions are performed for this group.

For the pregnant group:

As with the non-pregnant group, every week the Department draws federal funds based on Medicaid expenditures for that week. These funds include expenditures for undocumented alien pregnant women. For expenditures attributable to pregnant clients, however, once a quarter the Department reviews this group's expenditures and identifies those with diagnosis codes that have "labor and delivery" in the description. The money for these expenditures is retained by the state. The Department stated it received permission from the Centers not to defer these funds.

The Department reported that Medicaid expenditures, both pregnancy and non-pregnancy related, made on behalf of pregnant undocumented alien women, culminating in a birth, are transferred to the State Children's Health Insurance program, another federal program.

Our audit found an improvement in this area in that the Department monitors to ensure labor and delivery costs are identified.

However, we also saw weaknesses. The Department:

- Includes, in its claims for reimbursement, labor and delivery codes that are not solely for the delivery of the baby, but for other routine pregnancy care.
- Reports all expenditures related to these codes on the claim to the federal government and commingles them with expenditures reserved for citizens, instead of on Line 6, Item 27.
- Has no effective controls to ensure that unallowable expenditures related to undocumented aliens are not paid by Medicaid.

Cause of Condition

The Department:

- Believes use of Medicaid funds that will eventually be reimbursed by another federal program is allowable even though such expenditures are not allowable for the federal Medicaid program.
- Believes that a child born to a non-citizen pregnant woman is automatically eligible for Medicaid even though the mother was not eligible for Medicaid.
- Has not developed account coding to differentiate between emergent and non-emergent services for undocumented alien clients so these expenditures can be reported accurately on the claim to the federal government.

Effect of Condition

For the non-pregnant group:

- If the federal government rescinds the deferral and allows the money paid for undocumented alien services that was previously incurred, our audit work showing $1,856,037 in costs paid on behalf of 54 clients for the period between July 1, 2005, and December 31, 2005, would be unallowable. Of this, $928,018 would be paid with federal funds.

- The state is drawing, weekly, funds for expenditures that should have been deferred and has the use of these federal funds for at least a quarter prior to repayment to the federal government.

For the pregnant group:

- The claim form filed quarterly to the federal government is not accurate.

- Unallowable Medicaid expenditures are being transferred to another federal program for refunding.

- Federal Medicaid funds continue to pay for all expenditures incurred by pregnant undocumented alien women. This includes allowable services such as labor and delivery and unallowable routine pregnancy procedures and other services not related to pregnancy, such as dental and vision care.

- The state has use of federal funds for a minimum of a quarter for expenditures that are unallowable under federal Medicaid regulations. For the 55 clients that we reviewed in this group, we found:

    - $60,228 in questioned costs for routine pregnancy care. Of this, $30,114 was paid with federal funds.

    - $20,901 in questioned costs for non-emergent, non-pregnancy services. Of this, $10,450 was paid with federal funds.

    - $896,484 in costs that the Department was unable to identify allowable vs. unallowable costs as not enough information was available in its records. Of this, $448,242 was paid with federal funds. We are reporting these as costs at risk.

    - $56,436 in costs that the Medicaid program paid for medical services to newborns born to undocumented alien women. We are reporting these as costs at risk.

For both groups, although the directive by the federal government to defer drawing funds for undocumented alien clients is still in effect, the state continues to draw federal funds for non-emergent services rendered to undocumented alien clients. This could jeopardize future federal funding for the Medicaid program.

Recommendation

We recommend the Department:

- Carefully follow the federal directive of May 6, 2005, regarding drawing federal funds for emergency services rendered to undocumented aliens.

- Develop account coding to differentiate emergency from non-emergency services for undocumented aliens so that when reimbursements for these services are again allowed, the accurate amount of funds can be drawn and reported on the Medicaid claim.

- Work with the US Department of Health and Human Services to determine if any un-deferred costs or unallowable costs charged to Medicaid must be returned.

Department's Response

The Health and Recovery Services Administration (HRSA) partially agrees with the auditor's finding. Discussion of each recommendation follows.

- *Carefully follow the federal directive of May 6, 2005 regarding drawing federal funds for emergency services rendered to undocumented aliens:*

HRSA intends to comply with the directive with respect to non-pregnant aliens. HRSA already complies with the directive for pregnant aliens.

For the Non-Pregnant group: *HRSA has coordinated with the Office of Accounting Services, (OAS) to both set up unique account coding for Alien Emergency Medical (AEM) charges, and change the frequency of adjustments that move these charges from federal funds to state funds. In the past these adjustments were done once a quarter, just prior to preparing the CMS 64 report. The Department will now make monthly adjustments. Because OAS draws Title XIX revenue once a week, they will use the unique cost allocation coding that has been established to avoid drawing any federal revenue for AEM expenditures during the time period between when the expenditures are incurred and the adjustment takes place. This will ensure that Medicaid funds are used for allowable expenditures only. (Completion date - January 31, 2007)*

For the Pregnant group: *HRSA currently complies with the federal directive regarding drawing federal funds for pregnant alien women. Beginning with State Fiscal Year 2007, only labor and delivery claims are being charged to Title XIX. These claims are being identified by their Diagnostic Related Group for inpatient hospital claims or by diagnosis code for physician and other ancillary claims. All non-labor and delivery claims for Pregnant Alien women except pregnancy related claims are charged to State-only funds. The prenatal claims are identified and moved from state dollars to Title XXI (SCHIP) only if there are related labor and delivery claim for the births. This procedure was specifically approved by the Centers for Medicare and Medicaid Services (CMS) in writing. A copy of the approval was provided to the auditor.*

- *Develop account coding to differentiate emergency from non-emergency services for undocumented aliens so that when reimbursements for these services are again allowed, the accurate amount of funds can be drawn and reported on the Medicaid claim:*

HRSA fully intends to comply with the Office of Inspector General's (OIG) audit report once it is completed. It will provide guidance to differentiate between emergent and non-emergent services.

- *Work with the US Department of Health and Human Services to determine if any un-deferred costs or unallowable costs charged to Medicaid must be returned:*

When the OIG audit report is completed, HRSA will work with CMS to identify unallowable costs in the AEM program and return those funds in a timely manner to the federal government.

Auditor's Concluding Remarks

We thank the Department for its response. We will follow up in this area during our next audit.

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 . . . .

45CFR74.21 (b)(3) Standards for financial management systems states in part:

> . . . Effective control over and accountability for all funds, property and other assets. Recipients shall adequately safeguard all such assets and assure they are used solely for authorized purposes . . . .

OMB Circular A-87 (Revised) Section C (Basic Guidelines) Item 3.c (Allocable Costs) 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 awards, or for other reasons.

42 Code of Federal Regulations, Section 440.255, Limited services available to certain aliens, states in part:

(a) FFP for services. FFP is available for services provided to aliens described in this section which are necessary to treat an emergency medical condition as defined in paragraphs (b)(1) and (c) or services for pregnant women described in paragraph (b)(2) . . .

. . . (c) Effective January 1, 1987, aliens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of law must receive the services necessary to treat the condition defined in paragraph (1) of this section if --

(1) The alien has, after sudden onset, a medical condition (including emergency 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:

(i) Placing the patient's health in serious jeopardy;
(ii) Serious impairment to bodily functions; or
(iii) Serious dysfunction of any bodily organ or part, and

(2) The alien otherwise meets the requirements in Sections 435.406(c) and 436.406(c) of this subpart.

42 U.S.C. Section 1396(b) states 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.

Code of Federal Regulations, Section 435.117, Newborn children, states:

(a) The agency must provide categorically needy Medicaid eligibility to a child born to a woman who is eligible as categorically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible as categorically needy for one year so long as the woman remains eligible as categorically needy and the child is a member of the woman's household. If the mother's basis of eligibility changes to medically needy, the child is eligible as medically needy under Section 435.301(b)(1)(iii). (b) The requirements under paragraph (a) of this section apply to children born on or after October 1, 1984.

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 (4) 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.

RCW 74.04.050, Department to administer public assistance programs, states:

> The department shall serve as the single state agency to administer public assistance. The department is hereby empowered and authorized to cooperate in the administration of such federal laws, consistent with the public assistance laws of this state, as may be necessary to qualify for federal funds for:
>
> > (1) Medical assistance;
> > (2) Aid to dependent children;
> > (3) Child welfare services; and
> > (4) Any other programs of public assistance for which provision for federal grants or funds may from time to time be made.
>
> The state hereby accepts and assents to all the present provisions of the federal law under which federal grants or funds, goods, commodities and services are extended to the state for the support of programs administered by the department, and to such additional legislation as may subsequently be enacted as is not inconsistent with the purposes of this title, authorizing public welfare and assistance activities. The provisions of this title shall be so administered as to conform with federal requirements with respect to eligibility for the receipt of federal grants or funds . . . .

RCW 74.04.055, Cooperation with federal government -- Construction -- Conflict with federal requirements, states:

> In furtherance of the policy of this state to cooperate with the federal government in the programs included in this title the secretary shall issue such rules and regulations as may become necessary to entitle this state to participate in federal grants-in-aid, goods, commodities and services unless the same be expressly prohibited by this title. Any section or provision of this title which may be susceptible to more than one construction shall be interpreted in favor of the construction most likely to satisfy federal laws entitling this state to receive federal matching or other funds for the various programs of public assistance. If any part of this chapter is found to be in conflict with federal requirements which are a prescribed condition to the receipts of federal funds to the state, the conflicting part of this chapter is hereby inoperative solely to the extent of the conflict with respect to the agencies directly affected, and such finding or determination shall not affect the operation of the remainder of this chapter.

RCW 74.09.530, Medical assistance -- Powers and duties of department, states:

> The amount and nature of medical assistance and the determination of eligibility of recipients for medical assistance shall be the responsibility of the department of social and health services. The department shall establish reasonable standards of assistance and resource and income exemptions which shall be consistent with the provisions of the Social Security Act and with the regulations of the secretary of health, education and welfare for determining eligibility of individuals for medical assistance and the extent of such assistance to the extent that funds are available from the state and federal government. The department shall not consider resources in determining continuing eligibility for recipients eligible under section 1931 of the social security act.

Federal Findings and Questioned Costs - continued

The federal directive of May 6, 2005 regarding drawing federal funds for emergency services rendered to undocumented aliens:

May 6, 2005

Douglas Porter, Assistant Secretary, Medical Assistance Administration
Department of Social and Health Services
P.O. Box 45080
Olympia, Washington 98504-5080
WA-2005-1-E-01-MAP

Dear Mr. Porter:

This letter is written to notify you that a deferral in the amount of $3,636,690 Federal Financial Participation (FFP) has been made in your annual grant award for FY 2005, initially issued October 1, 2004 and subsequently revised in January 1, 2005 and January 12, 2005. The claim in question was included on line 6 of the Quarterly Statement of Expenditures for the Medical Assistance Program (form CMS-64) for the quarter ended December 31, 2004.

The claim was for emergency services for undocumented aliens, and was reported on line 6, Expenditures in This Quarter, on the CMS-64. Your office needs to provide us with the necessary documentation in support of the expenditures in order for us to determine the allowability of the claim.

CMS recently provided the State of Washington (an annual grant award state) with an estimated FY 2005 Medicaid grant award. Your 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.

In accordance with 42 CFR 430.40 the above requested documentation should be made available to us in readily reviewable form within 60 days from the receipt of this letter. The required information should be submitted to the Seattle Regional Office. If more time is needed to have the documents and materials available for review; you may request an extension of 60 additional days. If you have any questions pertaining to this matter, please contact John Lynch at (206) 615-2357.

Sincerely,

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

cc: Susan Lucas, Director, Division of Budget & Finance, MAA
Mariann Schols, Acting Chief, Office of Accounting Services

06-08 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.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	$22,344

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 and 2005 Medicaid and State of Washington Single Audit reports, we described concerns about payments to providers for clients whose Social Security numbers were the same as people reported as deceased in the Social Security Administration's Death Index.

Description of Condition

During our current audit, we found 334 clients with payments totaling over $1.6 million whose Social Security numbers matched those of deceased persons. We selected 117 of those clients for review. The payments attributed to their care were $896,888.

We found:

- $4,899 in costs was allowable. Although most of the payments were authorized after the individuals' date of death, services were actually rendered prior to death. Many of these payments consisted of training costs to caregivers.

- The Department concurred that $32,399 in payments were not allowable and has initiated efforts to recoup these overpayments. As a result of its investigation of the exceptions raised by the Auditor, the Department has determined it will attempt to recoup an additional $5,634 in overpayments to certain providers.

- $814,903 in costs were initially determined to be exceptions as the payment system from which we obtained our testing data reported a Social Security number of a deceased person. However, the Department was able to show us that it had obtained, prior to our audit, a valid Social Security number for those clients for which these payments were made. We found the Department's eligibility system does not communicate with its payment system. While we recognize these costs to be an indicator of significant computer issues, we do not question them for our eligibility testing.

- $44,687 in payments to providers indicated their services were rendered after a client's date of death. For these transactions, the Department could not provide support that the services were provided to the client while living.

Cause of Condition

- The Department is largely dependent on the provider or family members to report a client's death.
- The Department does not verify a client's Social Security number upon application to the Medicaid program to ensure that each Social Security number provided by a client was issued to that individual.

Effect of Condition and Questioned Costs

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 and state laws.

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

Questioned costs as a result of this issue totaled $44,687. Of that, $22,344 is 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 the State On-line Query.
- Work with the U.S. Department of Health and Human Services to determine if any unallowable costs must be reimbursed.

Department's Response

The Department concurs with the auditor's recommendation that staff be required to verify Social Security numbers on-line, through the use of the State On-line Query (SOLQ).

The Department's current verification procedures use SOLQ as a standard of practice to verify clients' SSN at the time of financial eligibility determination in ACES.

For the majority of exceptions identified by the auditor, the department was able to verify that the social security number in ACEs was correct at the time payments were made. Most of the errors in the payment system data can be attributed to data entry type errors.

The Department will re-issue the Management Bulletin (last sent to field staff on April 5, 2006) reminding them of SSN verification requirements and the importance of accuracy when entering data into the payment system.

The Department concurs with the auditor's recommendation to work with the U.S. Department of Health and Human Services to determine if any unallowable costs must be reimbursed.

Auditor's Concluding Remarks

We thank the Department for its response. We will follow up in this area during our next audit.

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 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.

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.

06-09 The Department of Health and the Department of Social and Health Services, Health and Recovery Services Administration, are not ensuring compliance with federal law regarding hospital surveys.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Special Tests and Provisions: Provider Health & Safety
Questioned Cost Amount:	None

Background

Hospitals statewide received more than $654 million in state and federal Medicaid funds in calendar year 2005 for services to Medicaid clients. Federal regulations require states to ensure healthcare facilities meet prescribed health and safety standards 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 standards are designed to protect the health and safety of patients. In order to be eligible for federal matching funds for reimbursements to Medicaid providers, the Department of Social and Health Services 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 surveying agency must retain documentation and note whether each inspection requirement was met.

Conditions of Participation for hospitals are made up of 29 areas related to all aspects of patient care, including patients' rights, staffing and infection control, and requirements for each type of service the hospital offers.

Description of Condition

During our current audit, we found no changes in the condition that we reported in our audit of fiscal year 2005. Although required to do so by federal regulation, the Department of Social and Health Services' agreement with the Department of Health does not include all of the methods and procedures for completing survey reports.

The Department of Health could not provide documentation supporting that its employees had conducted surveys according to federal regulations. Specifically, we found that the Department of Health did not:

- Note whether each inspection requirement was met.

- Keep on file all information used in determining whether participating facilities met Federal requirements. This particular condition precluded us from performing compliance testing to determine whether all conditions of participation were reviewed as federal regulations require.

Cause of Condition

The Centers for Medicare and Medicaid Services does not provide states with instructions consistent with federal Medicaid laws regarding surveys of hospitals receiving Medicaid funds.

The Departments believe they are required to follow the Centers' reporting requirements for this area. In following these requirements they also believe that they are in compliance with federal Medicaid laws.

The Department of Health does not have policies and procedures requiring surveyors to retain all records supporting hospital survey results.

Effect of Condition

Survey activities that are not performed according to federal requirements leave Medicaid clients vulnerable to substandard care. The state is paying hospitals for services to Medicaid clients with little assurance the services provided are meeting health standards and regulatory requirements.

When the Department of Health does not retain supporting documents for its surveys, we are unable to determine whether it has complied with federal requirements. Not retaining survey records is a violation of federal regulations and could jeopardize future Medicaid funding.

Payments to the hospitals for the period January 1, 2005, through December 31, 2005, were at least $654,174,179. Of this, $327,085,589 was paid with federal funds and the remainder with state funds. We are reporting these as the costs the Department may not have spent in accordance with federal Medicaid laws and regulations due to internal control and monitoring issues. If such disbursements were tested to the transaction level, all or part of these payments may be found to be unallowable and thus not eligible for federal matching funds.

Recommendation

We recommend:

- The Centers 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 Social and Health Services monitor the Department of Health's compliance with survey procedures.
- The Department of Health retains all records supporting the result of surveys.

Departments' Response

Department of Health

We are concerned that the Auditor's Office interpretation of 42 CFR 431.610 (f) is without contextual reference to 42 CFR 488 Survey, Certification, and Enforcement Procedures, specifically 42 CFR 488.18 Documentation of Findings. This cites in detail the documentation requirements for the survey process.

In addition, 42 CFR 488.26 (d) clearly directs that the state survey agency must use the survey methods, procedures, and forms that are prescribed by Centers for Medicare & Medicaid Services (CMS). CMS guidance is composed of the State Operations Manual (SOM) and other directives including documentation retention policies.

CFR 431.610(f) (2) (ii) states that inspectors will note on completed reports whether or not each requirement for which an inspection is made is satisfied. The State Auditor's Office is interpreting this to mean that documentation must be provided on survey reports that each survey requirement was performed. This is a subtle but important difference. We believe that Chapter 2 of the State Operations Manual §2728 provides the administrative guidance for this requirement when an entity is in compliance with all conditions of participation. Further direction is provided under §2728A if deficiencies are noted.

Federal law and administrative guidance do not include a clear requirement for the retention of surveyor field notes for the purposes of supporting prescribed survey report formats outside of an administrative appeal or legal challenge. Surveyor's notes, rough copy survey report forms, and other work papers which are merged into and superseded by a final product are specifically excluded from CMS State Survey Agency Record Retention policies.

In an effort to ensure that our agency is in compliance with federal law, we have presented our questions to the Heath and Human Services (HHS) Office of Inspector General in Washington, D.C. After review by high-ranking officials in the OIG Office of Audit Services, we were directed to forward our questions to the Regional Office of the federal Centers for Medicare & Medicaid Services (CMS).

*After conferring with the Regional Office of the federal CMS and explaining our position, we have been told that our current process is in compliance with federal law. Any assertion that the Department of Health is placing Medicaid clients at risk for substandard care is erroneous. In addition, the classification of funds provided to hospitals as "**at risk**" due to the current Department of Health survey process is also incorrect.*

CMS has communicated that the Department of Health is in compliance with applicable federal law to the State Auditor's Office through the HHS Division of Financial Management. The CMS response was as follows:

> *Concur with the state's response to the findings. For clarification, any direction or directive provided to the state agency cascades from the Social Security Act, to the CFR, down to the State Operations Manual. If there is any perception that CMS is directing states to deviate from the law, is unfounded.*
>
> ***The state response to the finding is appropriate.***

While the document retention process endorsed by SAO is not required by federal law or rule, we share an interest in adopting best practices. It is our intention to implement a documentation retention policy consistent with the business needs of our agency.

Department of Social and Health Services

The Department of Social and Health Services concurs with the Department of Health's response. The Department of Social and Health Services will work with the Department of Health to develop an appropriate document retention policy.

Auditor's Concluding Remarks

We thank the Departments for their responses. We will follow up in this area during our next audit.

Applicable Laws and Regulations

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

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

42 CFR 431.610(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 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.

42 CFR 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, 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.

Federal Findings and Questioned Costs - continued

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 . . . .

Federal Findings and Questioned Costs - continued

06-10 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.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Special Tests and Provisions: Provider Health & Safety
Questioned Cost Amount:	None

Background

Intermediate care facilities for the developmentally disabled were funded by state or local government funds until 1971. 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 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. These standards are federally mandated and consist of eight conditions of participation which detail more than 400 standards. Certification surveys are required each year to ensure that participating facilities are in substantial compliance with these conditions.

During our audit for state fiscal year 2005, we found the Department did not perform its certification surveys of intermediate care facilities for the developmentally disabled according to federal law. During that audit, we reviewed records for 14 out of 14 facilities. We found 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 had been surveyed according to the requirements of federal law.

Description of Condition

For our current audit, the Department reported it had made no changes in the way it conducted its surveys of intermediate care facilities for the developmentally disabled. Facilities are being inspected according to the guidelines of the State Operations Manual. However, these guidelines do not require all the conditions of participation or all the standards that a facility must achieve in order to participate in the Medicaid program.

Cause of Condition

The Centers for Medicare and Medicaid Services does not provide states with instructions consistent with federal Medicaid laws regarding surveys of hospitals receiving Medicaid funds.

The Department reported it is conducting surveys according to the protocol established by the Centers as outlined in the State Operation Manual, Appendix J. The Department believes it is required to follow the Centers' reporting requirements for this area. In following these requirements, it also believes it is in compliance with federal Medicaid laws.

Effect of Condition

Survey activities that are not performed according to federal requirements leave Medicaid clients vulnerable to substandard care. The state is paying intermediate care facilities for the developmentally disabled for services to Medicaid clients without assurance the services provided are meeting health standards and regulatory requirements.

Payments to these facilities for the state fiscal year 2005 were $131,117,232. Of this, $62,998,404 was paid with federal funds and the remainder with state funds. We are reporting these as costs at risk or money the Department may not have spent in accordance with federal Medicaid laws and regulations. If survey activities were performed as required by federal regulations, all or part of these payments may be found to be unallowable and thus not eligible for federal matching funds.

Recommendation

We recommend:

- The Centers 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 conduct certification surveys to include all eight conditions of participation and over 400 standards as required by federal law.

Department's Response

The Department agrees that the Centers for Medicare and Medicaid Services (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 for ICF/MR's in accordance with 42 CFR 488.26(b)(c)(d)(e).*

During an initial certification survey the Department reviews all eight Medicaid conditions of participation, including the associated 489 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, which require state agencies to review four conditions of participation and the associated 57 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 continues to investigate all potential regulatory violations. CMS oversees the Department to ensure the required processes are being followed and has not identified any performance issues.

In reviewing this finding from last year's audit, the CMS regional office disagreed with the auditor's recommendations. The CMS review states, "CMS RO's [regional office] review indicates the State Agency is following Federal guidelines and applicable regulations. 42 CFR 488.26(d) states, 'The State survey agency must use the survey methods, procedures, and forms prescribed by CMS'. The CMS State Operations Manual (SOM) gives the State agency the guidelines they follow in doing their certification or recertifications."

Auditor's Concluding Remarks

We thank the Department for its response. We will follow up in this area during our next audit.

Applicable Laws and Regulations

Washington State Medicaid Plan 4.13 states:

> . . . for all providers, the requirements of 42 CFR 431.107 and 42 CFR 442 Subparts A and B (if applicable) are met.

42 CFR 488.110 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) . . . ."

42 CFR 442 Subpart B, Provider Agreements, 42 CFR 442.12(a), states in part:

> . . . 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

42 CFR 442 Subpart C, 42 CFR 442.100 states:

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

42 CFR 442 Subpart C, 42 CFR 442.101, 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.

42 CFR 483, Subpart I, Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded,

Section 42CFR 483.400 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.

Section 483.405 relationship to other HHS regulations

Section 483.410 Condition of participation: Governing body and management

Section 483.420 Condition of participation: Client protection

Section 483.430 Condition of participation: Facility Staffing

Section 483.440 Condition of participation: Active treatment services

Section 483.450 Condition of participation: Client behavior and facility practices

Section 483.460 Condition of participation: Health care services

Section 483.470 Condition of participation: Physical Environment

Section 483.480 Condition of participation: Dietetic Services

Federal Findings and Questioned Costs - continued

06-11 The Department of Social and Health Services does not have adequate internal controls to ensure clients seeking to obtain medical benefits through the Medicaid program have applied according to federal regulations.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	None

Background

Federal regulations state the agency administering Medicaid must require a written application from each prospective client, authorized representative or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The application must be on a form prescribed by the agency for the purpose of applying for Medicaid and must be signed under a penalty of perjury. The Department of Social and Health Services uses a multiple-program application form entitled *Application for Benefits* that contains clearly identifiable Medicaid only sections that are consistent with federal regulations.

Certain circumstances allow automatic entitlement to Medicaid. For instance, the agency must not require a separate application for Medicaid from an individual receiving assistance under Temporary Aid for Needy Families or Supplemental Security Income. Newborns are exempt from the application requirement if the mother was eligible for Medicaid, receiving benefits at the time of the child's birth and the child has lived in the mother's household for the first year of life.

Federal law requires annual re-determination of Medicaid eligibility for most clients. To support this effort, the Department requires clients in the Medicaid program to complete an *Eligibility Review* form.

In Washington State, an applicant for Medicaid is not required to apply in person. Applications are accepted at the counter at a local Community Service Office, by mail or over the Internet. However, when a client applies for medical benefits, it is most often processed at a Community Service Office.

Description of Condition

The Department's computer claims system indicated that from July 1, 2005, through December 31, 2005, more than 945,000 individuals received medical services that were paid by Medicaid. Our audit attempted to determine if the Department had:

- Controls to ensure that these clients had, at one time, applied for Medicaid as federal regulations require, or
- Documentation to support the client's exemption from application.

Our audit found the Department's controls do not ensure that:

- Written applications, clearly indicating a request for Medicaid benefits and signed under penalty of perjury, are obtained where required.
- Documentation supporting initial eligibility determinations for the Medicaid program is retained.
- Management is monitoring to make certain policies and procedures pertaining to the application process are followed.

At the Department's Community Services offices located throughout the state, we found variations in how applications are processed, in management oversight and that each office is managed and run independently. While the Department's headquarters sets the policies and procedures, the administrators are free to establish procedures to suit the conditions and the clientele their office serves.

Cause of Condition

The Department:

- Reported it was unaware that the established controls were not effective.
- Believes that an *Eligibility Review* is sufficient documentation to support that an application was filed at one time.
- Reported that original documentation was discarded before the state instituted electronic and other archiving requirements.

Effect of Condition

To determine the effect of the control weaknesses that we found we randomly selected 575 clients for review. For each client we attempted to find an initial application for the person's entrance into the program that was:

- Written.
- Signed under penalty of perjury.
- Completed, including a medical section that was clearly checked and the request for benefits affirmatively checked for that particular individual.
- Readily available with all supporting documentation.

For clients for whom we could not find evidence of an application, we sought to determine if an exemption to the application process applied.

Of 575 clients reviewed, for 148 (26 percent) the Department did not have evidence showing compliance to federal Medicaid application requirements. Specifically:

- The applications for eight clients (5 percent of the exceptions) were not signed. Most of these applications were from clients who had applied over the Internet.

- For applications of 118 clients (80 percent of the exceptions), we found no indication the clients wanted medical benefits for themselves or that they were specifically exempted from application. Most of these clients requested food assistance or benefits for others in the household.

- For 19 clients (13 percent of the exceptions), we found no application to any program within the Department or any exemption to Medicaid application requirements.

- We found three clients (2 percent of the exceptions) were newborns of women who the Department could not prove were eligible for Medicaid at the time of the child's birth.

Total costs on behalf of Medicaid clients for whom the Department had no evidence to support these clients applied to the program per federal requirements were $261,645. Fifty percent of this was paid with federal funds. We are reporting these as costs at risk. Although we have no evidence that the Department complied with federal Medicaid application requirements at the time the client applied (which in some cases was years ago), we performed no tests to determine if the client is eligible to receive services for the period we tested.

Recommendation

In view of the almost one million clients the Department serves under the Medicaid program, we recommend the Department:

- Establish policies and procedures that would ensure compliance with federal Medicaid application requirements.

- Require the Community Service offices to consistently implement policies set by headquarters.

- Institute management oversight procedures at the executive level and local Office level to ensure policies are being followed.

- Work with Department of Health and Human Services to determine the corrective action that must be taken for clients who have applied for Medicaid many years before and for whom we found no evidence of proper initial application.

Department's Response

The Department partially concurs with this finding.

Of the total 500 cases audited, the Department agrees that 14 cases were in error for calendar year 2005 (11 totally ineligible and 3 ineligible for only part of the year) due to lack of valid applications covering at least one month of the audited period. This amounts to 2.8% of the audited cases or 9.4% of the cases the SAO reported as exceptions.

The Department notes that five of the fourteen errors were "Take Charge" applications, stored in medical and family planning clinics. Unfortunately, the turnaround time for the audit response prohibited retrieving the applications from those clinics. Clinic operating hours are not consistent – some clinics operate only one day per week. Had more time for audit review been possible, the Department believes the auditors would have received the applications, eliminating those errors.

The Department also notes that some errors were due to lack of signatures on applications, mainly for online applications. While the Department has an online application form that uses an electronic signature upon submission, the Department does not accept this electronic signature for Medicaid applications. The process for those submitting Medicaid applications electronically includes mailing the submitted application (or at least the application's signature page) to the client and requiring its return with a written signature.

One problem with this procedure is that applications (or signature pages) are returned with indecipherable signatures and no other identifying information. Unless the Department is able to identify the client to which the page belongs, the information cannot be stored in the correct case record. The Department added a name and case number line to each page of the revised application, effective January 1, 2007, to eliminate the identification problem. This will assist with identification of forms returned with unreadable signatures and will allow the forms to be stored in the correct case records.

The Department does not agree with the remainder of exceptions cited by the auditor. Three general categories of disagreement include:

1. *What constitutes an application for benefits?*

   The Department defines an application for medical benefits as required by federal rule (42 CFR 435.907(c)). Allowable forms include the application, eligibility review form, and the Social Security Administration (SSA) data exchange. Washington does not require an application for a newborn when the newborn's mother is receiving Medicaid at the time of birth. In many cases, a child's application is filed in the parent's file, making some of the applications appear lost to the auditor. These applications were subsequently found by the Health and Recovery Administration staff.

2. *Which benefits to consider on an application?*

   When a person requests benefits through a Community Services Office, the Department worker checks for eligibility for any services offered and considers the client for all possible assistance. Eligibility for a program does not require checking a specific benefit (or "box") on a written form. Federal rule requires that the Department furnish Medicaid promptly and regularly to all eligible individuals until they are found ineligible (42 CFR 435.930).

3. *Verification and signature requirements.*

   Clients eligible for Supplemental Security Income benefits are verified through an automated data exchange with SSA. Data received through this process has already been verified by SSA eligibility workers. This exchange constitutes verification of income from a federal agency.

   Medical eligibility review periods do not coincide with eligibility reviews for other programs such as cash or food assistance. Children are continuously eligible, meaning that a review is completed only once per year regardless of most changes in eligibility factors. The auditor said they interpreted these cases as the client "declining" medical assistance.

The following table summarizes the Department's partial disagreement on this finding:

Citation	Description	SAO # cases	SAO $ Exceptions	DSHS # cases	DSHS $ Exceptions
42 CFR 435.907b	Application not signed	8	$8,994.88	1	$433.75
42 CFR 435.909b(1)	Box not checked	19	$50,758.65	2	<$1,729.41
42 CFR 435.117a	No application, newborn	3	$4,703.10	0	0
42 CFR 435.909b(1)	No application, no exemption	118	$197,188.63	11	<$6,475.88
TOTAL		148	**$261,645.26**	**14**	**<$8,639.04**

< Accurate dollar totals unknown due to partial year eligibility of some clients.

Auditor's Concluding Remarks

We thank the Department for its response. We will follow up in this area during our next audit.

Applicable Laws and Regulations

42CFR 435.907 states in part:

> Written application.
>
> > (a) The agency must require a written application from the applicant, an authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.
> >
> > (b) Subject to the conditions specified in paragraph (c) of this section, the application must be on a form prescribed by the agency and signed under a penalty of perjury.

42CFR 435.909 states in part:

> Automatic entitlement to Medicaid following a determination of eligibility under other programs. The agency must not require a separate application for Medicaid from an individual, if—
>
> > (a) The individual receives AFDC; or
> >
> > (b) The agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act for determining Medicaid eligibility; and—
> >
> > > (1) The individual receives SSI . . .

42CFR 435.117 states in part:

> Newborn Children.
>
> > (a) The agency must provide categorically needy Medicaid eligibility to a child born to a woman who is eligible as categorically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible as categorically needy for one year so long as the woman remains eligible as categorically needy and the child is a member of the woman's household . . . .

06-12 The Department of Social and Health Services, Office of Financial Recovery and Health and Recovery Services Administration, does not have adequate internal controls to ensure that final settlement amounts are refunded to the federal government and in a timely manner.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Cost Principles
Questioned Cost Amount:	None

Background

The federal Medicaid program requires quarterly federal payments to states must be adjusted for prior overpayments or underpayments. In the event of overpayment, federal regulations require the adjustment to 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. 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

In our fiscal year 2005 audit, we found the Department did not have adequate internal controls to ensure that the federal portion of provider overpayments was refunded to the federal government as regulations require. During the current audit, we found the Department recognized this condition and started to establish new policies and procedures. However, no significant changes in the condition were made during our audit period.

Cause of Condition

- The Department did not have adequate procedures in place to ensure the federal share of overpayments is refunded within 60 days of discovery as the law requires.
- Administrations within the Department do not communicate regarding Medicaid overpayments in a timely manner.
- No one office or person monitors overpayments identified by administrations in the Department of Social and Health Services and the Medicaid Fraud Control Unit to ensure all overpayments are referred to the Office of Financial Recovery and are refunded to the federal government in an accurate and timely manner.

Effect of Condition

For the period July 1, 2005, through June 30, 2006, the Department found 142 overpayments amounting to $10,449,911. We reviewed 27 (56 percent) of these, totaling $5,904,621.60, to determine whether the federal

portion of the overpayments identified were refunded to the government and whether they were refunded within 60 days of discovery as federal regulations require.

For the overpayments reviewed our tests showed that the Department:

- Did not refund the federal portion of $438,138 in overpayments. However, after our audit work was completed, the Department reported that, of this amount, it refunded the federal portion of $322,940. We will review this during our next audit.

- Did not process $4,454,397 in overpayments within 60 days of discovery. Approximately 50 percent was paid with federal funds.

Recommendation

We recommend the Department:

- Establish and follow policies and procedures to ensure the federal share of overpayments is refunded at the end of the 60-day period following discovery.

- Establish and follow internal controls and monitoring procedures to ensure all overpayments identified by administrations in the Department of Social and Health Services and the Medicaid Fraud Control are referred to the Office of Financial Recovery and are refunded to the federal government in an accurate and timely manner.

Department's Response

The Department partially agrees with this finding. The following are responses to each condition in the finding:

The Department agrees with the cited condition that the Department did not have adequate procedures in place to ensure the federal share of overpayment was refunded within 60 days of discovery as the federal rule requires. On September 1, 2006, the Financial Services Administration (FSA) implemented the recommended Health and Recovery Services Administration's (HRSA) Administrative Policies 02-02, 02-03 and 02-04, to ensure the items noted do not reoccur. Overpayments received prior to September 1, 2006, were corrected to meet the new policy requirements on October 26, 2006. Any refunds to the CMS will occur on the next quarterly submission of the CMS 64 Report.

The Department respectfully disagrees with the cited condition that the Department does not communicate regarding Medicaid Overpayments. The following communication occurs within the Department:

- *The Office of Financial Recovery (OFR) and HRSA meet monthly to discuss future overpayments and on-going collections.*

- *FSA periodically meets with the Economic Services Administration, Aging and Disabilities Services Administration, Juvenile Rehabilitation Administration and Children's Administration to discuss future overpayments and on-going collections.*

- *The Fraud and Abuse Coordination Team (FACT) meets monthly to coordinate fraud cases. Representatives from various Department administrations that receive Medicaid funding participate in the meetings with the Medicaid Fraud Control Unit, including FSA. This is another forum for FSA to obtain information to help their overpayment collection efforts.*

The Department respectfully disagrees with the cited condition that no one office or person monitors overpayments in the Department and the Medicaid Fraud Control Unit to ensure all overpayments are referred to the OFR and refunded to the federal government in an accurate and timely manner. On December 31, 1987 the Department established Administrative Policy 10.02 to create a uniform methodology for identifying, notifying, reporting and processing all overpayments and debts from providers and vendors. This policy states that each administration is required to establish written policies and procedures regarding the identification and resolution of questionable bills from, or payments to, providers and vendors. OFR receives a copy of these policies and procedures as they are developed or modified. These policies and procedures indicate that overpayments must be referred to OFR and they must comply with all relevant laws and administrative policies. The Department believes that Administrative Policy 10.02 provides the assurance that all Department administrations will refer all Medicaid overpayments to the OFR in a timely manner.

Auditor's Concluding Remarks

We appreciate the actions taken by the Department to correct the conditions identified. We will follow up during our next audit.

Applicable Laws and Regulations

42 CFR 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.

42 CFR 433.318, Overpayments involving providers who are bankrupt or out of business, states:

(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 Section 433.320.

42 CFR 433.320, Procedures for refunds to CMS, states:

(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 Section 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.

Federal Findings and Questioned Costs - continued

06-13 The 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.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	Department of Social and Health Services
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Special Tests and Provisions: Managed Care
Questioned Cost Amount:	None

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 more seriously ill people will receive higher rates and the plans including healthier people will be given lower rates.

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 was actually provided. This gives the impression that the provider is treating more seriously ill 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 fiscal year 2003 state of Washington Single Audit Report and in our fiscal years 2004 and 2005 Medicaid and state of Washington Single Audit reports, we described concerns regarding the Administration's controls to determine the accuracy of data received from providers that is used to determine the rates for its Healthy Options managed care program.

Description of Condition

During our current audit, we attempted to determine what improvements the Department had made to strengthen controls. We found the Administration does have policies and procedures that include monitoring functions required by federal regulations and the Centers for Medicare and Medicaid Services reviewed procedures and found the Administration was able to identify when managed care plans had failed to meet regulatory requirements.

However, weaknesses still exist. We found the Administration does not monitor for accuracy the data that is being sent to the actuary by the managed care plans. The Administration is depending on the plans to report accurate encounter data. It is the encounter data that is used to determine the rates the managed care will receive.

Our tests also showed the Centers for Medicare and Medicaid Services' review of the rate-setting process indicated the data obtained from the managed care plans had shortcomings that prevented it from being used directly for rate-setting purposes.

Cause of Condition

The Department reported it does not have access to the data the managed care plans send to the actuary. This is because the information is considered proprietary.

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 at all.

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.

From January 2005 through December 2005, the state made over $1 billion in payments to managed care providers, 50 percent of which was paid with federal funds. This represents the expenditures the state has made to providers and for which we have no reasonable assurance that the rate was based on accurate data. This is an increase of almost $83 million over last year for the same period.

Recommendation

We recommend 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 this finding.

The Centers for Medicare and Medicaid (CMS) has provided a review of the 2005 finding on this issue. Their conclusion indicates that the State's activities regarding managed care rates satisfy federal requirements. CMS has approved the State's managed care rates and has mandated improvements to data used for rate setting. The Department continues to work with CMS to implement improvements, while recognizing that implementation of the new Provider One information system will finally satisfy all requirements for improved managed care data.

Auditor's Concluding Remarks

We thank the Department for its response. We will follow up in this area during our next audit.

Applicable Laws and Regulations

The federal 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).

Federal Findings and Questioned Costs - continued

The March 2006 federal Office of Management and Budget Circular A-133 Compliance Supplement, page 4-93.778-6, states in part:

> The State plan must provide methods and procedures to safeguard against unnecessary utilization of care and services . . . In addition, the State must have:
>
> > (1) methods of criteria for identifying suspected fraud cases;
> >
> > (2) methods for investigating these cases; and
> >
> > (3) procedures, developed in cooperation with legal authorities, for referring suspected fraud cases to law enforcement officials.
>
> These requirements may be met by the State Medicaid agency assuming direct responsibility for assuring the requirements or by contracting with a quality improvement organization (QIO) (formerly know as peer review organization (PRO)) to perform such reviews. The reviewer must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services.
>
> The State Medicaid agency must have procedures for the ongoing post-payment review, on a sample basis, for the necessity, quality, and timeliness of Medicaid services. The State Medicaid agency may conduct this review directly or may contract with a QIO.
>
> Suspected fraud identified by utilization control and program integrity should be referred to the State Medicaid Fraud Control Units.

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 . . . .

Federal Findings and Questioned Costs - continued

06-14 The Department of Social and Health Services does not have adequate controls to ensure home health agencies are licensed, Medicare-certified and have signed Core Provider Agreements as required by law.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Special Tests and Provisions: Provider Eligibility
Questioned Cost Amount:	None

Background

Home health care services cover a broad range of services that are offered in a client's home including skilled nursing care, paraprofessional services, custodial care and high-tech pharmaceutical services. The elderly are the primary recipients of services offered by home health care agencies. For January 1, 2005, through December 31, 2005, the Department reports it spent approximately $4.5 million for home health services. Half of these expenditures were paid with federal Medicaid funds.

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

- A Washington state business license, unless specifically exempted.
- Medicare certification.
- 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.
- A Core Provider Agreement on file with the Department.

Description of Condition

While we found improvements this year, the Department continues to have inadequate controls in place to ensure that all home health providers:

- Meet the criteria for participating in the Medicaid program prior to issuing a provider number.
- Continue to meet the requirements for participating in the Medicaid program after initial enrollment.

This condition was reported in the 2005 state of Washington Single Audit Report.

Cause of Condition

The Department states it does not have sufficient resources to establish these controls.

Effect of Condition

Our testing showed that the control weaknesses allowed at least some portion of the required documentation to be either not present, not readable or expired. We saw this for 26 out of 27 providers tested in a total population of 62 home health agencies with unique provider numbers.

Due to these control weaknesses, we do not have reasonable assurance that home health providers are meeting eligibility requirements. If home health agencies are not eligible to participate in the Medicaid program, the Department would not be entitled to receive federal matching funds for reimbursements made to these providers. Noncompliance with federal regulations could jeopardize future Medicaid funding.

Recommendation

We recommend the Department make it a priority to evaluate and improve internal controls and allocate sufficient resources to ensure all home health agencies meet the criteria for participating in the Medicaid program initially and throughout their enrollment.

Department's Response

As a result of the 2005 Medicaid SAO audit, HRSA began a project to bring all HHA licensing files up to date. Work on the project has progressed, and improvements continue to be made. Staff are ensuring that all required documents are included in the provider file. These documents are:

- *Washington State business license*
- *Medicare certification*
- *In-home services license by the Department of Health*
- *Core Provider Agreement*

In addition, staffs are ensuring that the provider's W-9 is in each file.

As part of the 2006 audit, HRSA staff supplied missing licensing documents for HHA providers to the auditor that were on file with Department of Health. These documents do exist at the State, and are being included in the HRSA licensing files as they are identified. It is expected that this activity will continue into 2007, as the files require a lot of work to be brought up to standards.

Once the files are up to date, the Department will examine procedures to confirming that existing providers continue to meet requirements.

Auditor's Concluding Remarks

We appreciate the actions taken by the Department to correct the conditions identified. We will follow up during our next regularly scheduled audit.

Applicable Laws and Regulations

<u>Core Provider Agreement</u>

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; . . .

Department of Health 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. 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 . . . .

Federal Findings and Questioned Costs - continued

06 -15 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 and children, as the law requires.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Activities Allowed or Unallowed
Questioned Cost Amount:	None

Background

Federal regulations require state authorities to establish and maintain health and other standards for institutions participating in Medicaid.

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 to make a full disclosure of any crimes committed prior to employment. The Department of Health, as the licensing authority, has the responsibility for ensuring 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

In our fiscal year 2005 audit, we found the Department significantly complied with the requirement to perform criminal background checks and disclosures for administrators of home health agencies during the licensing process. However, during that audit we saw no evidence that the Department monitors that home health agencies are performing background checks on all employees that have unsupervised access to vulnerable adults and children. This condition was reported in a finding for state fiscal year 2005.

During our current audit, we found no changes in the condition. The Department did not concur with the finding and therefore made no changes in its survey activities or its records retention policies. We were unable to review this area for compliance as the Department does not retain records to support the result of its surveys.

Cause of Condition

The Department believes it is following the Center for Medicare and Medicaid Services' reporting requirements for this area.

The Department states retaining survey records is neither necessary nor cost-effective. It reported that retaining records would not result in any additional protection for vulnerable clients of home health agencies.

Effect of Condition

When the Department does not retain supporting documents for its surveys, we are unable to determine whether it is monitoring home health agencies for compliance with the requirement to perform background checks and obtain necessary disclosures.

Not retaining survey records is a violation of federal regulations and could jeopardize future Medicaid funding.

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 vulnerable adults.

- Retain survey records supporting the result of its surveys.

Department's Response

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 and children, as the law requires.

We are concerned that the Auditor's Office interpretation of 42 CFR 431.610 (f) is without contextual reference to 42 CFR 488 Survey, Certification, and Enforcement Procedures, specifically 42 CFR 488.18 Documentation of Findings. This cites in detail the documentation requirements for the survey process.

In addition, 42 CFR 488.26 (d) clearly directs that the state survey agency must use the survey methods, procedures, and forms that are prescribed by CMS. CMS guidance is composed of the State Operations Manual (SOM) and other directives including documentation retention policies.

To clarify, the State Auditor's Office is interpreting federal law as requiring the retention of surveyor's notes, rough copy survey report forms, and other work papers created by a surveyor during the survey process.

Our position, and that of the cognizant federal agency, is that federal law and administrative guidance do not include a clear requirement for the retention of surveyor field notes. Outside of an administrative appeal or legal challenge there is no requirement to maintain these documents for the purposes of supporting prescribed survey report formats. Surveyor's notes, rough copy survey report forms, and other work papers which are merged into a superseded by a final product are specifically excluded from CMS State Survey Agency Record Retention policies.

We compile the survey results on CMS Form 2567 for every survey event whether deficiencies were found or not. CMS Form 2567 serves as the official document of the survey event and is recorded on the national data base for use by CMS and state agencies. By nature, the current reporting format is an exception reporting process. Although exception reporting is not preferred by the State Auditor's Office it is the process currently directed by federal law.

While the document retention process endorsed by SAO is not required by federal law or rule, we share an interest in adopting best practices. It is our intention to implement a documentation retention policy consistent with the business needs of our agency.

Auditor's Concluding Remarks

We thank the Department for its response. We will follow up in this area during our next audit.

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(a) states:

> (1) Section 1902(a)(9) of the Act, concerning the designation of State authorities to be responsible for establishing and maintaining health and other standards for institutions participating in Medicaid; and
>
> (2) Section 1902(a)(33) of the Act, concerning the designation of the State licensing agency to be responsible for determining whether institutions and agencies meet requirements for participation in the State's Medicaid program.

42 CFR 431.610(f)(2) states in part:

> (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; and
> >
> > (iii) Document deficiencies in reports

42 CFR 431.610(f)(3) states in part:

> (3) The survey agency will keep on file all information and reports used in determining whether participating facilities meet Federal requirements; and
> 42 CFR 431.610(f)(4)
>
> (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 . . . .

RCW 43.43.834(2) states:

> 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:
>
> > 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

Federal Findings and Questioned Costs - continued

(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 . . . .

06-16 The Department of Social and Health Services does not have adequate controls in place to ensure providers of durable medical equipment exist, are properly licensed and have submitted accurate information.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Special Tests and Provisions: Provider Eligibility
Questioned Cost Amount:	None

Background

Durable medical equipment is equipment that can withstand repeated use, is primarily used to serve a medical purpose and is appropriate for use in the home. Examples include hospital beds, wheelchairs and oxygen delivery systems**.**

Providers of this equipment paid for through the Medicaid program must be approved by the Department of Social and Health Services. These providers submit documentation and completed agreements to the Department to verify they are able to supply certain products. The Department is responsible for reviewing the information prior to issuing a provider number for an individual or organization. This number, when accompanied by a claim and an authorization, if necessary, causes the Department's system to generate an approval and payment to the provider. For the period January 1, 2005, through December 31, 2005, the Department reported that it spent approximately $54.6 million for durable medical equipment and related supplies. Half of these expenditures were paid with federal Medicaid funds.

In our last two audits, we found the Department did not perform adequate reviews of providers to ensure the information the providers submitted was accurate and the providers were legitimate businesses prior to assigning a provider number.

Description of Condition

During our current audit, we found the Department has made progress in addressing weaknesses identified in the prior audit findings. However, most of the control weaknesses continued. We found the Department:

- Does not verify that all durable medical equipment providers continue to meet the requirements for participating in the Medicaid program after initial enrollment.
- Does not monitor providers for compliance with Core Provider Agreements.
- Does not have internal policies defining what is needed in terms of a business license for in-state and out-of-state providers.

While the Department has put in place new controls that included "drive-by" reviews to ensure durable medical equipment providers are legitimate businesses, it does not yet follow up on instances in which the providers appear not to have viable businesses.

Cause of Condition

The Department states it does not have sufficient resources to establish these controls.

Effect of Condition

Based on inquiry and observation performed in our current audit, we found that many of the control weaknesses that were evident in our testing for our fiscal year 2005 audit continued to exist. For the controls that were improved, we found lack of follow-up on the high risk situations that the Department identified.

Due to the control weaknesses, the Department cannot be sure durable medical equipment providers are meeting the requirements for eligibility and are legitimate businesses. These weaknesses could allow providers to submit fraudulent requests for payment that would not be detected in a timely manner, if at all. If durable medical equipment providers are not eligible to participate in the Medicaid program, the Department would not be entitled to receive federal matching funds for reimbursements made to such providers. Noncompliance with federal regulations could jeopardize future Medicaid funding.

Recommendation

We recommend the Department make it a priority to evaluate and improve internal controls and allocate sufficient resources to ensure all providers of durable medical equipment meet the criteria for participating in the Medicaid program initially and throughout their enrollment.

Department's Response

HRSA initiated a project to examine the files of all DME providers. This project ensures that all licensing requirements are met for all providers, identifies and collects missing business licenses and contacts providers that have not had claims in two years for possible termination. This action shows that HRSA made a priority of ensuring that all DME providers meet the criteria for participating in the Medicaid program. This activity was communicated to the auditor in follow-up to the 2005 audit. In the future, these actions will be made more streamlined by the Provider One system, which will check for expired business licenses. The department will evaluate monitoring processes once all provider files have been reviewed.

The Department now has a policy in place regarding acceptable business licenses for DME providers. This policy was established as a result of the 2005 Medicaid SAO audit and was communicated to the auditor.

During fiscal year 2006, the department implemented a plan to verify the physical locations of DME providers. That plan included building a database of DME providers for identifying, scheduling and tracking DME drive-by's and results. Subsequent to developing that plan the database was built, staff were trained, and drive-by's initiated. DME vendors that appeared questionable based on the initial drive-by review were referred for an additional follow up review to ensure the providers were truly not operating legally before termination and/or recoupment activities began. Follow up reviews are scheduled into the existing workload based on risk and materiality to the Department.

The auditor examined drive-by reviews that the State began performing in response to the 2005 Medicaid audit. Given the short period of time between initiation of the drive-by activity and the auditor's review, the process of following up and verifying the provider's status was not complete. Since that time, it has been verified that some providers initially thought not to be located where their address indicated were indeed operating legally. The Department intends to be careful not to terminate or recoup from a DME provider that is actually operating appropriately but whose address is not clear in our system.

Auditor's Concluding Remarks

We appreciate the actions taken by the Department to correct the conditions identified. We will follow up during our next regularly scheduled 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 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, regulation, and the provision of contracts or grant agreements that could have a material effect on each of its Federal programs . . .

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 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 388-543-1200 states in part:

Federal Findings and Questioned Costs - continued

(1) MAA requires a provider who supplies DME and related supplies, prosthetics, orthotics, medical supplies and related services to an MAA client to meet all of the following. The provider must:

(a) Have the proper business license;
(b) Have appropriately trained qualified staff; and
(c) Be certified, licensed and/or bonded if required, to perform the services billed to the department. Out-of-state prosthetic and orthotics providers must meet their state regulatory requirements.

(2) MAA may reimburse qualified providers for DME and related supplies, prosthetics, orthotics, medical supplies, repairs, and related services on a fee-for-service (FFS) basis as follows:

(a) DME providers for DME and related repair services . . . .

06-17 The Department of Social and Health Services is not adequately reviewing pharmaceutical claims to identify patterns of fraud and abuse.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Activities Allowed or Unallowed
Questioned Cost Amount:	None

Background

Federal regulations require states to 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. This examination must include an analysis of physician's prescribing practices, drug use by individual patients and dispensing practices of pharmacies. The review must be accomplished through the Medicaid Management Information System (MMIS) through analysis of predetermined standards.

This requirement is designed to prevent payment of false pharmaceutical claims. In an effort to comply, the Department has set up 10 fields for providers to complete on claims. These fields are:

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.

In our audit of state fiscal year 2005, we found the Department had no means of validating the prescriber number in its control system. The prescriber number is the number the practitioner obtains when it registers with the Drug Enforcement Authority. It permits physicians, dentists and other licensed practitioners to prescribe certain types of narcotics, depending on the registration they obtain. We also reported the Department had never done a retrospective drug use review of the prescriber number.

Description of Condition

During our current audit, we attempted to determine if the Department had put in place any controls to improve conditions noted in the previous year. According to its corrective action plan, the Department stated most of the improvements were made during the last month of our audit period. Since these changes were not representative of most of the time period we were reviewing, we were unable to determine their effect on the control system. However, some of the modifications the Department reported to us included:

- The system that pharmacists use to submit claims was changed so that it would verify the prescriber's number for validity and expiration when the claim is submitted.
- A computer function that prevents processing of claims from prescriber numbers that the Department knows to be invalid or to belong to veterinarians.

We were informed the Department does not plan to establish controls that would ensure the validity of Medicaid claims from Washington pharmacists for prescriptions written by prescribers licensed to practice in distant states such as Florida or New York.

Although we found evidence of a retrospective drug use review, weaknesses continue due to the lack of controls over the validity of the prescriber number field.

As a result of our prior audit, the Department selected 63 invalid prescriber numbers it found in its system and identified 15,269 claims using these numbers. Overpayment notices totaling $769,825 were sent to pharmacy providers for 219 of those claims. A process was set up that allowed the pharmacies who received a notice to send valid prescriber numbers for these claims. If valid numbers could not be obtained, then the pharmacy was required to repay the funds. For the remaining 15,015 claims that did not receive an overpayment letter, a process called "Provider Self Review" has been established to allow pharmacies on-line access to claims with invalid prescriber numbers submitted from May 2003 through November 2005. With this system, it is up to the pharmacy to determine whether a valid number can be provided or if repayment is necessary.

The Department could not tell us how many valid prescriber numbers were provided or how much money was refunded from this effort. We saw no plans for additional post-payment review that would identify other invalid prescriber numbers other than the original 63.

Cause of Condition

- With respect to controls ensuring the validity of claims having prescriber numbers for out-of-state practitioners, the Department believes it is not reasonable to deny these claims because using an out-of-state practitioner is reasonable in some instances.

- With respect to the continuing weaknesses in the retrospective drug use review, the Department reported the changes that would strengthen the controls in this area were not put in place until the last month of our audit period.

Effect of Condition

The federally required review of claims data and other records to ensure the validity of pharmaceutical claims is not effective. If controls are weak, the state cannot prevent or deter the unauthorized use of prescription medications. Such costs would be unallowable for federal Medicaid matching funds.

Recommendation

We recommend the Department

- Validate the prescriber number on all pharmaceutical claims when they are submitted.
- Continue the post-payment review process for all claims submitted with an invalid prescriber number.
- Establish a monitoring system that will ensure that providers who have submitted claims with invalid prescriber numbers will refund federal Medicaid funds.

Department's Response

The Department does not concur with this finding.

The Department has a strong retrospective utilization review program and effective system of internal controls, including the validation of Drug Enforcement Authority (DEA) numbers submitted on pharmacy Point of Sale (POS) claims. The following items demonstrate the Department's commitment to payment integrity and compliance with federal regulation:

1. *The Department's POS vendor, Affiliated Computer Services, Inc., completed a Computer Service Request (CSR) that loaded DEA numbers from the national DEA database. The CSR was implemented June 5, 2006 and the pharmacy POS system now validates against the full DEA national database at the time of adjudication. The result is that pharmacy claims are paid only if the prescriber has either a valid DEA or Medicaid provider identification number, either of which may be utilized on the claim as a valid prescriber identifier.*

2. *The Department has a procedure to block specific DEA numbers in the POS if certain conditions are met. The Department's Health and Recovery Services Administration (HRSA), Quality Management Team (QMT) follows a rigid set of procedures regarding client, prescriber and pharmacy notification. Federal Office of Inspector General (OIG) exclusion guidelines are also followed, i.e. when the OIG excludes a prescriber, Medicaid is no longer allowed to honor their prescriptions. Unlicensed medical practitioners are also blocked since they have no legal right to practice or write scripts. Prescription drug claims submitted with a blocked DEA number in the prescriber field are denied.*

3. *The Department has an active post-payment review and audit program that includes review of pharmacy claims and identification of patterns of fraud and abuse. The Department's Payment Review Program works with subject matter experts to identify patterns of fraud and abuse and determines whether to issue overpayments or refer pharmacies for audit. The Office of Payment Review and Audit conducts on-site and desk audits of pharmacy claims. In 2005, thirty-four pharmacy audits were conducted and in 2006, twenty-five were completed. None of these audits resulted in overpayments, suspensions or referrals to MFCU. Pharmacy audits measure compliance with regulations stated in the Code of Federal Regulations (CFR), Revised Code of Washington, Washington Administrative Code, and the provider's Core Provider Agreement, billing instructions, and numbered memoranda. Pharmacy audits are prioritized by area of greatest risk i.e. dollars, suspected fraud and abuse, etc.*

   When fraud or abuse is detected, pharmacies cases are referred to the Attorney General's Medicaid Fraud Control Unit (MFCU). Monthly coordination meetings between the Department and MFCU occur, as outlined in the Department's memorandum of understanding with MFCU. These meetings allow the Department and MFCU to coordinate on cases, resulting in successful prosecutions and civil overpayment recoveries.

Federal Findings and Questioned Costs - continued

4. *The Department's Payment Review Program has and continues to utilize identified invalid DEA numbers to identify overpayments and subsequently notify and recover improperly paid claims.*

5. *The Department has a rigorous and extensive Drug Utilization Review (DUR) Program and is in full compliance with 42 CFR Sec. 456.709. DUR staffs are employed by Washington State in HRSA. The Department conducts retrospective review of pharmacy claims and has an extensive program that includes direct contact with prescribers each month. A summary of Retrospective DUR during Federal Fiscal Year 2006 is available.*

Auditor's Concluding Remarks

We thank the Department for its response. We will follow up in this area during our next audit.

Applicable Laws and Regulations

42 CFR Chapter IV, Section 456.709, Retrospective drug use review, states in part:

> (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).

42 CFR Section 456.722, Electronic claims management system, states in part:

> (a) Point-of-sale system. Each Medicaid agency, at its option, may establish, as its principal (but not necessarily exclusive) means of processing claims for covered outpatient drugs, a point-of-sale electronic claims management (ECM) system to perform on-line, real-time (that is immediate) eligibility verifications, adjudication of claims, and to assist pharmacists and other authorized persons (including dispensing physicians) in applying for and receiving payment. The State determines who must participate in an ECM system and who may decline to do so. If the State exercises this option and wishes to receive FFP for its ECM system, the system must meet the

functional and additional procurement and system requirements in paragraphs (b) and (c) of this section.

(b) Functional requirements. The ECM system developed by the State must include at least the on-line, real-time capabilities specified in paragraphs (b) (1) through (3) of this section. The real-time requirement for prescriptions filled for nursing facilities and prescriptions filled by mail order dispensers may be waived by the State to permit claims to be processed in the batch mode at the end of the day or other time mutually agreed to by the nursing facility or mail order dispenser and Medicaid agency.

(1) Eligibility verification, including identification of the following:

(i) Third-party payers.

(ii) Recipients in managed care programs.

iii) Recipients and providers in restricted service programs (for example, lock-in and lock-out)

(iv) Properly enrolled providers.

(2) Claims data capture, including the following:

(i) Transfer of claims information from the pharmacy to the Medicaid agency or the Medicaid agency's contractor . . .

(ii) Identification of prescriber

(Emphasis added.)

06-18 The Department of Social and Health Services has not established effective procedures in all administrations to ensure compliance with the federal Medicaid requirements for reporting adult victims of residential abuse to the Medicaid Fraud Control Unit.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Special Tests and Provisions: Utilization Review and Program Integrity
Questioned Cost Amount:	None

Background

As a condition for receiving Medicaid funds, states must establish and operate State Medicaid Fraud Control Units. 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. In order to accomplish its function and be in compliance with federal regulations, the Department must report all allegations of residential abuse in a timely manner to the Fraud Unit.

In our audit of fiscal year 2005, we found non-compliance with federal Medicaid requirements for reporting adult victims of residential abuse to the Medicaid Fraud Control Unit. We indicated in that audit the cause was a lack of procedures in some administrations while others were not consistently following the procedures they had established.

Description of Condition

During our current audit, we sought to determine what improvements the Department made. We found:

- The Department has established policies and procedures for investigating and reporting allegations of abuse and neglect of Medicaid clients as stipulated in the agreement with the Attorney General's Office and required by federal law.

- The Division of Alcohol and Substance Abuse corrected the weaknesses found in last year’s audit and has established monitoring procedures to ensure that reporting procedures are being followed.

We also saw some continued weaknesses:

- The Mental Health Division has not established effective monitoring procedures to ensure reporting procedures are being followed.

- The Department does not have policies requiring staff to follow up on cases referred to them by the Medicaid Fraud Control Unit.

Federal Findings and Questioned Costs - continued

Cause of Condition

- The Mental Health Division reported that criteria for compliance are not clear.
- The Department has not completed their procedures requiring staff to follow up on cases referred to them by the Medicaid Fraud Control Unit.

Effect of Condition

Control weaknesses lead to the possibility that not all cases of fraud and abuse will be reported to the Medicaid Fraud Control Unit as federal regulations require. When the Fraud Unit is not aware of all abuse allegations of Medicaid clients, it is unable to perform its investigatory role. 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 establish effective monitoring procedures to ensure reporting procedures are being followed.
- Monitor administrations to ensure procedures are being followed.
- Continue working on establishing policies and procedures requiring Department staff to follow up on cases referred to them by the Medicaid Fraud Control Unit.

Department's Response

The Mental Health Division recognizes the importance of having appropriate policies and procedures involving the referral of substantiated allegations involving Medicaid patients to the Medicaid Fraud Control Unit (MFCU). The value of having a process that involves timely investigation, referrals, communication, corrective action and close out of case files is also noted. The MHD is in compliance with the federal reporting requirement.

A. Over the 2005 fiscal year, the Division completed the following actions to strengthen controls:

1. *Eastern State Hospital (ESH), Western State Hospital (WSH) and MHD central office reviewed and updated all policies surrounding the reporting of incidents to include mandatory reporting of substantiated incidents to the MFCU.*

B. Over the 2006 fiscal year, the Division completed the following actions to strengthen controls:

1. *Implementation of an incident management database at MHD central office for incident tracking and monitoring.*
2. *All incidents elevated to MHD central office are reviewed and tracked by the Federal Compliance Officer.*

3. *MHD representation (Federal Compliance Officer) at the MFCU monthly committee meetings chaired by Mike Keller (MFCU Director) established.*

4. *Designation of a single Point of Contact (Federal Compliance Officer) for all referrals originating from the MFCU.*

5. *Participation in the establishment of a Memorandum of Understanding between the Medicaid Fraud Control Unit and DSHS.*

C. Fiscal year 2007 resulted in the following actions:

1. *In response to the auditor's finding both ESH (Oct 2006) and WSH (Dec 2006) updated incident reporting policies to include a feedback loop for cases referred to and from external entities.*

2. *Approval of funding for a central office Incident Manager (Aug 2006).*

   - *Recruitment is currently underway for this position.*

3. *MHD is presently reviewing the feasibility of adopting a shared electronic incident reporting system within DSHS that will track and trend all incidents.*

   - *Once adopted:*

     - *A review of all related policies will be needed to establish appropriate guidelines.*

     - *Contract language will also be developed to establish guidelines for contracted entities.*

     - *Partial implementation of this system is expected prior to July 2007.*

D. The following documents are available for review if necessary:

1. *MHD Policy 4.08*
2. *ESH Policy 2.9*
3. *WSH Policy 1.1.7*
4. *DSHS MFCU MOU*

Auditor's Concluding Remarks

We thank the Department for its response. We will follow up in this area during our next audit.

Applicable Laws and Regulations

Title 42 of the Code of Federal Regulations, Section 1007.11, stipulates the residential abuse responsibilities of the fraud unit and states 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.

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.

42CFR 455.14 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.

42CFR 455.15 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 Section 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.

42CFR 455.16 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.

06-19 The agreement between the Department of Health and the Department of Social and Health Services, Health and Recovery Services Administration, covering hospitals' survey activities does not comply with federal requirements.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-0705WA5028, 5-0705W5048
Applicable Compliance Component:	Special Tests and Provisions: Provider Health & Safety
Questioned Cost Amount:	None

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 that stipulates what activities the survey agency must do. In Washington, the designated Medicaid agency is the Department of Social and Health Services and the survey agency is the Department of Health.

During our fiscal year 2004 and 2005 audits, we found the agreement between the Departments did not meet all federal requirements.

Description of Condition

In our current audit, we followed up to determine whether progress had been made in correcting the conditions we found in previous audits. The Departments reported in their corrective action plan that they had finalized and signed an agreement they believed complied with the Medicaid State Plan and federal requirements. However, our tests showed deficiencies in the agreement. Specifically, we found there was no stipulation for the requirement that:

- Surveyors will note on completed reports whether each requirement of the survey was performed.
- The Department of Health will keep on file all information and reports used in determining whether participating facilities meet federal requirements.

For both these provisions the agreement indicated that:

> All technical and administrative details concerning administration, record keeping and processes employed will be as documented in the current edition of the CMS State Operation Manual.

However, the State Operation Manual does not mention the federal requirements to include each requirement in the completed inspection report and to keep the file containing inspection information.

The statement that information will be accessible for the purposes consistent with the Medicaid agency's effective administration of the program also was not found in the agreement.

Cause of Condition

The Departments believed that including a reference to the Center for Medicare and Medicaid Services' State Operation's Manual would address all federal requirements for the interagency agreement.

Effect of Condition

Without an agreement that conforms to federal regulations, the state is making significant payments to hospitals for services to Medicaid clients without assurance 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

Department of Social and Health Services

The Department of Social and Health Services (DSHS) disagrees with this finding. Clarification has been received from the Centers for Medicare and Medicaid Services (CMS) that the authority over Department of Health (DOH) in conducting hospital surveys lies with the Regional Office of the Centers for Medicare and Medicaid (CMS), not with the State Medicaid agency. CMS states:

> *CMSO [Centers for Medicaid and Medicare Services Office] contracts with DOH to perform surveys for non-long term care hospitals . . . CMS has oversight responsibility of state agencies to ensure regulatory requirements are met. CMS RO, therefore needs clarification from the State regarding the purpose of the agreement between DSHS and DOH, and why such an agreement is necessary.*

Due to this, the agreement between DSHS's Health and Recovery Service Administration (HRSA) and DOH is not required to contain or enforce all federal requirements. DOH is responsible to CMS for these requirements.

The agreement between the two agencies ensures adequate and timely communication on survey results, and allows HRSA to complete federal reports accurately and on time. The agreement's purpose does not extend beyond this purpose.

Department of Health

We are concerned that the Auditor's Office interpretation of 42 CFR 431.610 (f) is without contextual reference to 42 CFR 488 Survey, Certification, and Enforcement Procedures, specifically 42 CFR 488.18 Documentation of Findings. This cites in detail the documentation requirements for the survey process.

In addition, 42 CFR 488.26 (d) clearly directs that the state survey agency must use the survey methods, procedures, and forms that are prescribed by Centers for Medicare & Medicaid Services (CMS). CMS guidance is composed of the State Operations Manual (SOM) and other directives including documentation retention policies.

CFR 431.610(f) (2) (ii) states that inspectors will note on completed reports whether or not each requirement for which an inspection is made is satisfied. The State Auditor's Office is interpreting this to mean that documentation must be provided on survey reports that each survey requirement was performed. This is a subtle but important difference. We believe that Chapter 2 of the State Operations Manual §2728 provides the administrative guidance for this requirement when an entity is in compliance with all conditions of participation. Further direction is provided under §2728A if deficiencies are noted.

Federal law and administrative guidance do not include a clear requirement for the retention of surveyor field notes for the purposes of supporting prescribed survey report formats outside of an administrative appeal or legal challenge. Surveyor's notes, rough copy survey report forms, and other work papers which are merged into and superseded by a final product are specifically excluded from CMS State Survey Agency Record Retention policies.

In an effort to ensure that our agency is in compliance with federal law, we have presented our questions to the Department of Health & Human Services (HHS) Office of Inspector General in Washington, D.C. After review by high-ranking officials in the OIG Office of Audit Services we were directed to forward our questions to the Regional Office of the federal Centers for Medicare & Medicaid Services (CMS).

After conferring with the Regional Office of the federal CMS and explaining our position, we have been told that our current process is in compliance federal law. Furthermore, CMS has communicated that the Department of Health is in compliance with applicable federal law to the State Auditor's Office through the HHS Division of Financial Management. The CMS response was as follows:

> *Concur with the state's response to the findings. For clarification purposes, it is a requirement for state agencies to produce a "Statement of Deficiencies and Plan of Correction" CMS Form 2567 for every survey event, whether deficiencies were found or not. The CMS Form 2567 serves as the official document of the survey event, and is recorded as such on a national database for use by CMS and the state agencies. To produce such a report, it is prudent for surveyors to take complete notes of all observations and should document the date and time of the observations; location; patient identifiers, individuals present during the observation, and the activity being observed, etc., for recall purposes. This is based on the survey protocols outlined in the State Operations Manual for each provider and supplier type.*
>
> ***The state response to the finding is appropriate***

While the document retention process endorsed by SAO is not required by federal law or rule, we share an interest in adopting best practices. It is our intention to implement a documentation retention policy consistent with the business needs of our agency.

Auditor's Concluding Remarks

We thank the Department of Social and Health Services and the Department of Health for their responses. We will follow up in this area 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 in part:

> 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 (DSHS) and the Department of Health (DOH).

Federal Findings and Questioned Costs - continued

42 CFR 431.610(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.

06-20 The Washington State Department of Health has not established sufficient internal controls to safeguard gift cards used as incentives for participants in research studies done for the Centers for Disease Control and Prevention Investigations and Technical Assistance Program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	CFDA 93.283 Centers for Disease Control and Prevention Investigations and Technical Assistance.
Federal Award Number:	U50/CCU022438-03-3 CP-97053501-1 R-82978101-2
Applicable Compliance Component:	Allowable Costs/Cost Principles
Questioned Cost Amount:	$14,170

Background

The Washington State Department of Health administers the Centers for Disease Control and Prevention Investigations and Technical Assistance Program (CFDA 93.283). The Department used funds from this program to purchase $40,150 in department and grocery store gift cards as incentives for participants in research studies. We determined this is an allowable use of grant funds. The Department expended $33,465,847 for this program in fiscal year 2006.

Description of Condition

During our audit, however, we determined the Department did not maintain an inventory of the gift cards, did not perform periodic reconciliations of the gift cards and did not ensure that the gift cards were kept in a secure location. The Department performed a reconciliation at our request, and was unable to account for $14,170 in gift cards. The Department has initiated an investigation into the loss.

Cause of Condition

The Department's office responsible for the gift cards did not inventory, reconcile, or adequately secure the cards. The Department's internal controls over these cards were inadequate to prevent or detect loss or misuse.

Effect of Condition and Questioned Costs

Items purchased with federal funds were not adequately safeguarded and may not have been used for their intended purpose. We question $14,170, the value of the cards unaccounted for.

Recommendations

We recommend the Department:

- Consult with its grantor to determine whether questioned costs should be repaid
- Complete an inventory of all gift cards
- Perform periodic counts of gift cards and reconcile amounts to accounting records
- Ensure that all gift cards are kept in secure location

Department's Response

We appreciate the input of the State Auditor's Office in working with us to strengthen our internal control procedures to provide better record-keeping and a more secure procedure for safeguarding our supply of gift cards. Although we respectfully disagree with how portions of this audit finding are articulated, we now have improved procedures which have been put in place with the help of the staff of the State Auditor's Office.

Although we have recently improved our procedures, it is important to note that we have always routinely inventoried our supply of gift cards and performed reconciliations of our records. In the past, the gift cards were kept in a locked drawer and the key to the drawer was kept in a separate location. Unfortunately, $2,463 worth of gift cards was found missing in 2006. Through our internal controls, we quickly identified the problem and reported it to the Tumwater Police Department. In addition, we completed an inventory and verified the number of missing cards through our record-keeping system in place at the time. With the exception of the $2,463 in missing cards, we were able to account for the entire remaining inventory of the gift cards.

As a result of the lost cards, we have taken actions to strengthen our internal controls. We inventoried all gift cards and arranged with our Financial Services Division to establish a routine of performing periodic counts of gift cards and reconciling amounts to accounting records. We have also arranged to use their vault to secure the gift cards.

Since the value of lost assets ($2,463) is not an allowable charge against federal funds, we did not charge the granting agency for this loss.

Auditor Remarks

During the course of our audit we requested records in order to provide evidence that gift cards purchased were accounted for. This increased attention to department store gift cards led to the Department's identification of $3,250 in unaccounted for cards. Prior to our request, the Department stated reconciliations between cards and participants were not performed as it believed this was an area of low risk.

In addition to the department store gift cards, the Department was unable to account for $10,920 in grocery store gift cards. The Department stated these cards were used to support studies related to the grant but did not have adequate evidence to support this because of inadequate recordkeeping.

We acknowledge that the Department is continuing to improve internal controls over gift card inventories. We appreciate the Department's response and its commitment to resolving this issue.

Applicable laws and Regulations

45 CFR 92.20

…(3) Internal control. Effective control and accountability must be maintained for all grant and sub-grant cash, real and personal property, and other assets. Grantees and sub-grantees must adequately safeguard all such property and must assure that it is used solely for authorized purposes.

Federal Findings and Questioned Costs - continued

06-21 The Department of Health is not complying with federal requirements for time and effort reporting for the Centers for Disease Control and Prevention Investigations and Technical Assistance grant.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CDFA Number and Title:	93.283 Centers for Disease Control and Prevention Investigations and Technical Assistance
Federal Award Number:	U58/CCU023317-03-3
Applicable Compliance Component:	Allowable Costs
Questioned Cost Amount:	None

Background

The State Department of Health administers the Centers for Disease Control and Prevention Investigations and Technical Assistance Program (CFDA 93.283). The program is designed to assist state and local health authorities in developing emergency-ready public health departments by upgrading, integrating and evaluating preparedness for and response to public health emergencies. The Department expended $33,465,847 for this program in fiscal year 2006.

Description of Condition

Federal requirements specify the standards expected for payroll documentation for employees whose salaries and benefits are charged to federal grants. Requirements state that if an employee works on only one federal activity, semi-annual certifications signed by the employee or a direct supervisor meet federal requirements.

We found 30 employees who charged 100 percent of their time to this grant during fiscal year 2006 did not complete semi-annual certifications.

Cause of Condition

The Department's office responsible for ensuring the certifications were completed did not know the federal requirements for time certifications.

Effect of Condition

Without adequate time and effort certifications, federal grantors cannot be assured that salaries and wages charged to their programs are accurate and valid. This could jeopardize future federal funding. We were able to determine by other methods that these staff members did work 100 percent of their time on their assigned program and we are not questioning these costs.

Recommendations

We recommend the Department:

- Require employees who work 100 percent on a single federal program or a supervior with first hand knowledge of their work to certify, in writing, their time spent working on the program on a semi-annual basis.

- Provide training to employees to ensure the requirements of Circular A-87 are met.

Department's Response

We concur with the State Auditor's Office and have already taken steps to ensure that certification and or timekeeping documentation is accurately recorded and retained.

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 2007 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-87, Cost Principles for State, Local and Indian Tribal governments provides in:

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:

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 award.

06-22 The Department of Social and Health Services, Economic Services Administration, is not in compliance with eligibility requirements for the Temporary Assistance for Needy Families Program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.558 Temporary Assistance for Needy Families
Federal Award Number:	G-0501WATANF 2005, G-0602WATANF 2006
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	$32,041

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. The Department expended $234,316,666 in federal dollars on the program in 2006.

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 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 2005 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

During the fiscal year 2005 audit, we identified 102 individuals receiving benefits who were using invalid or missing Social Security numbers. In our current audit, we determined the Department had addressed or resolved those cases. However, during our current audit, we found an additional 28 individuals with invalid or missing Social Security numbers receiving benefits. Of those, 24 had Social Security numbers that did not match Social Security Administration records, two were using Social Security numbers belonging to deceased individuals, and two received benefits without providing a Social Security number.

Cause of Condition

The Department has been taking action to correct this condition, but had not completed it at the time of our audit. We will review this area again during our fiscal year 2007 audit.

Effect of Condition and Questioned Costs

Failure to obtain and verify proper Social Security numbers may cause the Department to provide benefits to ineligible persons. This also deprives other, eligible individuals, use of those funds. We question $32,041 in benefits paid to people who were using invalid or missing Social Security numbers.

Recommendation

We recommend the Department:

- Compare Social Security numbers provided by applicants to those in records maintained by other state or federal agencies and investigate any discrepancies.

- Require employees to follow state regulations regarding Social Security numbers and investigate and resolve invalid numbers.

Department's Response

The Department concurs with the finding.

The 28 cases, reviewed by the Department, have been corrected or pended and letters issued requesting verification of information.

To ensure the field staff is adhering to policies and procedures related to obtaining the correct Social Security number (SSN) for clients at application and reviews, the Department has implemented the following requirements:

- *Developed and required State On-line Query (SOLQ) on- line training for field staff. All six regions have reported all appropriate staffs have completed this training.*

- *Required supervisors add medical cases to their monthly case audits and focus on SSN mismatched alerts. Supervisors are also required to check for consistent use of SOLQ for SSN verification.*

- *Community Services Division (CSD) Headquarters will be conducting quarterly random audits on medical cases and checking for consistent use of SOLQ at application and reviews.*

- *CSD supports the Department's Health and Recovery Services Administration's change request for an Automated Client Eligibility System hard edit at the time of medical recertification for individuals who have a SSN application pending more than 60 days.*

The Department does not concur with the questioned costs as the cases in error were reviewed, corrected, and determined eligible for benefits during the audit time frame.

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 2007 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,* 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.

Federal Findings and Questioned Costs - continued

(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.

Federal Findings and Questioned Costs - continued

06-23 The Department of Social and Health Services, Division of Child Support, is not complying with federal requirements for time and effort reporting for the Child Support Enforcement grant.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CDFA Number and Title:	93.563 Child Support Enforcement
Federal Award Number:	G0604WA4004
Applicable Compliance Component:	Allowable Costs
Questioned Cost Amount:	$23,259

Background

The Department of Social and Health Services, Division of Child Support administers the federal Child Support Enforcement Program (CFDA 93.563). The program is designed to enforce support obligations owed by non-custodial parents, to locate absent parents and to establish paternity. The Division expended $69,518,104 for this grant program in fiscal year 2006.

Federal requirements specify how employee salaries and wages charged to the grant are -to be documented. For employees who work on multiple activities or cost objectives, payroll costs charged directly to federal awards are to be supported by monthly personnel activity reports or equivalent documentation, such as time sheets. The time records are to reflect the actual hours that employees work on each program, and must account for the total activity for which each employee is compensated. These records are used as a basis for requesting federal funds. Budget estimates are allowable on an interim basis if adjustments to actual costs are made at least quarterly.

If an employee works on one federal activity, only semi-annual certifications signed by the employee or supervisory official who has direct knowledge of the work performed, are required.

The Office of Financial Management has delegated the responsibility for determining the best method for fulfilling these requirements to each state agency receiving federal money.

Description of Condition

During the 2006 audit, we found that two employees who worked on multiple grants used budgeted distributions of their time but quarterly adjustments to actual costs were not made.

We also found that the Division director signed one certification covering more than 1,100 Division employees who worked 100 percent on the grant. This did not meet federal requirements because the director was not a supervisor who had first-hand knowledge of the work of each employee.

Also, 11 employees who worked on multiple grants did not report all of their compensated time on activity reports as required. They only reported hours where their actual work varied from their budget time allocation. The exception time reporting system does not meet federal requirements because the monthly time record does not account for the total activity of the employee for the month. However, we did find quarterly adjustments based on these exception reports to actual charges against the program. Therefore, we are not questioning costs for these 11 employees.

Federal Findings and Questioned Costs - continued

Cause of Condition

DSHS federal time and effort policy requires employees who work on multiple projects or cost objectives to submit semi-annual certifications. Employees believed that if they signed these semi-annual certifications that they met the federal requirements even though monthly time records were required.

The division did not clearly understand that supervisory officials who sign semi-annual certifications must have direct knowledge of the work performed by the employee.

Additionally, employees using exception time reporting were not aware that this was not adequate to meet federal time and effort reporting requirements.

Effect of Condition and Questioned Costs

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 costs of $23,259 for two employees' overcharged payroll costs to the federal Child Support Program.

Recommendations

We recommend the Department:

- Require employees who work 100 percent on a single federal program or supervisory officials who have direct knowledge of their work completed, to certify, in writing, their time spent working on the program on a semi-annual basis.
- Revise its policy to meet federal requirements for time and effort reporting for employees who work on more than one grant program.
- Consult with the federal grantor to determine whether any questioned costs should be repaid.
- Provide training to employees to ensure these reporting requirements are met.

Department's Response

The Department agrees with the finding and the Division of Child Support (DCS) and Economic Services Administration (ESA) will take the following corrective steps:

For employees that did not report all their compensated time on activity reports, ESA Fiscal office (in conjunction with DCS) will by January 31, 2007:

- *Develop procedures, a revised time reporting form, and provide training to ensure staffs report actual time worked completely and*
- *Continue to make quarterly adjustments based on time reported.*

Federal Findings and Questioned Costs - continued

For the certification for employees that work 100% on the primary Child Support Enforcement grant, the following process changes were made in October 2006:

- *A list of employees for each field office is verified by their District Manager,*
- *Headquarters section chiefs verify staff in their units, and*
- *These lower level verifications are attached to the semi-annual certification that is signed by the DCS Division Director.*

For staff whose time was not adjusted quarterly to actual costs DCS will by January 31, 2007:

- *Establish a process to ensure that quarterly reconciliation is completed and supporting documentation maintained,*
- *Consult with the federal grantor to determine if questioned costs should be repaid, and*
- *Evaluate the staff and positions in question to determine if cost allocation models already established provides a better solution for these staff.*

Auditor 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 2007 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.3 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:

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:

Federal Findings and Questioned Costs - continued

(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.

Federal Findings and Questioned Costs - continued

06-24 The Department of Social and Health Services, Division of Child Support, does not have adequate internal controls to ensure compliance with federal reporting requirements for the federal Child Support Enforcement grant.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CDFA Number and Title:	93.563 Child Support Enforcement
Federal Award Number:	G0604WA4004
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The Department of Social and Health Services, Division of Child Support, administers the federal Child Support Enforcement Program (CFDA 93.563). The program objectives are to enforce support obligations owed by non-custodial parents, to locate absent parents, to establish paternity, and to obtain child and spousal support. The Division expended $69,518,104 for this grant program in fiscal year 2006.

Federal regulations require the Department to submit two financial reports specific to the grant: OCSE 34A, *Child Support Enforcement Program Quarterly Report of Collections*; and OCSE 396A, *Child Support Enforcement Program Quarterly Report of Expenditures and Estimates*.

Description of Condition

We found the Department had adequate internal controls over, and was in compliance with, the *Quarterly Report of Collections* (OCSE 34A) reporting requirement. However, we found the Department's internal controls were inadequate to prevent or detect significant errors in the *Quarterly Report of Expenditures and Estimates* (OCSE 396A). The Department uses a complex workbook containing various formulas to generate the expenditure information used for this report. We found that staff responsible for entering data into the workbook did not fully understand the functions of the workbook, and would not be able to detect formulaic or calculation errors, or errors resulting from incorrect input. For the OCSE 396A report dated March 31, 2006, we found current claims were under reported by $109,446.18, and prior period claim adjustments totaling $1,965.40 were not reported.

Cause of Condition

The Department placed reliance on a workbook developed several years ago and is being used by staff that do not have adequate knowledge or training on its use.

Effect of Condition

Without adequate internal controls, the Department cannot ensure accurate reporting of program activity to the Federal grantor. The Federal grantor relies on this information for making decisions about program operations and funding. Inaccurate reporting may impact the amount of Federal funding provided the State. The reporting errors identified did not result in any questioned costs.

Recommendations

We recommend the Department improve its controls over Federal financial reporting requirements to ensure accurate reporting of program activity.

Department's Response

The Department agrees with the finding and the Division of Child Support (DCS) and Economic Services Administration (ESA) will take the following corrective steps:

The ESA Fiscal office (in coordination with DCS) will be making the following changes to improve internal controls over federal financial reporting by March 30, 2007:

- *Develop an instruction workbook that is easier to understand and less error prone,*
- *Ensure the person creating the federal report is trained and fully understands the instruction workbook,*
- *Train an additional back-up person within the Fiscal Unit who can create the report,*
- *The supervisor of the Fiscal Unit will verify that the report is complete and accurate before it is entered into OLDC*
- *The supervisor of the Fiscal Unit will verify the accuracy of the report as entered into the federal On-Line Data Collection System (OLDC), and*
- *The report will be personally certified in the OLDC by the DCS Director.*

Auditor 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 2007 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable laws and Regulations

Title 45, Code of Federal Regulations, Section 301.15 Grants.

> To States with approved plans, a grant is made each quarter for expenditures under the plan for the administration of the Child Support Enforcement program. The determination as to the amount of a grant to be made to a State is based upon documents submitted by the IV-D agency containing information required under the Act and such other pertinent facts as may be found necessary.

Title 45, Code of Federal Regulations, Section 302.15 Reports and maintenance of records: The State plan shall provide that:

> (a) The IV-D agency will maintain records necessary for the proper and efficient operation of the plan, including records regarding:
>
> > (1) Applications pursuant to Sec. 302.33 for support services available under the State plan;
> > (2) Location of non-custodial parents, actions to establish paternity and obtain and enforce support, and the costs incurred in such actions;
> > (3) Amount and sources of support collections and the distribution of these collections;
> > (4) Any fees charged or paid for support enforcement services;
> > (5) Any other administrative costs;
> > (6) Any other information required by the Office; and
> > (7) Statistical, fiscal, and other records necessary for reporting and accountability required by the Secretary.

Federal Findings and Questioned Costs - continued

Title 45, Code of Federal Regulations, Section 92.20 - Standards for financial management systems.

> (a) A State must expand 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.

Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* 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.

06-25 The Department of Social and Health Services and the Department of Early Learning do not have adequate internal controls over direct payments made to child care providers.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: 93.575 Child Care and Development Block Grant
93.596 Child Care Mandatory and Matching Fund of the CCDF
Federal Award Number: G-0601WACCDF2, G-0601WACCDF3, G-0601WACCDF4
Applicable Compliance Component: Allowable Costs/Cost Principles, Activities Allowed or Unallowed
Questioned Cost Amount: $55,610

Background

The Washington Department of Early Learning administers the federal Child Care and Development program per an agreement with the Department of Social and Health Services (DSHS), the grantee. The purpose of the program is to assist eligible working families pay for child care provided by licensed and non-licensed (exempt) providers. Prior to 2006, this program was administered by DSHS, Division of Child Care and Early Learning.

During our fiscal year 2003 and 2004 audits, we reported the Department did not require all child care providers to maintain adequate documentation to support payments made for child care, such as attendance records. The Department implemented corrective action during fiscal year 2005 that required all child care providers to keep daily attendance records for all children. For the record to be considered complete, the following criteria must be present:

- Child's name
- Arrival and departure time of the child
- Full legal signature of the parent or person authorized to take the child to or from the center/home on both arrival and departure.

We have also reported in prior state accountability audits and the Fiscal Year 2005 State of Washington Single Audit report that the Department performed no monitoring of direct payments made to child care providers. Payments to providers are made through the Social Services Payment System (SSPS) maintained by DSHS. This internal control is imperative to ensure the allowability of payments. In FY06 the Department paid approximately $250 million to 1,876 Licensed Centers, 4,915 Family Home Providers, and 13,880 Exempt Providers through the Working Connections Child Care Program.

Description of Condition

The Department's lack of monitoring or reconciling payments to supporting documentation increases the risk of unallowable or unauthorized payments to providers. To test for this, we judgmentally selected and requested attendance records from 28 licensed centers and 30 licensed family home providers for the month of June 2006. We obtained SSPS payment data for the same month and attempted to reconcile the amounts paid to providers to the supporting records. By the end of our fieldwork we had received records from 44 providers. Attendance records requested were not received from 3 Family Homes and 11 Child Care Centers. Our review identified exceptions with 42 of the 44 (95%) providers tested. These exceptions fell into four general categories:

A. The provider billed the Department for days in excess of what was recorded in the attendance records. We took into consideration the Working Connections policy that allows the provider to bill for the maximum number of authorized days if the child was absent 5 or less days and was authorized for at least 22 days in the month.
B. The provider billed the Department when no records were present for a child to support any of the days paid through SSPS.
C. The child was signed in/out by the provider when the parent/guardian should have signed the child in/out.
D. Record was missing required criteria, such as a parent's signature signing their child in/out of care.

Cause of Condition

The cause of the exceptions is due to inadequate controls over direct payments to providers, a lack of monitoring by the Department, and inconsistencies in provider knowledge of when they are allowed to bill for services.

Effect of Condition and Questioned Costs

Questionable payments made to the providers are summarized below. We did not question the payments for those instances where an incomplete record was present (Type D) because we observed some evidence that the child had attended.

Licensed Centers:

Type of Exception:	Questioned Payments:
A – Days billed in excess of records	$12,259
B – No records in support of payment	$17,758
C – Child signed in/out by provider	$0
Total	**$30,017**

Licensed Family Homes:

Type of Exception:	Questioned Payments:
A – Days billed in excess of records	$7,498
B – No records in support of payment	$6,497
C – Child signed in/out by provider	$11,598
Total	**$25,593**

We cannot give an opinion as to the allowability of the payments made to those providers who failed to submit the requested documentation. We have referred these providers to the Department for follow up.

Based upon the results of our testing, we question a total of $55,610 in direct payments made to child care providers. Statewide, there are approximately 20,000 providers who participate in this program. While our testing selection was limited and based on risk criteria, the control weakness identified impacts all provider payments. This increases the risk and likelihood that additional unallowable payments have been made.

Recommendation

We recommend the Department improve internal controls to ensure child care providers:

- Adhere to Washington Administrative Code requiring the parent or custodian of each child sign the provider's attendance record when their child arrives and departs from care, noting the arrival and departure times.
- Maintain complete attendance records to support the payments they receive.
- Comply with records requests in a timely manner, as stated in the Washington Administrative Code.

We also recommend that the Department reconcile provider attendance records to payments made through SSPS to ensure grant expenditures are allowable.

We refer those providers who failed to submit attendance records to our Office to the Department for follow up.

Department's Response

The Department partially concurs with this finding:

The Washington Administrative Code (WAC) requires parents to sign their children in and out of care. The Department of Early Learning (DEL) 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 include 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.

DEL's licensing staffs monitor child care facilities on a regular schedule and write licensing compliance agreements when licensors discover providers who are not keeping adequate records. Licensors discuss attendance record requirements with the providers during orientation and routine licensing visits. DEL has developed standards and training for staff to provide information and guidelines related to attendance records, compliance agreements, and necessary follow-up. Providers who are chronically deficient in attendance keeping may be placed on a Probationary License and/or levied with Civil Penalties ($75/day for Family Home Child Care and $250/day for Child Care Centers) for each day they are out of compliance.

DEL concurs there are not adequate internal controls over support for payments made to licensed child care providers. To correct this problem, DEL continues to work with the Department of Social and Health Service's Payment Review Program to identify and collect overpayments identified through the use of algorithms.

Auditor's Concluding Remarks

We recognize that the Department performs monitoring of child care facilities and their records. The monitoring in place during the audit period did not include reconciling facility attendance records to provider payments.
We appreciate the Department's commitment to resolving the issues identified in the finding and will review the corrective action in the fiscal year 2007 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-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment A, Section C, Basic Guidelines, states in part:

Factors affecting allowability of costs.

Federal Findings and Questioned Costs - continued

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.

Washington Administrative Code 388-295-7030* states:

(1) The parent or other person authorized by the parent to take the child to or from the center must sign in the child on arrival and sign out the child at departure, using their full legal signature and writing the time of arrival and departure;

(2) When the child leaves the center to attend school or participate in 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 center; and

(3) Attendance records and invoices for state paid children must be kept on the premises for at least five years after the child leaves your care.

Washington Administrative Code 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.

Washington Administrative Code 388-290-0138 states in part:

What responsibilities does my eligible in-home/relative provider have?...

(6) Keep correct attendance records. Records must: (c) Be given to us, within fourteen consecutive calendar days, if we ask for them.

* Washington Administrative Code 388-295-7030 and 388-296-0520 were re-codified at WAC 170-295-7030 and WAC 170-296-0520 respectively and became effective July 13, 2006.

Federal Findings and Questioned Costs - continued

06-26 The Department of Social and Health Services and the Department of Early Learning do not have adequate internal controls in place to ensure only eligible clients receive federal child care subsidies.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.575 Child Care and Development Block Grant 93.596 Child Care Mandatory and Matching Fund of the CCDF
Federal Award Number:	G-0601WACCDF2, G-0601WACCDF3, G-0601WACCDF4
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	$7,368.62

Background

The Department of Early Learning administers the federal Child Care and Development program through an agreement with the Department of Social and Health Services (DSHS), which receives the money from the U.S. Department of Health and Human Services. The program is designed to assist eligible working families in paying for child care services provided by licensed and non-licensed (exempt) providers. Some program components are administered by DSHS.

DSHS Community Service Offices review client applications to determine whether a family is eligible for child care benefits. The Working Connections Automated Program is used by staff to process applications. According to management, the Department's key control over eligibility is a monthly supervisory review of 1 percent of cases at the regional level. DSHS has six Regional Community Service Division offices. During this review, supervisors document the results using a program titled Audit 99. Within Audit 99 is a guide for reviewers called the Child Care Audit Tool. According to DSHS, a "complete review" constitutes the use of this tool to ensure eligibility is properly reviewed, documented and followed-up on, if necessary, by a supervisor.

In addition to the regular monthly child care subsidy, certain exempt family-home providers can receive payment for care provided to school-age children during school holidays. This care is referred to as school holiday contingency hours. We reviewed the Department's internal controls over these payments as well.

Description of Condition

We reviewed the adequacy of Department's internal controls, including the Audit 99 program. We limited our review to the Working Connections Child Care Program because most of the federal grant expenditures were made through this program. We identified the total number of cases by month for each region and calculated a 1 percent expectation. After comparing the actual number of case reviews performed to our expectation we found that Region 4 completed only 8 percent of the reviews required. We also judgmentally selected 41 supervisor reviews from Regions 1, 2, 4, and 6 to determine if the Child Care Audit Tool was completed by the supervisor. Of the 41 cases reviewed, 32 (78 percent) of the Audit Tools were incomplete or blank.

In reviewing eligibility of clients being claimed for school holiday contingency hours, we identified the Working Connections payments made to providers when the amount was in excess of the total authorized amount and the service recipient (child) was under the age of 4. We used this criterion because most children under age 4 are not school aged and providers should not bill for their care. We found 1,259 records totaling $52,240 met this criterion. We judgmentally selected 45 payments for review and found:

- 44 activity schedules in the Working Connections Automated Program confirmed the child was not school-aged and not in school.

- 42 monthly payments made to providers included school holiday contingency hours. All 42 payments were for children who were not school aged and not attending school. These payments totaled $7,368.62.

- 11 clients were paid for school holiday contingency hours for both their normal and additional subsidy. This is unallowable because the provider should only be eligible for school holiday hours using the normal subsidy billing code.

Cause of Condition

The Department does not adequately monitor to ensure Community Service Offices are complying with the policy requiring review 1 percent of cases. In addition, monitoring is not done to ensure that exempt providers are billing only for eligible clients that were provided care on school holidays. In the current payment system, exempt providers can bill up to 70 additional hours/units for certain months with no authorization by a case worker.

Effect of Condition and Questioned Costs

By relying on the current controls, the Department does not gain reasonable assurance that providers are paid for serving only eligible clients. Based on our review of payments made to exempt providers for school holiday contingency hours, the Department does not have adequate support for payments made when the service recipient was under age 4. Therefore, although we question only $7,368.62, we have identified $52,240 in likely questioned costs related to program expenditures.

Recommendations

We recommend the Department:

- Improve program monitoring to ensure regional community service offices conduct the required 1 percent client eligibility case reviews and that those reviews are complete.
- Establish and follow controls over payments made to providers for school holiday contingency hours.
- Establish and follow a control that prohibits providers from billing for school holiday contingency hours for both the regular monthly subsidy and any additional subsidy.

Department's Response

The Department of Early Learning (DEL) is aware of the fact the 1 percent supervisory reviews have not been consistently completed by the Department of Social and Health Services' (DSHS) Community Services Division (CSD) child care supervisors. Prior to the audit, DEL and CSD were collaborating to resolve the problem. In mid-2006, DEL and CSD developed a Memorandum of Understanding, firmly establishing a process CSD will follow to

provide quarterly results to DEL regarding the findings of the 1 percent monthly audits and corrective action plans for issue resolution. The 1 percent audit requirement was re-established July 1, 2006, and DEL is monitoring the quarterly reports from CSD.

DEL and CSD are also working with information technology staff to modify the Audit 99 Program. The modification will result in the labeling of child care audits with an 'audit type', indicating whether the review is a full or partial case review. Only those labeled as full reviews will count toward the required 1 percent supervisory audit.

DEL is collaborating with DSHS's Payment Review Program (PRP) to run an algorithm to locate payments made for 'school holiday hours' for children under age 5. PRP will then establish overpayments for collection as appropriate. DEL will also mail a notification to all exempt providers clarifying the fact that school holiday hours can only be claimed for school-age children.

In addition, DEL has submitted a work request to the Social Service Payment System for an edit to the system which will prevent school holiday hour payments being made for children under 5 years of age.

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 2007 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* 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.

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....

State Plan for CCDF Services For the Period 10/1/05 – 9/30/07; Effective October 1, 2005:

Section 1.10.3 – Has your State developed strategies to identify errors in the determination of client eligibility?

> We require supervisor audits. Division data staff have the ability to conduct research for inconsistencies when needed.

06-27 The Department of Social and Health Services did not comply with federal requirements for suspension and debarment for the Social Services Block Grant.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.667 Social Services Block Grant
Federal Award Numbers:	FFY05 G-0501WASOSR, FFY06 G-0601WASOSR
Applicable Compliance Component:	Suspension and Debarment
Questioned Cost Amount:	None

Background

The Department of Social and Health Services administers the federal Social Service Block Grant (CFDA 93.667). The Department reported total SSBG expenditures of $43,872,173 for fiscal year 2006.
Funds are allocated to the states based on population. The program is designed to provide funds to states to enable them to furnish services that help individuals:

- Achieve or maintain economic self-sufficiency to prevent, reduce or eliminate dependency.
- Prevent or remedy neglect, abuse, or exploitation of children and adults unable to protect their own interests and preserve, rehabilitate or reunite families.
- Prevent or reduce inappropriate institutional care by providing for community-based care, home-based care or other forms of non-institutional care.
- Secure referral or admission to institutional care when other forms of care are not appropriate
- Provide services to individuals in institutions.

States are given wide discretion to determine services to be provided and who may be eligible for them. Additionally, states are allowed to use their allotment for staff training, administration, planning, evaluation, and technical assistance in developing or administering the programs.

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.

Federal regulations offer three options for grant recipients to verify that proposed contractors are not suspended or debarred. In addition, grant recipients must inform their sub-grantees that they are responsible for following the same suspension and debarment requirements.

Description of Condition

The Department did not comply with federal suspension and debarment requirements. We reviewed 10 provider contracts within Children's Administration. Of those, we found four, representing $1,295,218 in federal expenditures, that were not in compliance. However, we determined that the contractors in question were not currently suspended or debarred. As result, we are not questioning the costs for these contracts.

Cause of Condition

These contracts were for psychological/psychiatrist services. The Department stated it recently updated standard federal contract language to include adequate suspension and debarment language in the general terms and conditions. The Department stated psychological/psychiatrist service contracts were not updated as required due to an oversight.

Effect of Condition

When federal suspension and debarment requirements are not met, the Department could enter into contracts with parties excluded from participating in federal contracts. The Department may be liable for any amounts paid to contractors who have been suspended or debarred from receiving federal funds.

Recommendation

We recommend the Department review federal contracts in the Agency Contract Database to ensure they comply with federal suspension and debarment requirements.

Department's Response

The Department agrees with the finding. The Department will review all psychological and psychiatric contracts executed before debarment terms were revised. The Department will review each contractor's status using the Excluded Parties List System Internet Website (EPLS), printing the relevant screen for each search. The Department will date and file the EPLS information in the associated contract records. Necessary action will be taken for any contractors found to be in excluded status.

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 2007 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 76.220, 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 non-procurement transaction that is covered under Sec. 76.210, and the amount of the contract is expected to equal or exceed $25,000.

45 CFR 76.300 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.

Federal Findings and Questioned Costs - continued

45 CFR 76.330, 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 76.440 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."

Federal Findings and Questioned Costs - continued

06-28 The Department of Social and Health Services, Division of Alcohol and Substance Abuse used federal funds to pay contractors a guaranteed amount above the actual level of service being provided.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.959 Block Grant for the Prevention and Treatment of Substance Abuse
Federal Award Number:	05B1WASAPT
Applicable Compliance Component:	Allowable Costs
Questioned Cost Amount:	$78,589

Background

The Department administers a $41,218,081 Prevention and Treatment of Substance Abuse block grant. Money for the program is provided by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. The money is used to for drug and alcohol prevention, treatment and rehabilitation services.

The Division contracts to provide for these services. Division policy states that when a new drug or alcohol program is established, it may guarantee payment to cover up to 100 percent of the facility's capacity for the first 90 days of a new program, regardless of the level of service provided to program participants. Division policy and federal regulations prohibit the use of federal funds for this purpose.

Description of Condition

During our audit, we reviewed nine contracts, or 32 percent of the grant expenditures for fiscal year 2006. We found two contracts that used federal funds to make payment guarantees:

- Contract No. 0512-77992: The grant was charged $60,000 for the first month of the contract when only $30,028 in services were received. The contract guaranteed a minimum payment of $86,500 for the first two months and specified that the $60,000 of it was to be paid with grant funds. All other payments made under the contract were allowable. When we informed the Department of the unallowable cost, it repaid the grant with state funds. The total questioned costs for this transaction are $29,972 ($60,000 less $30,028 for services rendered).

- Contract No. 0512-76678: The grant was charged $48,617 to assist a contractor in converting from providing pregnancy and parenting services to providing adult care. This transition did not occur. The contract provided that $2,586 was to be paid with federal SAPT funds and $48,617 was to be paid with state funds, but this amount was charged to the grant in error. When we informed the Department of the unallowable cost, it repaid $48,617 to the grant. The total questioned costs for this transaction are $48,617.

Cause of Condition

DASA provided that there is a significant business need to obtain new providers and it is necessary to provide guaranteed payments to help cover start up costs to attract these providers to deliver critical services to our programs. The Division states an oversight led to these improper payments.

Effect of Condition and Questioned Costs

The federal grant was charged for services that were not provided. Total questioned costs are $78,589. The Department has repaid the federal grant with state funds.

Recommendations

The Department should ensure federal grant funds are used to pay only for services provided.

Department's Response

We concur with the auditor's finding and will amend future contracts to ensure payments are issued with deliverables.

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 2007 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable laws and Regulations

Title 45, Code of Federal Regulations, Section 92.22 states:

> (a) Limitation on use of funds. Grant funds may be used only for:
>
> > (1) The allowable costs of the grantees, sub-grantees and cost-type contractors, including allowable costs in the form of payments to fixed-price contractors; and
> > (2) Reasonable fees or profit to cost-type contractors but not any fee or profit (or other increment above allowable costs) to the grantee or sub-grantee.

Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Government*, Attachment A, Section C.1 and C.3 state:

C.1. Factors affecting allowability of costs. To be allowable 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 allocable to Federal awards under the provisions of this Circular….
> c. Be authorized or not prohibited under State or local laws or regulations…
> j. Be adequately documented.

C.3…A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received."

The Revised Code of Washington (RCW) 43.88.160 Fiscal management -- Powers and duties of officers and agencies…

> This section sets forth the major fiscal duties and responsibilities of officers and agencies of the executive branch. The regulations issued by the governor pursuant to this chapter shall provide for a comprehensive, orderly basis for fiscal management and control, including efficient accounting and reporting therefore, for

the executive branch of the state government and may include, in addition, such requirements as will generally promote more efficient public management in the state... 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."

DASA Policy 4.03

A cost reimbursement contract, total fee, or grant may not be extended to a for-profit sub-recipient.

DASA policy 4.06:

A Contract Manager may request that an initial contract will guarantee a level of payment for a new client service contract, other than Title XIX, in order to ensure that the program has an opportunity to recruit and train staff, establish its internal policies and procedures, and to recruit its client base...

Provider Facility Improvements and Start-up Costs...For projects in excess of $10,000 in total, the contract must include language that protects DASA's interest and ensures the long-term operation of the program. The contract will require a minimum five-year period of continued operation of the program and contracting with DASA after the improvements have been funded. If the contract is terminated for any reason before the five-year period is completed, the contractor will be required to refund 20 percent of the total funded improvement costs for every year less than five. Exceptions will require the approval by the Chief Financial Officer and the Division Director...

What is the process for starting up a new program?

A Contract Manager may request than an initial contract will guarantee a level of payment for a new client service contract, other than Title XIX, in order to ensure that the program has an opportunity to recruit and train staff, establish its internal policies and procedures, and to recruit its client base.

1. This is generally an 80 percent to 100 percent guarantee and is limited to the first 90 days after the admission of the first client. Start-up costs will not be paid using Title XIX funds.
2. Agreements for start-up must be approved by the Contract Manager's Office Chief and Chief Financial Officer or Division Director, before any contractual negotiations are made.
3. Additionally, a Contract Manager may request that certain costs necessary for starting up a new program will be covered as cost reimbursement. Again, the amount of start-up funds for setting up a new program and the scope of the items covered must be approved in advance by the Contract Manager's Office Chief, and the Chief Financial Officer, or Division Director. Examples of items that may be covered might be bedding, kitchen supplies, furniture, architectural drawings for Department of Health licensing, or initial lease payments for a residential program. There are no standards for these initial start-up costs for setting up a new program and will depend upon available State funds. Federal funds, from any source, will not be used for this type of start-up for setting up a new program.
4. Exceptions to the above will require written approval by the Division Director, or his designee, prior to the contract being submitted to the designated Contracts Staff person.

06-29 The Department of Social and Health Services, Economic Services Administration, reimbursed contractors for services that were not adequately supported.

Federal Awarding Agency:	U.S. Dept. of Agriculture
Pass-Through Entity:	None
CFDA Number and Title:	10.561 State Administrative Matching Grants for Food Stamp Program
Federal Award Numbers:	2005IS251447, 2006IS251447
Applicable Compliance Component:	Allowable Costs
Questioned Cost Amounts:	
Federal Portion:	$140,542
Local Matching Portion:	$140,542

Background

During fiscal year 2006, 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 providing these services. During 2006, $3,240,011was paid for these contracts, half by the federal State Administration Matching Grants for the Food Stamp Program (CFDA 10.561). The grant requires the Department to match, dollar for dollar, federal funds by ensuring an equal amount of local funds are spent on the program. During 2006, the total federal program expenditures were $44,200,787.

The program reimburses contractors each time they provide informational assistance to potential clients through a process known as intake contact. The contract defines intake contact as a five- to 30-minute discussion during which the contractor provides information on how to prepare an application for the program to a potential client. 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.

Contractor's billings sent to the Department must include an invoice, a summary of monthly contacts, and an on-line Basic Food Education Outreach Monthly Activity Report submitted by all contractors.

During our fiscal year 2005 audit, we questioned approximately $273,781, half of which was funded with federal dollars, because the Department did not require any supporting documentation, such as documents signed by clients acknowledging services were received.

Description of Condition

During the current audit, we found the Department made payments to two on-line sub-contractors who used the on-line billing system but did not provide adequate documentation that the contacts occurred.

Cause of Condition

The Department reported it made changes to its procedures June 1, 2006. Those changes included requiring client signatures from contractors for all applications and intake contacts. However, the Department did not have support for either intakes or applications for these two subcontractors for payments made throughout state fiscal year 2006.

Federal Findings and Questioned Costs - continued

Effect of Condition and Questioned Costs

We question $140,542 in federal dollars and $140,542 in local matching funds for payments made to two subcontractors. Conditions that allowed the 2005 condition to occur and go undetected continued through most of the fiscal year 2006.

Recommendation

We recommend the Department continue its efforts to improve contract monitoring, including requiring client signatures as support for contractor payments.

Department's Response

The Department concurs with this finding.

The auditor completed the audit in February 2006 and the Department completed the Corrective Action Plan (CAP) in April 2006. With desired implementation of the CAP effective June 1, 2006:

The Department stated in the new CAP that changes would be made effective June 1, 2006. Due to the short time frame between audit completion and CAP implementation and a large backlog of monthly monitoring for verification, June information was not available at the time of the audit for the auditor to review. This backlog has been corrected and information/verification is now being received and reviewed by the Department in a timely manner.

In June 2006, the Department began monitoring to the conditions of the new contract and the Department continues to monitor signature documentation for Outreach contracts. The new contract states: "Contractors will be required to maintain back up documentation of client intake and application assistance contacts… to contain a minimum of client name, date of birth, signature, phone number or contact information, and date of service".

The Department disagrees with the questioned costs of $140,542 in federal dollars and $140,542 in local matching funds listed in the finding for Fiscal Year 2006. Prior to the amended contract changes in June 2006, the contractors were not required to provide proof of signatures or dates of service for intake contacts. However in last years audit the Department sampled 75% of over 7,000 contacts and were able to verify that a contact or assistance occurred in each of the samples. The contractors are providing these services and should be eligible to receive payment for services provided in the contract.

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 2007 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Federal Findings and Questioned Costs - continued

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 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 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....

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.

Federal Findings and Questioned Costs - continued

06-30 The Interagency Committee for Outdoor Recreation did not comply with federal requirements for suspension and debarment for the Salmon Recovery Program.

Federal Awarding Agency: U.S. Department of Commerce
Pass-Through Entity: None
CDFA Number and Title: 11.438 Salmon Recovery
Federal Award Numbers: NA05NMF4381269, NA04NMF4380260, NA03NMF4380227, NA16FP2596, NA06FP0201
Applicable Compliance Component: Suspension and Debarment
Questioned Cost Amount: None

Background

The Interagency Committee for Outdoor Recreation administers the federal Salmon Recovery Program. The program is designed to protect or restore salmon habitat and to assist with related activities such as conservation. The Agency reported federal Salmon Recovery Program expenditures of $28,105,653. Of this, $27,245,689 was passed through to sub-grantees 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.

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 sub-grantees they are responsible for following the same suspension and debarment requirements.

Description of Condition

The Agency included a certification of suspension and debarment in the contracts but did not include a notification that the sub-grantees also have responsibilities regarding suspension and debarment when they make further awards or vendor payments.

Cause of Condition

The Agency thought the contracts contained the prescribed language regarding suspension and debarment.

Effect of Condition

Sub-grantees' lack of knowledge could make them susceptible to 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 sub-grantees to contractors who have been suspended or debarred from receiving federal funds.

Recommendations

We recommend the Agency review its contracts to ensure they comply with the suspension and debarment requirements.

Federal Findings and Questioned Costs - continued

Entity's Response

The Agency agrees with this audit finding. We believed our certification format was adequate, but we have learned the specific text was out of date. We have included new language in our contracts, which has been reviewed by the Auditor. This new language includes an expanded certification regarding suspension and debarment, and sub-contract agreements. Effective January 10, 2007 all federally funded agreements will include this certification.

Auditor Concluding Remarks

We appreciate the Agency's commitment to resolving the issues identified in the finding and will review the corrective action in the fiscal year 2007 audit. We appreciate the cooperation from Agency staff during this audit.

Applicable laws and Regulations

Title 15 of the Code of Federal Regulations (CFR), Section 26.220, 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 non-procurement transaction that is covered under Sec. 26.210, and the amount of the contract is expected to equal or exceed $25,000.

15 CFR 26.300 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), 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.

15 CFR 26.330, 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 26.440 requires a specific method he 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.

06-31 The Department of Social and Health Services is not complying with federal requirements for time and effort reporting for the federal Vocational Rehabilitation Program.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CDFA Number and Title:	84.126 Vocational Rehabilitation Grants to States
Federal Award Number:	H126A050071
Applicable Compliance Component:	Allowable Costs
Questioned Cost Amount:	$20,815

Background

The Department of Social and Health Services, Division of Vocational Rehabilitation, administers the federal Vocational Rehabilitation Program (CFDA 84.126). The program's purposes are to design, assess, plan, develop, and provide VR services for individuals with disabilities, consistent with their strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice, so that such individuals may prepare for and engage in gainful employment. The Department received $48,633,147 through this program in fiscal year 2006.

Federal requirements specify how employee salaries and wages charged to the grant are to be documented. For employees who work on multiple activities or cost objectives, payroll costs charged directly to federal awards are to be supported by monthly personnel activity reports or equivalent documentation, such as time sheets. The time records are to reflect the actual hours employees work on each program and are used as a basis for requesting federal funds. Budget estimates are allowable on an interim basis if adjustments to actual costs are made at least quarterly. If an employee works on one federal activity, only semi-annual certifications signed by the employee or a supervisor are required to meet federal requirements.

The Office of Financial Management has delegated the responsibility for determining the best method for fulfilling these requirements to each state agency receiving federal money.

Description of Condition

We have reported findings in this area for the Division for the past three years. We reported time charged to the program funds was based on budgeted percentages rather than actual amounts and that the Division was not aware of federal time and effort reporting requirements for employees who work 100 percent on a grant program.

During this year's audit, we found that six employees who worked on multiple grants used budgeted distributions of their time, but adjustments to actual costs were not made. The employees also did not complete required monthly time records.

Cause of Condition

In response to prior findings, the DSHS revised its time allocation policy. Employees who worked on multiple projects or cost objectives were required to submit semi-annual certifications under the DSHS policy. Employees believed that if they signed these semi-annual certifications that they met the federal requirements.

Although the six employees in question charged time to the Vocational Rehabilitation grant, they were not Division of Vocational Rehabilitation employees, and the division stated it did not have the authority to require time and effort documentation because of this. The division relied on other DSHS divisions to ensure that these employees met time and effort reporting requirements. The Division of Vocational Rehabilitation still has responsibilitiy to ensure all costs charged to the federal program are adequately supported in accordance with federal requirements.

Federal Findings and Questioned Costs - continued

Effect of Condition and Questioned Costs

Without adequate time and effort documentation, federal grantors cannot be assured that salaries and benefits charged to programs are accurate and valid. This could jeopardize future federal funding to the state. We are questioning costs of $20,815.

Recommendations

We recommend the Department:

- Consult with the federal grantor to determine whether questioned costs should be repaid.
- Revise its policy with to meet federal requirements for time and effort reporting for employees who work on more than one grant program.
- Further the policy should require employees who work for more than one division, to submit a copy of their monthly time and effort records to all federal programs so that each division can have effective control over payroll costs charged to its federal programs.
- Provide training to employees to ensure these reporting requirements are met.

Department's Response

The Department agrees with the finding.

The past time certifications have been completed but without adequate time and effort documentation. While the Department understands its responsibility to ensure all costs charged to the federal program are adequately supported in accordance with federal requirements, fiscal staff have not been successful getting the required documentation from programs outside the Department's Division of Vocational Rehabilitation (DVR).

DVR will work with the program(s) which own the position. The owning of a position has been clarified recently for positions that are split between/among programs, the program identified in the HRMS org unit will be responsible for completing the certification. It will be the responsibility of the identified program to update the Personnel Action Request form with the data obtained from the Personnel Activity records on a quarterly basis. This will allow the costs associated with these positions to be charged correctly to the various federal funding sources.

The Department agrees that training should and will be provided later this year to its administrations on the recordkeeping and cost allocation for positions that are coded to multiple programs.

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 2007 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Federal Findings and Questioned Costs - continued

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.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:

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.

Federal Findings and Questioned Costs - continued

06 – 32 The Department of Social and Health Services, Division of Disability Determination Services received reimbursement for unallowable costs for the Social Security Disability Insurance Programs.

Federal Awarding Agency:	U.S. Social Security Administration
Pass-Through Entity:	None
CFDA Number and Title:	96.001 Social Security-Disability Insurance 96.006 Supplemental Security Income
Federal Award Number:	4-0604WAD100
Applicable Compliance Component:	Allowable Costs
Questioned Cost Amount:	$62,931.38

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. State agencies make initial disability determinations for the federal government, which pays the agencies for making the determinations. During fiscal year 2006, the Division spent $33,361,519 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. Washington has minimum standards for documentation to support expenditures.

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 unit to investigate cases of possible disability fraud. The agreement names specific allowed costs for the Patrol and states the Division will reimburse the Patrol only for those costs. The agreement does not include any provision for indirect costs.

We reported this issue as a finding in the 2005 Statewide Single Audit. We questioned $76,021 in payments made under this contract for unallowable indirect costs and payments made without adequate support.

During the current audit, we reviewed a summary of costs paid to the Patrol for July 2005 through March 2006, which included payment of $62,931.38 in indirect costs to the Patrol. These payments were unallowable under terms of the agreement and federal and state regulations.

Cause of Condition

The Division did not adequately review the transaction and the memorandum of understanding to determine which costs were allowable.

Effect of Condition and Questioned Costs

The Division was paid $62,931.38 in unallowable costs. We are questioning these costs.

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 reimburse the federal grantor for these amounts.

Department's Response

During State Fiscal Year 2006, the Division of Disability Determination Services (DDS) was operating under a Memorandum of Understanding (MOU) between Social Security Administration (SSA), the Office of Inspector General (OIG), the Washington State Patrol (WSP) and DDS that was dated October 2004. This MOU did not have any written provisions for paying WSP indirect costs.

Per our State Fiscal Year 2005 corrective action plan, the Division was to incorporate language that includes the payment of indirect costs in the next revision of the MOU expected to be issued and signed October 2006. However, due to the number of appointing authorities required to sign this document and geographical dispersion, the MOU has not been signed by all parties.

The Division fully expects that the MOU will have all required signatures by February 2007

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 2007 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 sub-grantees must meet the following standards:
>
> > (5) Allowable cost. Applicable OMB cost principles, SSA program regulations, and the terms of grant and sub-grant 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 sub-grant award documents, etc.

Federal Findings and Questioned Costs - continued

The Office of Financial Management's State Administrative and Accounting Manual lists the following accounting and control requirements for State Agencies in Section 85.32.10:

> 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.

Federal Findings and Questioned Costs - continued

06-33 The Department of Social and Health Services, Division of Disability Determination Services charged unallowable costs to Social Security Disability Insurance Programs.

Federal Awarding Agency:	U.S. Social Security Administration
Pass-Through Entity:	None
CFDA Number and Title:	96.001 Social Security Disability Insurance 96.006 Supplemental Security Income
Federal Award Number:	4-0604WADI00
Applicable Compliance Component:	Allowable Costs
Questioned Cost Amount:	$10,520

Background

The state Department of Social and Health Services, Division of Disability Determination Services administers the Social Security Disability Insurance and the Supplemental Security Income programs. The disability insurance program was established to provide benefits to disabled wage earners and their families should the wage earner become disabled. The supplemental security income program provides benefits to financially needy individuals who are aged, blind or disabled. These programs are funded by the U.S. Social Security Administration. During fiscal year 2006, the Division spent $33,360,715 in federal funds to determine claimants' medical eligibility for disability benefits.

The disability process begins when an applicant completes a claim for benefits. The claim is forwarded to the Department for a medical determination of disability. In addition to making disability determinations for claimants under Social Security Administration programs, the Department also performs disability determinations for individuals applying for assistance under Medicaid Title XIX. Medicaid is not funded by the Social Security Administration.

The cost of making disability determinations is shared by the Social Security Administration and Medicaid programs. The Department and the Social Security Administration have entered into an agreement that stipulates how costs are to be charged to each grant.

Description of Condition

In reviewing charges to the grant, we found the Department used an incorrect percentage to allocate shared costs. In September 2006, the Division had identified an error that affected the percentages used from January 2006 through August 2006, but did not adjust its billing.

Cause of Condition

The Department stated it did not determine the amount of the error or adjust the billing because staff assumed the error was minimal.

Effect of Condition and Questioned Costs

The Department charged the Social Security Administration $10,520 in unallowable costs. We are questioning these costs.

Recommendations

We recommend the Department

- Return the unallowable reimbursements to Social Security Administration.
- Strengthen internal controls to ensure accurate calculations.

Department's Response

The Department agrees with this finding.

The Division of Disability Determinations Fiscal Unit staff use an Excel spreadsheet to calculate monthly the rate of non-grant/Medicaid only cases that will be charged in the cost allocation system the following month. The spreadsheet is used to determine the amount of administrative cost to be charged to the Social Security Administration and the amount to be charged to Medicaid. The spreadsheet contained a formula error that carried forward for the next six months. The formula error caused the rate to be off by a thousandth of a percentage. The formula error in the spreadsheet was noticed and corrected in September 2006. Based on our calculations, the Division overcharged the Social Security Administration $10,520 over the six month period that the formula error went undetected. The Division will contact SSA to determine if repayment is necessary.

Auditor 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 2007 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-87, *Cost Principles for State, Local and Indian Tribal Governments*, states:

Attachment A, Section C

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:…

   b. Be allocable to Federal awards under the provisions of this Circular.

3. Allocable costs.

   a. A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received.

Federal Findings and Questioned Costs - continued

The Memorandum of Understanding between the U.S. Social Security Administration and the State of Washington Department of Social and Health Services provides:

Section E. Determination of Costs

On a monthly basis, the total cost for processing the Title XIX workload will be determined by both actual charges for such items as postage, medical evidence and claimant travel, and by using the cumulative shared costs method for other cost items

1. Direct Costs
   a. Those items that can be actually charged to individual Title XIX cases:
      i. Purchased Medical Evidence of Record
      Ii. Consultative Examinations/Testing
      iii .Applicant Travel
      iv. Interpreter Service, if required
      v. Postage
   b. The cost of purchased evidence will be charged as incurred directly to the Medicaid program.

2. Shared Costs:
   a. To arrive at total shared costs, the cost of the services listed under direct charges for Medicaid will be subtracted from DDS total costs.
   b. The remaining costs will be computed using the following formula:

$$\text{Medicaid \%} = \frac{\text{The Number of Medicaid Cases}}{\text{Total Number of SSA, Purified Cases + Medicaid Cases}}$$

   c. The Medicaid percentage will be applied to the total shared costs for the period to arrive at Medicaid's cumulative shared cost obligation for the period. . .

Federal Findings and Questioned Costs - continued

06-34 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.

Federal Awarding Agency:	U.S. Social Security Administration
Pass-Through Entity:	None
CFDA Number and Title:	96.001 Social Security Disability Insurance 96.006 Supplemental Security Income
Federal Award Number:	4-0604WADI00
Applicable Compliance Component:	Procurement
Questioned Cost Amount:	None

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 2006, the Division spent $33,360,715 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 2006, the Division spent $6,077,258 for consultative evaluations.

During our state fiscal year 2005 audit, the Department received a finding because the Division did not follow state competitive procurement processes applicable to personal service contracts. The Division disagreed with the finding, stating it believed the services were considered client services, which are exempt from competitive procurement requirements. The Office of Financial Management was consulted regarding the proper classification for these services, and subsequently determined that the services provided to claimants by physicians, psychologists, and psychiatrists are in fact, to be classified as personal services and therefore subject to competitive procurement procedures.

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.

Federal Findings and Questioned Costs - continued

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 written contracts existed for any of these services.

Cause of Condition

The Department did not change its contracting practices pending a formal determination from the Office of Financial Management on the proper classification of the services in question. The determination was made at the end of Fiscal Year 2006, so any contracts let for 2006 were still not in compliance with Personal Service Contracting Rules. The department has changed its contracting for consultative evaluations effective for State Fiscal Year 2007.

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 $6 million in services is purchased without written contracts and terms.

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 practitioners.

Department's Response

The Department agrees with the finding.

The Division of Disability Determinations Services obtains the services of medical providers to perform medical and psychological evaluations that assist with disability determinations of claimants who apply for Social Security Disability payments. During State Fiscal Year 2005, the Division received a finding for not competitively procuring for these services and not contracting with these providers.

Federal Findings and Questioned Costs - continued

As a result of the 2005 finding, the Division received a decision from the Washington State Office of Financial Management (OFM) in April 2006 regarding whether a contract with a medical provider who examines disability claimants would be considered a personal service contract or a client service contract. OFM determined that these types of contracts were personal service contracts. As we indicated in our corrective action plan for the 2005 finding, the Division is in the process of developing a personal service contract for our medical providers. Our goal is to develop and implement the new contracts by October 2007. Once implemented, the Division will have all medical providers who examine disability claimants under contract.

The Division has received guidance from and will work with the Department's Central Contract Services to meet the competitive procurement requirements for personal service contracts as defined by OFM.

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 2007 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;

Federal Findings and Questioned Costs - concluded

(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 provided 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.