

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs

07-01 The Department of Natural Resources did not comply with federal requirements for payroll costs charged directly to the Cooperative Forestry Assistance grant.

Federal Awarding Agency:	U.S. Department of Agriculture, Forest Service
Pass-Through Entity:	None
CFDA Number and Title:	10.664 Cooperative Forestry Assistance
Federal Award Number:	2006-DG-11062764-599
Applicable Compliance Component:	Allowable Costs/Cost Principles
Questioned Cost Amount:	\$234,527.48

Background

The federal Cooperative Forestry Assistance grant (CFDA 10.664) is administered by the Resource Protection Division of the Department of Natural Resources. Grant funds may be used to assist the State Forester or equivalent agencies in forest stewardship programs on private, state, local, and other nonfederal forest and rural lands. The grant program is designed to assist in forest resources management; to encourage the production of timber; to control of insects and diseases affecting trees and forests; to control of rural fires; to efficiently use wood and wood residues, including the recycling of wood fiber; to improve and maintain fish and wildlife habitat; and to plan and conduct urban and community forestry programs. The Department spent \$3,813,159 in grant funds in fiscal year 2007.

Federal regulations specify the documentation that must be kept to support employee compensation charged to federal grants. Requirements state that for employees who work on multiple programs or cost objectives, payroll costs charged directly to federal grants must be supported by personnel activity reports or equivalent documentation, such as timesheets. These reports must:

- Reflect an after-the-fact distribution of the actual activity of each employee.
- Account for the total activity for which each employee is compensated.
- Be prepared at least monthly and coincide with one or more pay periods.
- Be signed by the employee.

Budget estimates as a basis for payroll charges are allowable on an interim basis if adjustments to actual costs are made at least quarterly. If an employee works solely on only one federal activity or cost objective, detailed activity reports are not required. Instead, federal regulations allow the employee to certify, semi-annually, that he or she worked solely on that program or cost objective. Closely related programs with differing funding sources may be deemed a single cost objective, and therefore are subject only to the semi-annual certifications. This designation, however, must be applied for and approved by the federal grantor. The Department has not applied for approval for this designation for any of its programs. The federal requirements are detailed in the federal Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Tribal Governments*.

Description of Condition

We determined the Department did not comply with federal requirements for direct payroll charges. The Resource Protection Division administers a number of closely related federal and state programs. The work performed by administrative personnel support multiple programs and objectives.

Payroll costs for eleven employees were allocated to programs based on percentages provided by Resource Protection Division management. These allocations were not supported by approved time samples or cost allocation methods, nor were they reconciled to actual time spent on the various programs. We are questioning costs of \$234,527.48 charged to the Cooperative Forestry Assistance Grant.

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Payroll costs attributed to the Cooperative Forestry Assistance Grant are split between the Cooperative Forestry Assistance Grant and the Forest Health Protection Grant based on a budgeted percentage. Two employees charge a portion of their time on a 50/50 split between the Cooperative Forestry Assistance Grant and the Forest Health Protection. In addition, five employees charge their time in part on a budget basis in which the time and effort records are not maintained and the remainder of their time is charged on a 50/50 split between the Cooperative Forestry Assistance Grant and the Forest Health Protection grant. While these programs are very closely related, the federal grantors have not determined they are a single cost objective. We are questioning costs of \$50,130.97 for these employees.

Three employees time was incorrectly charged to the Cooperative Forestry Assistance Grant due to a data entry error. We are questioning costs of \$899.61 for these employees.

Cause of Condition

Resource Protection Division management responsible for allocating payroll costs to the grant did not understand the requirements of Circular A-87. The Department did not have adequate internal controls to ensure compliance with federal 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 Department.

We identified \$234,527.48 in direct payroll charges to the Cooperative Forestry Assistance grant that were not supported in accordance with federal requirements. We are questioning those costs as unallowable charges for salaries and benefits.

The conditions noted affect a number of other federal programs at the Department. We will review those programs to determine if questioned costs are associated with those programs.

Recommendations

We recommend Department review Circular A-87 to gain an understanding of the federal requirements for documentation of direct payroll charges to grants. Policies and procedures should be established and followed to ensure payroll charges are adequately supported. Additionally, the Resource and Protection Division should assess its administrative payroll costs to determine if these costs should be allocated using an indirect cost rate as described in Circular A-87, Attachment E. The Department should consult with its federal grantor to determine the most appropriate method for charging these costs to federal grants.

We further recommend the Department reconcile the payroll costs it charged to the Cooperative Forestry Assistance grant to actual time worked on the grant to determine the amount that should have been charged to the grant. The Department should then consult with its federal grantor to determine whether any questioned costs should be repaid.

Department's Response

The lion's share of expenses charged to federal grants administered by DNR are direct payroll expenses charged to specific grants. DNR is in compliance with federal requirements for these types of charges. The auditors expressed concerns over specific cases in which time was charged to grants on budget allocations.

Schedule of Findings and Questioned Costs

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Federal Findings and Questioned Costs - continued

These cases involved charging time to different grants with program objectives that were very similar. In some cases the work between grants was indistinguishable, and time charged was split evenly between two funding sources. In other cases, the effort and cost to reconcile actual work to the budgeted allocations would exceed any possible benefit from avoiding a potential miscoding to a particular grant. In both of these situations our grantor was aware of our processes and had given their verbal approval.

We have discussed this issue with our grantor and will work with them to ensure that our process meets with their approval, and that the approval for the process is documented in writing.

In addition to the steps we are taking on these specific findings I have directed the formation of a DNR federal grant oversight committee. This group will be comprised of representatives of all agency programs involved in federal grant administration, and will work to ensure that we are fully compliant with the guidelines for all federal grants.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

The Federal criteria for the determination of costs for states is U.S. Office of Management and Budget's Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*.

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 reasonable 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

Schedule of Findings and Questioned Costs

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Federal Findings and Questioned Costs - continued

- (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.

Attachment B, Section 8(d) of the Circular states in part:
Fringe benefits.

- (2) The cost of fringe benefits in the form of regular compensation paid to employees during periods of authorized absences from the job, such as for annual leave, sick leave, holidays, court leave, military leave, and other similar benefits, are allowable if:(b) the costs are equitably allocated to all related activities, including Federal awards;.....

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-02 The Recreation and Conservation Office does not have adequate internal controls over sub-recipient monitoring.

Federal Awarding Agency: U.S. Department of Commerce
Pass-Through Entity: Washington State Recreation and Conservation Office
CFDA Number and Title: 11.438 Pacific Coast Salmon Recovery
Federal Award Number: NA06FP0201, NA16FP2596, NA03NMF4380227, NA04NMF4380260, NA05NMF4381269, and NA06NMF4380091
Applicable Compliance Component: Subrecipient Monitoring
Questioned Cost Amount: None

Background

The Recreation and Conservation Office receives federal grants from the U.S. Department of Commerce for salmon recovery efforts. Approximately 97 percent of these funds are passed through the Office to sub-recipients. Eligible sub-recipients include cities and towns, counties, state agencies, special-purpose districts, non-profit organizations, Indian tribes and private landowners. Federal regulations require the Office to monitor sub-recipients to ensure they are complying with grant requirements.

Description of Condition

We reviewed the Office's internal controls over the Pacific Coast Salmon Recovery grant funds and determined the Office did not have adequate internal controls over sub-recipient monitoring. We found:

Allowable costs/cost principles

Pass-through entities are to provide reasonable assurance that the costs of goods and services charged to federal awards are allowable and charged in accordance with the applicable regulations. While the Office reviews sub-recipients' costs for allowability prior to reimbursement, the Office does not require supporting documentation such as receipts, invoices or timesheets. We also found compensating controls were not operating as designed: inspections of sub-recipient project sites are not regularly documented and the Office does not review sub-recipient financial records. The Office also does not conduct risk assessments of subrecipients prior to funding to determine the appropriate level of monitoring.

Earmarking

Up to one percent of grant funds may be used for administrative costs related to the grant. Pass-through entities are to provide reasonable assurance that only allowable costs which are properly calculated and valued are included in these administrative costs. We reviewed grant No. NA06FP0201, and could not determine whether these requirements were met due to the inadequacy of supporting documentation.

Audit requirement

Pass-through entities should perform procedures to provide reasonable assurance that sub-recipients obtain required audits and take appropriate corrective action on audit findings. The Office does not sufficiently monitor or communicate with subrecipients who have not complied with the federal Office of Management and Budget A-133 audit requirements.

Cause of Condition

Allowable costs/cost principles

The Office believed the documentation it receives on sub-recipient costs was sufficient evidence of allowability. In addition, the compensating controls the Office has in place are not operating as designed, and therefore cannot be relied upon. The Office cannot ensure that costs reimbursed to subrecipients are accurate or allowable.

Schedule of Findings and Questioned Costs

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Federal Findings and Questioned Costs - continued

Earmarking

The Office's internal controls were inadequate to ensure goods and services charged to federal awards were allowable in accordance with applicable cost principles.

Audit requirement

The Office's policies and procedures over monitoring subrecipients' compliance with federal audit requirements do not address what the Office will do if a sub-recipient does not comply with the requirements.

Effect of Condition

Allowable costs/cost principles

The Office spent approximately \$28 million of Pacific Coast Salmon Recovery grant funds in fiscal year 2007. Due to the lack of supporting documentation, it was not possible to determine if these costs were allowable. Although certain types of costs would be allowable, the Office requires only a check number or the term "payroll" as documentation for reimbursement. Also, because the Office distributes grant money to non-profits, tribes and private landowners who are not required to have an audit unless their federal expenditures are more than \$500,000, the risk of non-compliance is increased. In calendar year 2006, the Office provided federal funding to at least 25 subrecipients who were not required to have an audit.

Earmarking

Without appropriate internal controls designed to ensure only allowable costs are reimbursed, the Office is not able to ensure federal funds are being used appropriately. The Office cannot ensure that sub-recipients have not exceeded the 1 percent earmark for administrative costs.

Audit requirement

The federal audit requirement is designed to ensure federal funds are spent appropriately. The Office is to ensure all sub-recipients comply with this audit requirement. A lack of monitoring, particularly over delinquent audit reports, increases the risk that federal funds are being spent inappropriately. During the fiscal year 2007 audit, we found:

- The Office reimbursed \$111,050 in federal funds during fiscal year 2007 to a sub-recipient that was not in compliance with the federal audit requirement for fiscal year 2005.
- Two sub-recipients had audits completed, but did not remit their audit reports to the Office. The audit reports were found by the auditor after searching a federal audit report database. One of these audits had a finding related to the salmon recovery grant.
- The Office did not request audit information from one sub-recipient in 2004, 2005 or 2006 due to an administrative error. The subrecipient was in compliance with the audit requirement and had no findings during this time period.

Recommendations

Allowable costs/cost principals

We recommend the Office establish and follow policies and procedures to effectively monitor sub-recipients' use of federal funds. The Office should require supporting documentation such as receipts and invoices, or should establish adequate compensating controls such as documented site inspections, risk assessments of potential subrecipients prior to funding, and/or random audits of sub-recipients' financial records.

Earmarking

We recommend the Office establish and follow adequate policies and procedures to address and monitor grant earmarks.

Schedule of Findings and Questioned Costs

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Federal Findings and Questioned Costs - continued

Audit requirement

We recommend the Office modify existing policies and procedures to include actions to take in the event of sub-recipient non-compliance with audit requirements. The Office should continue to communicate with sub-recipients until their audits have been completed and should take progressive action, such as ceasing reimbursement payments to the sub-recipients, to help ensure compliance.

Office's Response

While we do not completely agree with this audit finding, we accept it. We believed the internal controls we had in place for sub-recipient monitoring were adequate but we thank the State Auditor for their suggestions on how we can improve our process.

Allowable costs/cost principles

Before our next funding round in late 2008, we will conduct a financial risk assessment of any new sponsor and for existing sponsors based on prior performance, A-133 audits and other relevant issues. This risk assessment will guide us in our sampling pool for further audit review and with the addition of new staff, we will be able to perform further audit review in the form of detailed desk reviews of sponsor billings to include receipts, invoices, timesheets and financial records. We will also be performing random site visits for sub-recipient monitoring and ensuring that site inspections are adequately documented with a final report in our grant-tracking system, Prism and the project file.

Earmarking

We do not agree that our internal controls were inadequate for tracking the one percent limitation on grant funds used for administrative costs related to the grant. We charged 1% administration for our agency, there were no administrative charges included from our sponsors. This earmark, defined by the MOU dated May 1, 2000 was followed.

Audit requirement

We are revising our current policy regarding A-133 audits to include steps we will take to ensure we receive the report. If an audit report is not provided in accordance with OMB Circular A-133 or an extension granted, one or more of the following sanctions will be imposed to include no new agreements, no new amendments or no processing of any reimbursement request.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws & Regulations

OMB 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.

Schedule of Findings and Questioned Costs

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Federal Findings and Questioned Costs - continued

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, outlines responsibilities for pass-through entities receiving federal funds and states in part:

Subsection D – Federal Agencies and Pass-Through Entities

400(d) Pass-through entity responsibilities:

A pass-through entity shall perform the following for the Federal awards it makes:

- (1) Identify Federal awards made by informing each subrecipient of CFDA title and number, award name and number, award year, if the award is R&D, and name of Federal agency. When some of this information is not available, the pass-through entity shall provide the best information available to describe the Federal award.
- (2) Advise subrecipients of requirements imposed on them by Federal laws, regulations, and the provisions of contracts or grant agreements as well as any supplemental requirements imposed by the passthrough entity.
- (3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and those performance goals are achieved.
- (4) Ensure that subrecipients expending \$300,000 (\$500,000 for fiscal years ending after December 31, 2003) or more in Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.
- (5) Issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.
- (6) Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.
- (7) Require each subrecipient to permit the pass-through entity and auditors to have access to the records and financial statements as necessary for the pass-through entity to comply with this part.

Subsection B – Audits

210(a) General:

An auditee may be a recipient, a subrecipient, and a vendor. Federal awards expended as a recipient or a subrecipient would be subject to audit under this part. The payments received for goods or services provided as a vendor would not be considered Federal awards.

Schedule of Findings and Questioned Costs

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Federal Findings and Questioned Costs - continued

07-03 The Department of Natural Resources did not have adequate internal controls to ensure compliance with federal matching requirements for the Cooperative Endangered Species Conservation Fund grant.

Federal Awarding Agency: U.S. Department of the Interior, Fish and Wildlife Service
Pass-Through Entity: None
CFDA Number and Title: 15.615 Cooperative Endangered Species Conservation Fund
Federal Award Number: Many individual grants
Applicable Compliance Component: Matching
Questioned Cost Amount: None

Background

The federal Cooperative Endangered Species Conservation Fund grant (CFDA 15.615), administered by the Asset Management Division of the Department of Natural Resources, to provide project grants for the purpose of assisting in the conservation of endangered and threatened species. The assistance can include animal, plant and habitat surveys; research; planning; monitoring; habitat protection, restoration, management, and acquisition; and public education.

Three types of grants are available through the Cooperative Endangered Species Conservation Fund:

- Recovery Land Acquisition Grants - provide funds for acquisition of habitat for and recovery of endangered and threatened species by supporting approved recovery plans.
- Habitat Conservation Planning Assistance Grants - provide funds for the development of Habitat Conservation Plans
- Habitat Conservation Plan Land Acquisition Grants - provide funds to acquire land associated with previously approved Habitat Conservation Plans

In addition to the Cooperative Endangered Species Conservation Fund grant, the Asset Management Division at the Department administers the federally funded Forest Legacy grant.

Federal requirements specify that DNR must provide a match for all federal dollars received:

- States and Territories must contribute a minimum non-Federal match of 25% for the estimated program costs of approved projects, or 10% when two or more States or Territories implement a joint project.
- States may receive up to 75 percent of the program costs. When two or more States have a common interest in one or more endangered or threatened species and enter into a joining agreement, the Federal share may be 90 percent. (CFDA 15.615)

Description of Condition

We determined the Department of Natural Resources, Asset Management Division, did not comply with federal requirements for matching. We reviewed match documentation for the Cooperative Endangered Species Conservation grants and identified the Department has not adequately met its matching requirement for four grants. We are not questioning the costs rather we are documenting internal control weaknesses over matching with the Cooperative Endangered Species Conservation grant.

Cause of Condition

The Asset Management Division management responsible for providing matching funds to the grant has not adequately provided such to the federal government for four grants. The Asset Management Division and DNR as an entity do not understand the matching requirements for this grant.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Effect of Condition and Questioned Costs

Without adequate matching funds and timely submittal of such matching funds to the federal grantors future federal funding to the Department could be jeopardized.

We identified four grants that the Department has not met match requirements in accordance with federal requirements. We are writing a finding over internal control weakness in this area.

DNR was required to provide match for four grants at time of grant closeout. To date, three grants have been in closeout status nearly a year and the fourth grant has been in closeout status since July 2007.

A letter to DNR from the United States Department of the Interior, Fish and Wildlife Service, dated October 18, 2007 states the following:

“If resolution cannot be reached within the next 30 days the Service will impose sanctions which will include withholding cash payments, denying use of Federal funds and matching credit for all or part of the cost of each project, and withholding further awards for the program until the required reports are received.”

Recommendations

We recommend the Department of Natural Resources' Asset Management Division review Circular A-133 as well as specific grant regulations to gain an understanding of the federal requirements for match to grants. Policies and procedures should be established and followed to ensure match funds are adequately obtained and provided.

Department's Response

The Description of Condition states, “---it has been unable to satisfactorily document the land valuation and use in accordance with federal requirements.” The department has been working with the Federal Services for over a year in an attempt to get clear direction on our proposed match properties. There have been differing interpretations and a moving target during that time on the use of Yellow Book standards for both acquired and match properties, time of appraisals and division of match properties for several grants.

With the confusing and sometimes conflicting responses from the Federal Services we were not able to reach finality on the non-federal match. In an effort to meet the requirements of these grants we met with U.S. Fish and Wildlife Service to address concerns of five specific grants, including Phases I, II, and III of the Hoh River Conservation Corridor Project. We reached agreement on November 16th regarding several issues which will allow us to close several grants. The matching requirements for these grants are projected to be completed by January 31, 2008. Additionally, we have been actively involved in reviewing new Draft Guidelines proposed by U.S. Fish and Wildlife Service which should resolve much of the ambiguity in administration of Section 6 grants.

In addition to the steps we are taking on these specific findings I have directed the formation of a DNR federal grant oversight committee. This group will be comprised of representatives of all agency programs involved in federal grant administration, and will work to ensure that we are fully compliant with the guidelines for all federal grants.

Auditor's Concluding Remarks

We appreciate the steps the Department has taken to resolve this issue, and thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

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Federal Findings and Questioned Costs - continued

Applicable Laws and Regulations

Circular A-133 Supplement states:

The specific requirements for matching, level of effort, and earmarking are unique to each Federal program and are found in the laws, regulations, and the provisions of contract or grant agreements pertaining to the program.

However, for matching, the A-102 Common Rule (§____.24) and OMB Circular A-110 (§____.23) provide detailed criteria for acceptable costs and contributions. The following is a list of the basic criteria for acceptable matching:

- Are verifiable from the non-Federal entity's records.
- Are not included as contributions for any other federally assisted project or program, unless specifically allowed by Federal program laws and regulations.
- Are necessary and reasonable for proper and efficient accomplishment of project or program objectives.
- Are allowed under the applicable cost principles.
- Are not paid by the Federal Government under another award, except where authorized by Federal statute to be allowable for cost sharing or matching.
- Are provided for in the approved budget when required by the Federal awarding agency.

- Conform to other applicable provisions of the A-102 Common Rule and OMB Circular A-110 and the laws, regulations, and provisions of contract or grant agreements applicable to the program.

Matching or cost sharing includes requirements to provide contributions (usually non-Federal) of a specified amount or percentage to match Federal awards. Matching may be in the form of allowable costs incurred or in-kind contributions (including third-party in-kind contributions).

The Catalog of Federal Domestic Assistance description provides the following guidance for matching requirements pertinent to CFDA 15.615:

States may receive up to 75 percent of the program costs. When two or more States have a common interest in one or more endangered or threatened species and enter into a joint agreement, the Federal share may be 90 percent.

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Federal Findings and Questioned Costs - continued

07-04 The Department of Natural Resources did not have adequate controls to comply with federal requirements for subrecipient monitoring in the Cooperative Endangered Species Conservation Fund grant.

Federal Awarding Agency: U.S. Department of the Interior, Fish and Wildlife Service
Pass-Through Entity: None
CFDA Number and Title: 15.615 Cooperative Endangered Species Conservation Fund
Federal Award Number: Multiple awards
Applicable Compliance Component: Subrecipient Monitoring
Questioned Cost Amount: None

Background

The federal Cooperative Endangered Species Conservation Fund grant (CFDA 15.615), is administered by the Asset Management Division of the Department of Natural Resources to provide money to assist in the conservation of endangered and threatened species. The assistance can include animal, plant and habitat surveys; research; planning; monitoring; habitat protection, restoration, management, and acquisition; and public education. The Department spent \$6,953,763 in grant funds during fiscal year 2007.

The Department provided \$1.4 million in federal grant funds to purchase an easement for wildlife conservation. The purchase contract required the Department to submit \$1.4 million in federal grant funds into closing, at which time the property would be deeded from the seller to a Land Trust. The Land Trust was then to grant a Conservation Easement to the Department. The contract identified the Land Trust as a subrecipient of the Department, stating the Land Trust would be accountable to the Department for the use of the funds provided.

Federal regulations require grant recipients who pass federal assistance through to sub-recipients ensure those sub-recipients are aware of and comply with all grant requirements. Pass-through entities must also ensure that sub-recipients receiving \$500,000 or more in federal assistance in a fiscal year are audited for compliance with federal requirements. Assistance passed-through must also be reported as such on the Schedule of Expenditures of Federal Awards (SEFA).

Description of Condition

We found the Department did not comply with all sub-recipient monitoring requirements. Although federal regulations and the contract language identify the Land Trust as a sub-recipient, the Department treated the Land Trust as a vendor and did not properly monitor or report the amount of federal assistance passed through to the Land Trust on the SEFA. The Department did not have controls in place to ensure the sub-recipient obtained a federal compliance audit as required. We were able to determine the Land Trust had such an audit, however the Department was unaware of this and had not obtained the audit report.

During our review, we identified one similar transaction, totaling \$2,937,685 in federal expenditures. We determined that, again, the Department incorrectly treated sub-recipients as vendors and did not comply with sub-recipient monitoring or reporting requirements.

Cause of Condition

Since the subrecipient was provided property purchased with federal funds, and not the actual funds, the Department did not recognize the transaction as a federal award subject to subrecipient monitoring requirements.

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Federal Findings and Questioned Costs - continued

Effect of Condition

By not accurately identifying and monitoring sub-recipients, the Department cannot ensure compliance with federal requirements or accurate reporting of federal assistance. This could jeopardize future federal funding to the Department.

The activities involved in these transactions were allowable per the grant, and so we are not questioning any costs.

Recommendations

We recommend the Department establish and follow communication and monitoring procedures to ensure sub-recipients are accurately identified by all Divisions responsible for federal compliance.

Department's Response

This type of transaction represents a unique case in which the land trusts are classified as subrecipients by virtue of receiving real property rather than the receipt of federal funds for them to expend. The actual expenditure of the federal funds was made by the department and was not called into question by the auditor.

In the case of other grants in which the department passes through federal funds for expenditure by the subrecipients, the department has demonstrated a clear understanding of our responsibilities for subrecipient monitoring. Although the land trust subrecipients do not actually expend federal funds, we now understand that our responsibility for monitoring also extends to them.

In August we identified three land trusts for which the grant period had ended and sent letters reminding them of the audit requirements in OMB Circular A-133. We have received audit reports from two of those land trusts. The third land trust is currently undergoing an audit and will forward the results to us upon completion.

Additionally, we have added language to the cooperative agreement to ensure that in future transactions the audit requirements are more clearly articulated to subrecipients.

In addition to the steps we are taking on these specific findings I have directed the formation of a DNR federal grant oversight committee. This group will be comprised of representatives of all agency programs involved in federal grant administration, and will work to ensure that we are fully compliant with the guidelines for all federal grants.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, states, in part:

§ __.105 Definitions

Federal financial assistance means assistance that non-Federal entities receive or administer in the form of grants, loans, loan guarantees, property (including donated surplus property), cooperative agreements, interest subsidies, insurance, food commodities, direct appropriations, and other assistance, but does not include amounts received as reimbursement for services rendered to individuals as described in § __.205(h) and § __.205(i).

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

§__.200 Audit requirements

(a) Audit required. Non-Federal entities that expend \$500,000 or more in a year in Federal awards shall have a single or program-specific audit conducted for that year in accordance with the provisions of this part.

§__.205 Basis for determining Federal awards expended.

(a) Determining Federal awards expended. The determination of when an award is expended should be based on when the activity related to the award occurs. Generally, the activity pertains to events that require the non-Federal entity to comply with laws, regulations, and the provisions of contracts or grant agreements, such as: expenditure/expense transactions associated with grants, cost-reimbursement contracts, cooperative agreements, and direct appropriations; the disbursement of funds passed through to subrecipients; the use of loan proceeds under loan and loan guarantee programs; the receipt of property; the receipt of surplus property; the receipt or use of program income; the distribution or consumption of food commodities; the disbursement of amounts entitling the non-Federal entity to an interest subsidy; and, the period when insurance is in force.

§__.400 Responsibilities

(d) **Pass-through entity responsibilities.** A pass-through entity shall perform the following for the Federal awards it makes:

... (4) Ensure that subrecipients expending \$300,000 (*\$500,000 for fiscal years ending after December 31, 2003*) or more in Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.

(5) Issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action. ...

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-05 The University of Washington's internal controls were inadequate to ensure compliance with requirements of its Gaining Early Awareness and Readiness for Undergraduate Programs Grant.

Federal Awarding Agency	U.S. Department of Education
Pass-Through Entity	None
CFDA Number and Title:	84.334 Gaining Early Awareness And Readiness For Undergraduate Programs (GEAR UP)
Federal Award Number:	P334A000128-05
Applicable Compliance Component:	Subrecipient Monitoring and Reporting
Questioned Cost Amount:	None

Background

The GEAR UP program seeks to encourage educational institutions to participate in programs designed to assist low-income students who wish to obtain a college degree or recognized equivalent. This may include financial assistance to students and support to entities wishing to provide counseling, mentoring, academic and other support services to elementary and middle schools and secondary school students at risk of dropping out of school and providing information to students and parents about the advantages of obtaining a postsecondary education and financing options.

Grant requirements state the University must submit a performance report to the U.S. Department of Education before the next budget period begins, which in this case would be July 1 of each year. The report is to contain grant administration and budget information, demographic data and data on services provided and outcomes.

State agencies, colleges, and universities often distribute federal funds to other organizations that provide services needed to accomplish federal program objectives. These organizations are known as sub-recipients, the actual grant recipient is considered to be a pass-through agency. To help ensure grant money is spent appropriately, the federal government requires pass-through agencies to monitor the activities of sub-recipients to ensure they are complying with federal requirements.

Monitoring may include reviewing reports submitted by sub-recipients and performing on-site reviews of sub-recipient financial and program records and operations. Monitoring also includes providing sub-recipients with program information, such as the award name and Catalog of Federal Domestic Assistance number, the name of the federal grantor and grant requirements. For sub-recipients spending \$500,000 or more in federal awards during a fiscal year, pass-through agencies must ensure appropriate audits are done and appropriate and timely corrective action is taken in instances in which findings are reported.

Description of the Condition

During fiscal year 2007, the University spent approximately \$3.7 million in GEAR UP money. Approximately \$3.1 million was distributed to Local Education Service Organizations (LESOs) for program activities including academic assessment and class planning; career and college planning, academic advising and tutoring; campus field trips; information sessions on financial aid, admissions, and other "college" readiness issues; service learning; mentoring; parent training and involvement; teacher training and development; and technology.

For review, we selected one contract, Seattle Early Scholars Outreach with expenditures of approximately \$2 million, \$1.6 million of which was distributed to LESOs. We requested all documentation from the University to support compliance with sub-recipient monitoring activities. The University initially refused to provide that documentation. Restricting access to information necessary for us to form an opinion on compliance with grant requirements improperly limits the scope of our audit, and would result in an audit finding. When notified of this, the University provided the documentation and we were able to continue our work.

The results of our review found the University did not have internal controls adequate to ensure compliance with these grant requirements:

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Sub-recipient Monitoring

We noted the University properly notified sub-recipients of the CFDA number, grant award number, program name and granting agency. The University also reviewed the costs claimed by the sub-recipient to ensure they were allowable under federal Office of Management and Budget Circular A-21; were charged within the grant's period of availability; and that sub-recipient reporting requirements were met.

However, the University did not adequately monitor the sub-recipients' activities between July 2006 and June 2007 when the sub-recipients were paid approximately \$1.6 million. Specifically, we found insufficient evidence that the University performed adequate monitoring to determine whether the sub-recipients were doing the work required by the grant, meeting the program goals, and complying with the terms and provisions of the grant agreement and regulations.

The U.S. Department of Education made similar observations when it reviewed the University's program in 2005.

Although the University did not adequately monitor the sub-recipients' activities during the period under review, the University subsequently was able to provide some evidence, such as e-mails from the sub-recipient, to show program activities occurred. As a result, we will not question these costs.

Reporting

The University collects data from the LESO to prepare the annual performance report to comply with grant requirements. The University could not provide documentation to support the accuracy of the report submitted. For example, it could not reconcile the number of students served on the report to the data provided by the LESO's.

Cause of Condition

During our audit, the program director responsible for monitoring program activities and performance reporting left the University. Other University staff were unable to locate supporting documentation and were not able to document the methodology used to produce the annual performance report.

Effect of Condition

The University cannot ensure sub-recipients are complying with grant requirements and that sub-recipient costs are allowable or that information reported to the Department of Education is accurate and complete.

Recommendation

Sub-recipient monitoring

We recommend the University strengthen controls to ensure sub-recipients are adequately monitored with sufficient evidence of monitoring retained.

Reporting

We recommend the University strengthen controls to ensure the annual performance report is accurate and properly supported.

University's Response

The University agrees with the recommendations. Although monitoring occurred on these sub-recipients, adequate program documentation was not maintained. The University will strengthen controls to ensure sufficient evidence of sub-recipient monitoring is retained.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

The University will also ensure that reporting methodology is documented so that in the event of employee turnover, the reporting process can be replicated. The particular grant noted in this finding was not renewed and therefore, has no remaining activities.

Lastly, the University takes its stewardship responsibilities very seriously. There was no intention to restrict access to any of the documentation related to the grant. Due to an unfortunate misunderstanding about what was being requested, there was a delay in providing some of the documentation related to sub-recipient monitoring. The University will improve the quality of the communication with the State auditors to ensure that this does not happen in the future.

Auditor's Concluding Remarks

We appreciate the University's concurrence with our recommendations and its intent to improve the quality of communications provided during future audits. During our next audit, we will review the University's improvements to internal controls to ensure compliance with grant requirements

Applicable laws and Regulations

OMB 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.

U.S. Office of Management and Budgets Circular A-133, *Audits of States, Local Governments, and Non-profit Organizations*, Section 400(d) states, in part:

A pass-through entity shall perform the following...

1. Identify Federal awards made by informing each sub-recipient of CFDA title and number, award name and number, award year...and name of Federal agency...
2. Advise sub-recipients of requirements imposed on them by Federal laws, regulations, and the provisions of contract or grant agreements as well as any supplemental requirements imposed by the pass-through entity.
3. Monitor the activities of sub-recipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.
4. Ensure that sub-recipients expending \$500,000 or more in; Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.
5. Issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.
6. Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

OMB Circular A-110, *Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and other Non-Profit Organizations*, states:

Section 21(b) - Recipients' financial management systems shall provide for the following.

(1) Accurate, current and complete disclosure of the financial results of each federally-sponsored project or program

Section 51(a):

Recipients are responsible for managing and monitoring each project, program, subaward, function or activity supported by the award.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-06 The Department of Social and Health Services and the Department of Early Learning do not have adequate internal controls over direct payments to child care providers.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Child Care Cluster:
93.575 Child Care and Development Block Grant
93.596 Child Care Mandatory and Matching Fund of the CCDF
93.558 Temporary Assistance for Needy Families
Federal Award Number: 5-0705WA5028, 5-0705W5048,
Applicable Compliance Component: Activities Allowed or Unallowed
Questioned Cost Amount: None

Background

The Washington Department of Early Learning (DEL) administers the federal Child Care and Development program under an agreement with the Department of Social and Health Services (DSHS), the grantee. The program is designed to assist eligible working families in paying for child care. Prior to 2006, this program was administered by DSHS' Division of Child Care and Early Learning.

Our audits of fiscal years 2005 and 2006 reported the Department did not monitor direct payments made to child care providers. Payments are made through the Social Services Payment System maintained by DSHS. Monitoring is critical to ensure payments are allowable. In fiscal year 2007, the Department paid approximately \$208 million to child care centers and providers through the Working Connections Child Care Program.

Description of Condition

DEL stated it would work with the DSHS Payment Review Program to identify and collect overpayments to providers. We determined a calculation is being used to identify specific types of potential overpayments, such as multiple payments for the same child during the same time period. Both departments stated no other changes to the payment review processes have been made. The inadequate monitoring of direct payments, specifically the lack of reconciliation between child attendance records and payment requests submitted by providers, has not been resolved. The departments are aware of overpayments made to licensees, and are aware that the licensees are claiming more than authorized amounts.

Cause of Condition

Both departments stated they use an honor system for providers to report attendance, without review or reconciliation by the Departments of attendance records to payment claims.

Effect of Condition

The lack of controls over payments to providers results in a high risk that overpayments to providers will be made and not identified or recovered. We performed a detailed review during our fiscal year 2006 audit and found more than \$55,000 in overpayments to providers. Since the control weakness identified during that audit persists, the Departments cannot ensure overpayments are not continuing.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Recommendation

We recommend the Department establish and follow adequate monitoring procedures for provider payments to include reconciliation of provider attendance records to payments made to ensure expenditures are allowable.

Department's Response

The Department of Early Learning (DEL) and the Department of Social and Health Services (DSHS) partially concurs with the auditor's finding that neither department has adequate internal controls over direct payments to child care providers.

The roles for each department include for Early Learning, administer, oversee and develop policy for subsidy payment, and provide training. DSHS determines eligibility and authorizes child care services for eligible participants based on DEL policy, processes payments to child care providers through the Social Service Payment System, and monitors payment accuracy.

The departments agree there is no process to routinely reconcile Social Service Payment System (SSPS) payments made to providers with the provider's attendance records. Both departments also agree that the program's integrity would be enhanced by such reconciliation but have not had sufficient resources to perform the complex, time consuming reconciliation on a routine basis. In lieu of a reconciliation process both agencies have focused their efforts on improving provider accuracy in billing and conducting alternate post-payment audits performed at various frequencies, to monitor the accuracy of service authorizations and payment. Examples of those efforts include:

- **The Payment Review Program (PRP):** *DSHS, through a contract with HWT, Inc., runs algorithms designed to identify child care payment errors. The algorithms identify potential overpayments for rates paid above the maximum, ineligible infant bonus, duplicate payments to providers, and payments made for school holiday hours for children who are not school age. PRP identifies overpayments and refers them to the DSHS Office of Financial Recovery who sends the overpayment letters to the child care provider and collects the overpayments. PRP works with providers through both an informal dispute resolution process and formal hearings if the provider disagrees with the overpayment assessment. Since 2003, 23 algorithms have been implemented to test the payment accuracy in Working Connections Child Care (WCCC), Children's Administration and Seasonal Child Care programs; the majority applied to WCCC payments. Since 2003, these reviews identified 2,156 providers with billing errors and resulted in the establishment of \$1,554,000 in overpayments. In 2007, 261 overpayment letters were issued for a total of \$185,000.*
- **2005 Family Home Provider Review:** *In October and November, 2005, the DSHS Division of Child Care and Early Learning (DCCEL) conducted a review of attendance records for select family home providers. The sample was selected from providers who cared for more than 20 WCCC children or received payments greater than \$10,000 in May 2005. The review found the majority of 37 selected providers billed accurately. A total of \$25,492.98 in overpayments were identified and established, as well as \$1,264.32 in under payments. The report issued in February, 2006, listed the top three reasons for the overpayments as: lack of attendance records documenting the billing, attendance records that failed to indicate time in and out and missing parent signatures, and misunderstanding of the billing instructions. Common problems making the reconciliation difficult were illegible handwriting, a.m. / p.m. designations missing, different last names of children and parents.*

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

- **2006 Family Home Eligibility and Payment Review:** *The DSHS Quality Assurance section in the Economic Services Administration conducted an eligibility and payment review of licensed family home providers and the families receiving services from those providers in April- July, 2006, for services delivered in the first four months of 2006. A total of 120 individual child care cases associated with 24 licensed family home providers were reviewed. The on-site reviews compared provider attendance, authorization, and enrollment records to the SSPS payments records. The report issued in September, 2006, indicated that some providers lacked a basic understanding of the billing rules, attendance records on a variety of different forms were often difficult to read or understand, and providers were also unclear on who they could contact with billing questions. The report, identifying 21 eligibility and payment process areas for improvement, was shared with both DSHS and DEL management.*
- **DSHS Field Office Reviews:** *DSHS field offices also identify overpayments to providers through the normal case review process and a mandatory monthly supervisory review of 1% of all child care authorizations. In Fiscal Year 2007, these reviews resulted in the establishment of overpayments on 3,085 invoices totaling \$1,711,500. To date, the department has recovered \$672,650 in overpayments associated with 1,763 of those invoice errors.*
- **DEL Provider Billing Training:** *DEL provides on-going training to providers on the billing instructions. While DCCCEL did not track the number of participants at each of the trainings, 493 providers did attend and submit evaluations in the last three years.*

In response to this finding DEL and DSHS will continue to cooperate in identifying and implementing internal controls that will improve billing practices by providers and increase payment accuracy.

DEL will:

- *Train licensed and license-exempt family child care providers per the requirements of the 2007-2009 Collective Bargaining Agreement (CBA) between the State of Washington and the Service Employees International Union 925. That agreement requires the State to provide, and all family child care providers to attend, training on subsidy payments. DEL will begin training these providers in the spring or summer of 2008 and document provider attendance at the training.*
- *Re-examine the state's attendance record policy and evaluate the impact of mandating the use of a standard attendance reporting form to reduce the difficulty of reconciling attendance and SSPS payment records.*
- *Review the current training for providers on billing instructions and as needed, use "plain talk" principles to make the training for billing instructions clearer.*

DSHS will:

- *Continue to utilize the PRP and mandatory monthly supervisory reviews to improve the accuracy of the authorization process and identify billing errors*
- *Develop audit procedures and implement audits involving the reconciliation of a representative sample of SSPS child care payments with attendance record documentation obtained through DEL. DSHS will work with DEL to develop protocols for obtaining the attendance record documentation needed to complete the audits.*

DEL and DSHS will jointly:

- *Implement the requirements of The Improper Payments Information Act (IPIA) of 2002 that requires states to conduct and report on audits of child care authorizations to U.S. Department of Health and Human Services on a 3 year cycle. To meet the IPIA requirements, DEL has requested funds from the State Legislature to contract with the Quality Assurance Unit of the Economic Services Administration. The Quality Assurance Unit will audit a random sample of 276 child care authorizations from federal fiscal year 2007 for accuracy. The results of the audit will be forwarded to DEL for reporting to U.S. Department of Health and Human Services (HHS) by June 30, 2008. DSHS will continue to conduct these reviews on an annual basis and report authorization issues to DEL.*

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

- *Review the SSPS payment system and evaluate whether or not changes to SSPS could make it easier for providers to bill accurately. DSHS will assess the resources needed to make recommended changes, and where feasible, make the changes.*
- *Establish and conduct a joint Child Care Review Committee that will meet monthly to review and assess child care authorization, training and payment errors through a root cause analysis to reduce and prevent future errors. Any issues and decisions will be brought forward to the Economic Services Administration (ESA) Assistant Secretary from DSHS and Deputy Director from DEL.*
- *Review the September, 2006 DSHS Quality Assurance Family Home Eligibility and Payment Review Report to assure appropriate actions were taken to resolve the issues affecting the accuracy of authorizations and payments.*
- *Formalize their roles and responsibilities for audit, authorization, and payment accuracy in the joint Service Level Agreement signed by the Deputy Secretary from DSHS and Deputy Director from DEL.*

Auditor's Concluding Remarks

We thank the Departments for their cooperation and assistance throughout the audit. We will review the status of the Departments' corrective action during our next audit.

Applicable Laws and Regulations

OMB 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.

OMB 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.

Washington Administrative Code 170-295-7030 states:

- (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 170-296-0520 states:

- (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.
- (4) When a child is no longer enrolled, the date of the child's withdrawal must be recorded in the child's file. You must maintain the child's file for at least five years from the child's last date of attendance. After five years the file may be destroyed or returned to the parent. The child's file must be made available for review by the child's parents and us during this period.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

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

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

Your in-home/relative provider must:

- (6) Keep correct attendance records. Records must:
 - (a) Show both days and times the care was provided;
 - (b) Be kept for five years; and
 - (c) Be given to us, within fourteen consecutive calendar days, if we ask for them.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-07 The Department of Social and Health Services, Office of Financial Recovery and Health and Recovery Services Administration, does not have internal controls to ensure that interest penalty collections are refunded to the federal government.

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: Allowable Costs/Cost Principles
Questioned Cost Amount: \$268,381

Background

The state Medicaid program spent more than \$6 billion during fiscal year 2007, approximately half of which was paid with federal funds. Most Medicaid expenditures are payments to providers of medical treatment, prescriptions, medical equipment, home health care, and other services to Medicaid clients. Providers submit payment claims to the Department of Social and Health Services for these services. Not all claims submitted are allowable or accurate. The Department has a number of internal post-payment audit functions designed to identify and recover inappropriate payments to providers, referred to as overpayments. When an overpayment is identified and notification is sent to the provider, the Department may assess a 1 percent monthly interest penalty on the amount owed until the overpayment is recovered.

Federal law requires the Department to pay back the federal portion of overpayments to the federal government. This occurs by crediting the federal share of the overpayments on the Quarterly Statement of Medicaid Expenditures for the Medical Assistance Program, which is the reimbursement claim submitted to the U.S. Department of Health and Human Services.

A report issued in September of 2005 by the federal Department of Health and Human Services Office of Inspector General, stated the Department of Social and Health Services had not remitted the federal share of interest penalties collected in conjunction with provider overpayments. The review covered October 1, 2001 through December 31, 2002 and recommended that the Department “establish and implement adequate written policies and procedures for processing and reporting...interest penalty collections.” The full report can be found at <http://oig.hhs.gov/oas/reports/region10/100400003.htm>.

Description of condition

As a result of the Inspector General’s report, the Department paid back interest penalty collections through fiscal year 2006, and stated it would develop and follow policies and procedures to ensure future compliance. During our current audit we found the Department has not refunded the federal share of interest penalties collected from providers in fiscal year 2007. In addition, the Department was unable to provide policies or identify procedures it is using to ensure interest penalties are properly paid back.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Cause of Condition

The Department did not have policies and procedures to ensure the federal share of interest penalties collected from the provider are refunded to the federal government.

Effect of Condition and Questioned Costs

For July 1, 2006 through June 30, 2007, the Department collected \$536,762 in interest penalties on overpayments from Medicaid providers. Half of this amount, or \$268,381, is the federal share of interest penalty collections. None of the interest penalty collections were refunded to the federal government. We are questioning this amount.

Recommendations

We recommend the Department:

- Refund \$268,381 to the federal government for unreported interest penalty collections. Additional interest may be assessed by the federal grantor since these funds were not remitted to the federal government in a timely manner.
- Establish and follow policies and procedures to ensure the federal share of interest penalty collected from providers is refunded to the federal government in an accurate and timely manner.

Department's Response:

The Department concurs with the finding that interest collections on overpayments were not remitted to the Federal government for Statewide Fiscal Year (SFY) 2007. The Department will work with the Federal liaison to determine the appropriate amount to remit to the federal grantor for SFY 2007.

The Department concurs with the finding that there are no policies or procedures for refunding interest penalties to the federal government. The Department's Office of Financial Recovery will establish and implement policies and procedures to ensure the federal share of interest penalties collected from providers is refunded to the federal government in a timely manner.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

State Medicaid Manual
2500.1 Preparation of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Summary Sheet and Certification, Form HCFA-64. - Section A - Quarterly Status

Line 3 - Interest

Line 3.A - Received On Medicaid Recoveries. -Enter the Federal share of any interest received or earned on Medicaid recoveries during the quarter.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

42 CFR 433.312 Basic requirements for refunds.

(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.

(a) Basic rules. (1) The agency is not required to refund the Federal share of an overpayment made to a provider as required by Sec. 433.312(a) to the extent that the State is unable to recover the overpayment because the provider has been determined bankrupt or out of business in accordance with the provisions of this section...

(b) Overpayment debts that the State need not refund. Overpayments are considered debts that the State is unable to recover within the 60-day period following discovery if the following criteria are met:

(1) The provider has filed for bankruptcy, as specified in paragraph (c) of this section; or

(2) The provider has gone out of business and the State is unable to locate the provider and its assets, as specified in paragraph (d) of this section...

(e) Circumstances requiring refunds. If the 60-day recovery period has expired before an overpayment is found to be uncollectible under the provisions of this section, if the State recovers an overpayment amount under a court-approved discharge of bankruptcy, or if a bankruptcy petition is denied, the agency must refund the Federal share of the overpayment in accordance with the procedures specified in Sec.

433.320.

42 CFR 433.320 Procedures for refunds to CMS.

(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.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

(b) Effect of reporting collections and submitting reduced expenditure claims.

(1) The State is not required to refund the Federal share of an overpayment when the State reports a collection or submits an expenditure claim reduced by a discrete amount to recover an overpayment prior to the end of the 60-day period following discovery.

(2) The State is not required to report on the Form CMS-64 any collections made on overpayment amounts for which the Federal share has been refunded previously.

(3) If a State has refunded the Federal share of an overpayment as required under this subpart and the State subsequently makes recovery by reducing future provider payments by a discrete amount, the State need not reflect that reduction in its claim for Federal financial participation...

(d) Expiration of 60-day recovery period. If an overpayment has not been determined uncollectible in accordance with the requirements of

Sec. 433.318 at the end of the 60-day period following discovery of the overpayment, the agency must refund the Federal share of the overpayment to CMS in accordance with the procedures specified in paragraph (a) of this section.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-08 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 the federal share of overpayments made to Medicaid providers are refunded 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: Allowable Costs/Cost Principles
Questioned Cost Amount: None

Background

The federal Medicaid program requires states to make quarterly adjustment for overpayments or underpayments to providers. In the event of overpayment, federal regulations require the adjustment to be made within 60 days of the date of discovery, even if the State has not recovered the overpayment from the provider.

States must refund the federal share of overpayments subject to recovery by reducing the amount claimed. If the state is unable to recover an overpayment because the provider filed for bankruptcy or went out of business, the state does not have to refund the overpayment.

In our audits for fiscal years 2005 and 2006, we reported findings regarding the Department's lack of controls to ensure that the federal portion of provider overpayments was refunded to the federal government as regulations require.

Description of condition

While we found improvements during the current audit, we still found deficiencies in internal controls designed to ensure the federal portion of provider overpayments was refunded to the federal government as regulations require:

Inadequate procedures

The Department did not have adequate procedures to ensure the federal share of overpayments is refunded within 60 days of discovery as the law requires. When the Office of Financial Recovery establishes accounts receivable, the 60-day clock starts. If a balance remains on day 61, the system runs a Medicaid Overpayment Management System report that is forwarded to the Office of Accounting Services (OAS) to process the refunds of any amount still owed the federal government. OAS processes refunds from these reports once per month. Because of this, it may take up to 90 days for these refunds to be sent to the federal government, instead of the 60 days required. The Department stated its federal grantor indicated it would not take issue with these instances of late refunding that are due to the timing of the Department's processing. Of the 117 overpayments identified by the Department for fiscal year 2007, we selected 17 overpayments for detailed review. Nine of them were not refunded within 60 days as required, however were refunded within 90 days. The late refunding of these payments appears to be due to the timing of the Department's processing.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Lack of Monitoring

The Department is not adequately monitoring for compliance with reporting policies.

The Department's policies describe how each of its administrative divisions identifies, manages, refers, collects, and reports overpayments related to providers. The policies state each responsible administration will send a report to the Office of Financial Recovery on the date the draft or final report is issued to the provider to ensure compliance with federal requirements. We found no one office or person monitors overpayments identified by administrations in the Department and the Medicaid Fraud Control Unit to ensure all overpayments are properly referred to the Office of Financial Recovery and are refunded to the federal government in an accurate and timely manner. We reviewed 17 of 117 overpayments the Department identified in fiscal year 2007. Five were not communicated to the Office of Financial Recovery in a timely manner. We found the amount of time elapsing between the draft or final report date and the date that the Office of Financial Recovery first received the report from each responsible administration ranged from 90 days to 17 months.

Cause of Condition

Inadequate procedures

The timing of the Department's internal processes often prevents it from complying with federal requirements for refunding overpayments. This issue appears to be inherent in the Department's system, and may not be easily remedied.

Lack of monitoring

The Department believes that the Administrative Policy 10.02 provides the assurance that all administrations in the Department will refer all Medicaid overpayments to the Office of Financial Recovery in a timely manner. However, compliance is not monitored.

Effect of Condition

Inadequate procedures

We recognize the federal grantor has indicated it would not take issue with these refunds occurring between 60 and 90 days, however the Department did not comply with federal regulations.

Lack of monitoring

We found five overpayments, totaling \$756,808, in which the federal portion of \$378,404 was refunded to the federal government more than 90 days after date of discovery, and up to 17 months after date of discovery. The lateness of these refunds would not be attributed to the Department's process timing, but rather to inadequate monitoring of the reporting requirements.

Recommendations

We recommend the Department:

- Establish adequate procedures to ensure the federal share of overpayments is refunded within 60 days of discovery.
- Establish monitoring to ensure all overpayments identified by administrations in the Department and the Medicaid Fraud Control Unit are referred to the Office of Financial Recovery and are refunded to the federal government in a timely manner.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Department's response

The Department partially concurs with the finding that there are not adequate internal controls to ensure the federal share of overpayments made to Medicaid providers are refunded in a timely manner.

The Department believes it is refunding overpayments in a timely manner. The Department reports overpayments on the CMS-64 in the quarter in which the 60-day period following discovery ends per 42 CFR 433.320(a)(2). On December 13, 2007, Treva Wornath, the federal liaison at the Centers for Medicaid Services (CMS) Seattle Regional Office, confirmed via email that, "If the State is reporting the overpayment on the CMS-64 based on the quarter in which the 60-day period following discovery ends, CMS would find this process to be in compliance with regulation."

The Department established and implemented policies and procedures in October 2006 to ensure the federal share of overpayments are refunded in a timely manner. The procedures implemented ensure the federal share of overpayments will be refunded at the end of the 60-day period following discovery. The policies identify whether overpayments are Fraud and Abuse or routine in nature, based on CFR 42.433.312 and 42.433.316. The Office of Financial Recovery made all corrections to the accounts receivable to address the change in policy. Adjustments related to these changes were completed on October 26, 2006 and reported on the November Medicaid Overpayment Management System (MOMS) report. The adjustments were refunded to the federal government on the CMS64 report for the period ending December 31, 2006 on March 6, 2007.

The Department concurs that there is inadequate monitoring to ensure all overpayments are referred to the OFR. The Department will develop and implement a corrective action plan for this finding to provide reasonable assurance that all overpayments are identified and referred to the Office of Financial Recovery.

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.

(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.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

42 CFR 433.318 Overpayments involving providers who are bankrupt or out of business.

(a) Basic rules. (1) The agency is not required to refund the Federal share of an overpayment made to a provider as required by Sec. 433.312(a) to the extent that the State is unable to recover the overpayment because the provider has been determined bankrupt or out of business in accordance with the provisions of this section...

(b) Overpayment debts that the State need not refund. Overpayments are considered debts that the State is unable to recover within the 60-day period following discovery if the following criteria are met:

- (1) The provider has filed for bankruptcy, as specified in paragraph (c) of this section; or
- (2) The provider has gone out of business and the State is unable to locate the provider and its assets, as specified in paragraph (d) of this section...

(e) Circumstances requiring refunds. If the 60-day recovery period has expired before an overpayment is found to be uncollectible under the provisions of this section, if the State recovers an overpayment amount under a court-approved discharge of bankruptcy, or if a bankruptcy petition is denied, the agency must refund the Federal share of the overpayment in accordance with the procedures specified in Sec. 433.320.

42 CFR 433.320 Procedures for refunds to CMS.

(a) Basic requirements.

- (1) The agency must refund the Federal share of overpayments that are subject to recovery to CMS through a credit on its Quarterly Statement of Expenditures (Form CMS-64).
- (2) The Federal share of overpayments subject to recovery must be credited on the Form CMS-64 report submitted for the quarter in which the 60-day period following discovery, established in accordance with Sec. 433.316, ends.
- (3) A credit on the Form CMS-64 must be made whether or not the overpayment has been recovered by the State from the provider.

(b) Effect of reporting collections and submitting reduced expenditure claims.

- (1) The State is not required to refund the Federal share of an overpayment when the State reports a collection or submits an expenditure claim reduced by a discrete amount to recover an overpayment prior to the end of the 60-day period following discovery.
- (2) The State is not required to report on the Form CMS-64 any collections made on overpayment amounts for which the Federal share has been refunded previously.
- (3) If a State has refunded the Federal share of an overpayment as required under this subpart and the State subsequently makes recovery by reducing future provider payments by a discrete amount, the State need not reflect that reduction in its claim for Federal financial participation...

(d) Expiration of 60-day recovery period. If an overpayment has not been determined uncollectible in accordance with the requirements of

Sec. 433.318 at the end of the 60-day period following discovery of the overpayment, the agency must refund the Federal share of the overpayment to CMS in accordance with the procedures specified in paragraph (a) of this section.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-09 The Department of Social and Health Services, Health and Recovery Services Administration's internal controls are inadequate to identify and recover Medicaid overpayments to pharmaceutical providers made through inappropriate use of billing override codes.

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

Medicaid is the “payer of last resort”, meaning that other payment sources should be identified and used prior to submitting claims to Medicaid. 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 seeking payment from Medicaid. Federal regulations require states to have processes to identify third parties liable for payment for services before Medicaid funds are used.

Pharmacies submit claims for Medicaid client prescriptions through an electronic Point of Sale system. This system interfaces with the Medicaid Management Information System (MMIS), which processes requests for payment through a series of criteria within the system, or edits. Claims are paid if they successfully pass all edits.

When pharmacies submit claims for payment to Medicaid they also must enter any third-party payers that may be liable for paying. If a provider submits a claim on behalf of a client who has other insurance without accurately entering the third-party resource, the Point of Sale system will deny the claim. However, the system edits which are intended to identify and deny these claims in the Point of Sale system can be rendered inoperative by use of manual override codes. 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. The override codes were established for uses such as processing payment for a drug the client's insurance does not cover, but which is covered by Medicaid.

In our audit for fiscal year 2006, we reported a lack of adequate controls over use of override codes. The accuracy of information entered into the system depends on the pharmacy. The pharmacy provider can enter either the accurate third-party payer information or enter the override codes to bypass the system that would deny payment on the claim should the information be inaccurate. Due to this significant, inherent control weakness, claims for pharmaceutical payments are susceptible to error or abuse. Claims that should have been paid, in whole or in part, by third-party payers could be paid by the Medicaid program. To compensate for this, the Department established a post-payment audit program to identify and recover payments made to providers who inappropriately billed Medicaid.

The Department of Social and Health Services paid more than \$399 million to pharmacy providers for pharmaceutical services to Medicaid clients in fiscal year 2007. This does not include payments for clients who are eligible for Medicare in addition to Medicaid. For those individuals, Medicaid will cover any costs not covered by Medicare, and so use of the override code would not be uncommon. We eliminated those payments from the scope of this review. Payments for Medicaid clients during fiscal year 2006 were approximately \$387 million.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Description of Condition

We reviewed the Department's post-payment audit program to determine whether it is effective in identifying overpayments and recovering amounts overpaid. We reviewed the Department's Third party Liability audit selection procedures, risk assessment and post-payment audit coverage.

We found the Department has a good understanding of where overpayment risks occur and what they are. Quarterly, the Department pulls data from MMIS and the Point of Sale system and analyzes claims in which override codes were used. Providers and payments to be audited are selected based on the results of claim analysis. As shown in the table below, a significant portion of the payments audited by the Department are found to be inappropriate, and are subsequently recovered from providers. These recoveries include both state and federal money. The table shows the post-payments audits which were completed during the fiscal year. These audits may have been initiated in previous years.

Fiscal Year	Audits completed	Claims audited	Principal recovered	Interest recovered	Total	Recovery percentage
2005	11	\$1,681,420.36	\$684,057.69	\$127,137.70	811,195.39	41%
2006	25	\$2,248,337.34	\$1,244,288.30	\$272,100.00	1,516,388.30	55%
2007	19	\$2,677,689.96	\$1,141,368.87	\$284,806.21	1,426,175.08	43%
Total		\$6,607,447.66	\$3,069,714.86	\$684,043.91	3,753,758.77	46%

We also reviewed the Department's post-payment audit coverage. While we found the process to be effective, the Department could not demonstrate that the amount of coverage is adequate to address the potential risk of overpayment. Specifically, we found that the Department has not analyzed its level of audit coverage to determine if it is identifying and recovering all the overpayments it should. The Department could not demonstrate a correlation between the amount of potential overpayments and the resources devoted by the Department to identifying and recovering those overpayments. For example, we found the number of post-payment audits initiated by the Department was reduced dramatically in fiscal year 2007:

Fiscal Year	Number of audits initiated	Total claims audited
2005	23	\$3,135,007.83
2006	26	\$2,477,797.43
2007	6	\$767,107.77

The number of post-payment audits initiated dropped significantly, yet payments to pharmacy providers increased by almost \$12 million from fiscal year 2006 to fiscal year 2007. The decreased coverage was not supported by any identification of decreased risk of overpayment or decreased use of override codes.

We found the Department's third party liability post-payment audit coverage is determined by the amount of resources committed to that program, not by an analysis of the resources required to adequately address the risks.

Cause of Condition

The Department stated all reasonable controls are in place for the Point of Sale system and any further controls would make the system too cumbersome to be effective for the user. It stated it will not place additional restrictions on the use of override codes because that would prevent timely service to Medicaid clients. The Department stated it has compensating controls in place to provide reasonable assurance that improper payments will be recovered through its post-payment audit process.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Effect of Condition

Inaccurate third-party liability coverage information can be entered into the Point of Sale system causing Medicaid dollars to be spent on pharmacy services that could have been paid by third parties. Due to the lack of risk analysis and adequate post-payment audit coverage the Department cannot reasonably assure improper payments will be identified and recovered.

The Department's own audit work shows that, of the claims audited, a significant portion was improperly billed to Medicaid. Approximately half of the funds recovered are federal, and half are state

Recommendation

We recommend the Department:

- Strengthen controls over entry of claims into the payment system to ensure third-party payers are properly billed before Medicaid is billed, as required by federal regulations.
- Perform ongoing risk analysis and assessment to determine the appropriate level of post-payment audit coverage for third-party liability claims to ensure improper payments will be identified and recovered.

Department's Response

The Department partially concurs with this finding and will continue to evaluate opportunities to strengthen controls over entry of claims into the payment system and to improve post-payment audit coverage.

The Department agrees that its post-payment audit program is constrained by the program's resources; however, the Department disagrees that the decreased audit coverage noted for FY2007 is unsupported by appropriate risk analysis and assessment. The Department continues to perform appropriate risk analysis related to the use of override codes. In calculating the number of audits initiated in 2007, the auditor only considered the traditional TPL audits and did not include 9 audits of managed care organizations initiated in 2007 by the TPL audit team that resulted in the identification and establishment of \$1,779,837 in overpayments. In addition, the auditor concluded the perceived decreased coverage in 2007 was not supported by any identification of decreased risk of overpayment or decreased use of override codes. In fact, the number of override codes used by pharmacy providers declined significantly from fiscal year 2006 to 2007; expenditures associated with override codes decreased from \$27 million in fiscal year 2006 to \$12 million in fiscal year 2007. This decrease is due in part to the implementation of Medicare Part D which decreased the total number of pharmacy claims processed and paid by the Department.

During the past year the Health and Recovery Services Administration (HRSA), in collaboration with the Washington State Pharmacy Association, developed a Pharmacy Focus Group to investigate opportunities that may mitigate risks associated with Pharmacy Third Party Liability (TPL) overpayments. As part of this initiative, the workgroup developed various projects designed to evaluate whether pharmacies are utilizing override codes appropriately. The collective actions of the workgroup are targeted at preventing payments for pharmacy claims not allowable under the Medicaid program. As of the end of 2007, the Focus Group met monthly, and will continue to meet, to evaluate potential system issues that could impact the use of override codes and pharmacy billing practices with similar impacts. As specific claim reviews are completed, appropriate system resolution and/or provider education will be discussed for implementation.

In addition to the work focused on improving controls over the accuracy of claims entered into the payment system, HRSA will continue to refine its strategy for adequate post payment audit coverage. The process will continue to focus on identifying and prioritizing audits by risk exposure, i.e., dollars by override code, but will also assess additional steps or resources to strengthen the over-all post payment review process and provide reasonable assurance that improper payments are identified and recovered.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

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

OMB 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.

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.

WAC 388-501-0200 states:

(1) MAA requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(2) MAA pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

- (a) Prenatal care;
 - (b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or
 - (c) Preventive pediatric services as covered under the EPSDT program.
- (3) MAA pays for medical services and seeks reimbursement from any liable third party when both of the following apply:
- (a) The provider submits to MAA documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and
 - (b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:
 - (i) Is not complying with an existing court order; or
 - (ii) Received payment directly from the third party and did not pay for the medical services.
- (4) The provider may not bill MAA or the client for a covered service when a third party pays a provider the same amount as or more than the MAA rate.
- (5) When the provider receives payment from the third party after receiving reimbursement from MAA, the provider must refund to MAA the amount of the:
- (a) Third-party payment when the payment is less than MAA's maximum allowable rate; or
 - (b) MAA payment when the third-party payment is equal to or greater than MAA's maximum allowable rate.
- (6) MAA is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills MAA, except as described under subsections (2) and (3) of this section.
- (7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:
- (a) Receives direct third-party reimbursement for such services; or
 - (b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.
- (8) MAA considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.
- (9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.
- (10) For third-party liability on personal injury litigation claims, MAA is responsible for providing medical services as described under WAC 388-501-0100.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-10 The Department of Social and Health Services, Health and Recovery Services Administration's, internal controls are inadequate 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 and Eligibility
Questioned Cost Amount: None

Background

The Washington State Health Care Authority administers the Basic Health Plan, which is designed to provide affordable health insurance to eligible Washington residents. Qualified Basic Health members with dependent children under age 19 may be able to enroll them in Basic Health Plus. Basic Health Plus is a Medicaid program and offers a comprehensive health plan including vision, dental, and physical therapy benefits to these dependants at no cost. Medicaid, administered by the state Department of Social and Health Services, pays for Basic Health Plus coverage, including monthly premiums and co-payments.

Basic Health Plus is jointly administered by the Department of Social and Health Services and the Washington State Health Care Authority. The Health Care Authority provides the insurance coverage under Basic Health Plus, while the Department of Social and Health Services (DSHS) pays the premiums. Eligibility for Basic Health Plus is determined by DSHS based on Medicaid eligibility criteria. More than \$35 million was paid in claims for medical services from July 1, 2006 through March 31, 2007 for Basic Health Plus clients. Approximately half of Medicaid expenditures were paid with federal funds.

In our audits for 2001 through 2005, we reported findings relating to weaknesses in the internal control structure in the Department's management of the Basic Health Plus program and noncompliance with federal regulations. In those years, the Department did not concur with our findings and did not make any significant changes.

In our 2006 audit, the Department concurred with our finding and is committed to ensuring accurate determinations of income eligibility. Training on income budgeting was provided in February 2007. Phase one of Self-employment training was completed for supervisors and leads in March 2007. Self employment training for all staff was completed in July 2007. The Department also implemented weekly audits of a sample of BHP cases, chosen from each of the four units that process these cases

Description of Condition

During our current audit we found improvement from previous years. For wage-earners, the Department consistently used shared database systems with other state and federal agencies to determine if adults other than the head-of-household are employed. For self-employed clients, the Department made better efforts to acquire income verification. Calculations for income are better documented in the Automated Client Eligibility System, the Department's eligibility system. The use of Barcode, the Department's data management system, has made access to client records easier for staff, enhancing the accuracy of eligibility calculations.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

While we found improvements this year, control weaknesses continue. The Department does not consistently:

- Follow its own policies and procedures for determining income eligibility. For example, sufficient documentation supporting a self-employed client's declaration of income was not always obtained.
- Document its method of calculating an estimate of a household's income clearly and completely.

Cause of Condition

Although the Department provided staff training to address the control weaknesses identified, this training was provided in phases and occurred between February and July of 2007. Our audit scope covers July 2006 through June 2007. Therefore, for most of the audit period, the control weaknesses present during the prior audit had not been addressed.

Effect of Condition

To determine the effect of the control deficiencies we selected files for 166 clients who received services from July 1, 2006 through March 31, 2007 for examination.

For 14 client files examined, the Department could not support its determination of income eligibility.

- For 9 client files examined, the Department did not have adequate documents on file supporting its estimate of a household's income.
- For five client files examined, the Department did not calculate a household's income according to its policies or did not account for all household income.

Total payments for services for these clients were \$33,331.46. Half, or \$16,665.73 was paid with federal funds.

Our work focused on evaluating the Department's controls over income eligibility determination. It was designed to determine the effectiveness of internal controls, not to determine if recipients were otherwise eligible for the Basic Health Plus program.

Under federal laws and regulations, a disallowance of federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's Medicaid Eligibility Quality Control program, a federally mandated Medicaid eligibility review process. Because of this, and because we could not perform work to determine if the clients associated with lack of supporting documents were or are Basic Health Plus program-eligible, we are not questioning payments associated with the services for those clients.

Recommendations

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.
- Document its method of calculating an estimate of a household's income clearly and completely.
- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid federal funds must be reimbursed.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Department's Response

The Department agrees with this finding.

The department will review the 14 case exceptions identified by the auditor and take whatever action is necessary to obtain the documentation needed to account for all household income, document the reported the household income, or calculate the income as required by policy.

The department requires staff to follow Department's policies and procedures when determining eligibility for all Medicaid programs, including the Basic Health Plus program. In response to last year's finding, the department completed targeted training for staff on specific eligibility and documentation requirements by July, 2007 and that training, along with the implementation of weekly internal audits of eligibility determinations, resulted in the improved accuracy of eligibility determinations cited by the auditor.

In January, 2008, the income calculation rules for the Children's Medicaid program, including Basic Health Plus, will change. The changes, intended to reduce application and renewal barriers for clients, will reduce the complexity of the verification process and increase the accuracy of eligibility decisions. The expectation is the new rules will increase accuracy by streamlining the calculation process and optimizing use of electronic wage and income interfaces. Part of the implementation plan for these changes includes additional internal auditing, also beginning in January, to ensure consistent application of the new calculation and verification standards for all Children's and Pregnancy Medicaid eligibility. Monthly audit reports will be reviewed by program staff to assess compliance with the program changes, assess the accuracy of staff eligibility decisions, and identify training needs.

DSHS uses the Health Care Authority's application form for DSHS Basic Health Plus program applicants. Because the form does not reference the separate documentation requirements for DSHS program applicants, the auditors must audit DSHS Basic Health Plus applications against the stated documentation requirements for the Health Care Authority's Basic Health Plan program. Since the documentation requirements are different, DSHS will work with the Health Care Authority to modify their application form to clearly state that Plus program applicants must meet the DSHS Medicaid program documentation requirements.

The Department will also work with the Department of Health and Human Services to determine if the identified costs charged to the Medicaid program need to be refunded.

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

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.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

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(1)(7)(A) of the Internal Revenue Code of 1954, for applicants during the application period and for recipients for whom the information has not previously been requested;

(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;

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(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.

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07-11 The Department of Social and Health Services does not have adequate internal controls to ensure new applicants meet federal citizenship requirements before receiving Medicaid benefits.

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

Medicaid is a jointly funded state and federal partnership providing health coverage for selected categories of people with low incomes who might otherwise go without medical care. The state of Washington Medicaid program spent more than \$6 billion during fiscal year 2007. Approximately half of Medicaid expenditures were paid with federal funds.

Under federal law, all U.S. citizens and certain legal immigrants who meet Medicaid's financial and non-financial eligibility criteria are entitled to Medicaid. The Medicaid program requires states to establish that individuals applying for Medicaid are U.S. citizens or satisfy the immigration requirements, which are detailed in the regulations.

The State has always required that individuals be citizens or certain classes of federally designated immigrants to be found eligible for Medicaid. Individuals have been allowed to "self-declare" citizenship on an application that is signed under a "penalty of perjury" statement. DSHS has not independently verified citizenship status, unless it found the client statement to be questionable based on information to the contrary.

The federal Deficit Reduction Act of 2005 made changes to the operations of many federal programs, including Medicaid. Among those changes is a requirement that all current Medicaid recipients and all new applicants who claim U.S. citizenship must provide evidence to prove their citizenship and identity, effective July 1, 2006, or at the first eligibility re-determination after the effective date of the Act. The regulation defines what constitutes acceptable proof in order of reliability, and requires the recipient or applicant to present original documents or copies certified by the issuing agency.

A rule issued by Centers for Medicare and Medicaid Services states individuals who already are enrolled in Medicaid must be given a "reasonable opportunity" to present the required documentation to verify citizenship before a state takes any action to terminate eligibility. Current Medicaid beneficiaries will continue to receive benefits if they demonstrate a good faith effort to present satisfactory evidence of citizenship and identity. What constitutes a "good faith effort" is not defined by the rule, and so is left to the judgment of DSHS.

Under the Act, however, new applicants are not eligible until they have presented the required documentation or are otherwise determined to be exempt from the requirements as described in the regulation.

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Description of Condition

DSHS adopted most of the Act's requirements in July 2006 and established a Citizenship Central Unit to help clients obtain citizenship documentation. During our audit, we found that DSHS has adequate processes to comply with the citizenship documentation requirements for current Medicaid beneficiaries.

However, the Department allows new applicants to "self-declare" citizenship by completing the Citizenship Documentation and Identity Declaration form. This form does not meet the federal citizenship verification documentation requirements. The Department provided Medicaid benefits to applicants prior to obtaining the required documentation to verify citizenship and identity, contrary to federal regulation.

Cause of Condition

The Department is aware of the requirement for new Medicaid applicants, but has elected not to follow it.

Effect of Condition

To determine the effect of the control weakness, we used both judgmental and random sampling to select 210 clients for testing. We eliminated from our testing those applicants exempted from the requirements per the regulation. Our test was designed to determine if the proof of citizenship requirements had been met prior to the Department providing Medicaid benefits. We picked our sample from the 85,759 new applications the Department processed between September 1, 2006 and March 31, 2007.

We found 28 out of the 210 clients tested received Medicaid benefits without having provided the required documentation. The total payments for services for these clients were \$20,088. Half of these expenditures, or \$10,044 was paid with federal funds.

The purpose of our testing was to determine if the Department complied with federal requirements for verifying citizenship prior to providing Medicaid benefits to new applicants. Our testing was not designed to determine if those applicants were U.S. citizens.

Recommendations

We recommend the Department establish and follow adequate controls to ensure compliance with Medicaid citizenship requirements.

We are not recommending refund of the questioned costs because, under federal laws and regulations, a disallowance of federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's Medicaid Eligibility Quality Control program, a federally mandated Medicaid eligibility review process.

Department's Response

The Department concurs with this finding. Systems will be put into place to ensure that medical costs will not be charged to the Medicaid program until all requirements are met.

The auditor noted that they found 28 clients who received Medicaid benefits without having provided the required citizenship documentation. The Department followed up on these 28 clients' status; out of the 28 exceptions found by the auditor:

13 clients have since had their citizenship verified

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

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14 clients have been terminated due to reasons that may or may not be related to citizenship verification

1 client is in the backlog of cases, yet to be checked for citizenship requirements

None of these clients were identified as non-citizens.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 42 USC 1396b(i)(22) states:

With respect to amounts expended for medical assistance for an individual who declares under section 1137(d)(1)(A) [42 USCS § 1320b-7(d)(1)(A)] to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title [42 USCS §§ 1396 et seq.], unless the requirement of subsection (x) is met.

Title 42 USC 1396b(x)(1) states:

For purposes of subsection (i)(22), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

Title 42 CFR 435.406, Citizenship and alienage, states:

(a) The agency must provide Medicaid to otherwise eligible residents of the United States who are —

(1) Citizens:

- (i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and
- (ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in §435.407.
- (iii) An individual for purposes of the declaration and citizenship documentation requirements discussed in paragraphs (a)(1)(i) and (a)(1)(ii) of this section includes both applicants and recipients under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in their expenditures, as though the expenditures were for medical assistance.
- (iv) Individuals must declare their citizenship and the State must document the individual's citizenship in the individual's eligibility file on initial applications and initial redeterminations effective July 1, 2006.
- (v) The following groups of individuals are exempt from the requirements in paragraph (a)(1)(ii) of this section:
 - (A) Individuals receiving SSI benefits under title XVI of the Act.
 - (B) Individuals entitled to or enrolled in any part of Medicare.
 - (C) Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on the individual's disability (as defined in section 223(d) of the Act).
 - (D) Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are recipients of foster care maintenance or adoption assistance payments under Title IV-E of the Act.

Schedule of Findings and Questioned Costs

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- (2) (i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified aliens), qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified aliens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or recipient is an alien in a satisfactory immigration status.
- (ii) The eligibility of qualified aliens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.
- (b) The agency must provide payment for the services described in §440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified aliens subject to the 5-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria, except non-qualified aliens need not present a social security number or document immigration status.

Title 42 CFR 435.407, Types of acceptable documentary evidence of citizenship, states:

For purposes of this section, the term “citizenship” includes status as a “national of the United States” as defined by section 101(a)(22) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(22)) to include both citizens of the United States and non-citizen nationals of the United States.

(a) *Primary evidence of citizenship and identity.* The following evidence must be accepted as satisfactory documentary evidence of both identity and citizenship:

(1) *A U.S. passport.* The Department of State issues this. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. Note: Spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented. Exception: Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.

(2) *A Certificate of Naturalization (DHS Forms N-550 or N-570.)* Department of Homeland Security issues for naturalization.

(3) *A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561.)* Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.

(4) A valid State-issued driver's license, but only if the State issuing the license requires proof of U.S. citizenship before issuance of such license or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen. (This provision is not effective until such time as a State makes providing evidence of citizenship a condition of issuing a driver's license and evidence that the license holder is a citizen is included on the license or in a system of records available to the Medicaid agency. The State must ensure that the process complies with this statutory provision in section 6036 of the Deficit Reduction Act of 2005. CMS will monitor compliance of States implementing this provision.)

(b) *Secondary evidence of citizenship.* If primary evidence from the list in paragraph (a) of this section is unavailable, an applicant or recipient should provide satisfactory documentary evidence of citizenship from the list specified in this section to establish citizenship and satisfactory documentary evidence from paragraph (e) of this section to establish identity, in accordance with the rules specified in this section.

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(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986 (NMI local time)). A State, at its option, may use a cross match with a State vital statistics agency to document a birth record. The birth record document may be issued by the State, Commonwealth, Territory, or local jurisdiction. It must have been recorded before the person was 5 years of age. A delayed birth record document that is recorded at or after 5 years of age is considered fourth level evidence of citizenship. (Note: If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories.) The following will establish U.S. citizenship for collectively naturalized individuals:

(i) *Puerto Rico*:

(A) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941; or

(B) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

(ii) *U.S. Virgin Islands*:

(A) Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession, or the U.S. Virgin Islands on February 25, 1927; or

(B) The applicant's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession, or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or

(C) Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or Territory, or the Canal Zone on June 28, 1932.

(iii) *Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI))*:

(A) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time); or

(B) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration before January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time); or

(C) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time).

(D) Note: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

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For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

- (2) *A Certification of Report of Birth (DS-1350)*. The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, DC. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.
- (3) *A Report of Birth Abroad of a U.S. Citizen (Form FS-240)*. The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.
- (4) *A Certification of birth issued by the Department of State (Form FS-545 or DS-1350)*. Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.
- (5) *A U.S. Citizen I.D. card*. (This form was issued until the 1980s by INS. Although no longer issued, holders of this document may still use it consistent with the provisions of section 1903(x) of the Act.) INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.
- (6) *A Northern Mariana Identification Card (I-873)*. (Issued by the DHS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986.) The former Immigration and Naturalization Service (INS) issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.
- (7) *An American Indian Card (I-872) issued by the Department of Homeland Security with the classification code "KIC."* (Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the United States/Mexican border.) DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship.
- (8) *A final adoption decree showing the child's name and U.S. place of birth*. The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
- (9) *Evidence of U.S. Civil Service employment before June 1, 1976*. The document must show employment by the U.S. government before June 1, 1976. Individuals employed by the U.S. Civil Service prior to June 1, 1976 had to be U.S. citizens.
- (10) *U.S. Military Record showing a U.S. place of birth*. The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth.)
- (11) *A data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens*. A State may conduct a verification with SAVE to determine if an individual is a naturalized citizen, provided that such verification is conducted consistent with the terms of a Memorandum of Understanding or other agreement with the Department of Homeland Security (DHS) authorizing verification of claims to U.S. citizenship through SAVE, including but not limited to provision of the individual's alien registration number if required by DHS.
- (12) *Child Citizenship Act*. Adopted or biological children born outside the United States may establish citizenship obtained automatically under section 320 of the Immigration and Nationality Act (8 U.S.C. 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000). The State must obtain documentary evidence that verifies that at any time on or after February 27, 2001, the following conditions have been met:

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- (i) At least one parent of the child is a United States citizen by either birth or naturalization (as verified under the requirements of this Part);
- (ii) The child is under the age of 18;
- (iii) The child is residing in the United States in the legal and physical custody of the U.S. citizen parent;
- (iv) The child was admitted to the United States for lawful permanent residence (as verified under the requirements of 8 U.S.C. 1641 pertaining to verification of qualified alien status); and
- (v) If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 U.S.C. 1101(b)(1) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States)), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred).

(c) *Third level evidence of citizenship.* Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when both primary and secondary evidence is unavailable. Third level evidence may be used only when the applicant or recipient alleges being born in the U.S. A second document from paragraph (e) of this section to establish identity must also be presented:

- (1) *Extract of a hospital record on hospital letterhead established at the time of the person's birth that was created 5 years before the initial application date and that indicates a U.S. place of birth.* (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) Do not accept a souvenir "birth certificate" issued by the hospital.
- (2) *Life, health, or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date that indicates a U.S. place of birth.* (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) Life or health insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.
- (3) *Religious record recorded in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made.* The record must be an official record recorded with the religious organization. CAUTION: In questionable cases (for example, where the child's religious record was recorded near a U.S. international border and the child may have been born outside the U.S.), the State must verify the religious record and/or document that the mother was in the U.S. at the time of birth.
- (4) *Early school record showing a U.S. place of birth.* The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of birth of the applicant's parents.

(d) *Fourth level evidence of citizenship.* Fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence should only be used in the rarest of circumstances. This level of evidence is used only when primary, secondary and third level evidence is unavailable. With the exception of the affidavit process described in paragraph (d)(5) of this section, the applicant may only use fourth level evidence of citizenship if alleging a U.S. place of birth. In addition, a second document establishing identity must be presented as described in paragraph (e) of this section.

- (1) *Federal or State census record showing U.S. citizenship or a U.S. place of birth.* (Generally for persons born 1900 through 1950.) The census record must also show the applicant's age. Note: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or State should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Medicaid eligibility. This form requires a fee.
- (2) *One of the following documents that show a U.S. place of birth and was created at least 5 years before the application for Medicaid.* (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) This document must be one of the following and show a U.S. place of birth:

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- (i) Seneca Indian tribal census.
- (ii) Bureau of Indian Affairs tribal census records of the Navajo Indians.
- (iii) U.S. State Vital Statistics official notification of birth registration.
- (iv) A delayed U.S. public birth record that is recorded more than 5 years after the person's birth.
- (v) Statement signed by the physician or midwife who was in attendance at the time of birth.
- (vi) The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.

(3) *Institutional admission papers from a nursing facility, skilled care facility or other institution created at least 5 years before the initial application date that indicates a U.S. place of birth.* Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

(4) *Medical (clinic, doctor, or hospital) record created at least 5 years before the initial application date that indicates a U.S. place of birth.* (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.)

Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. (Note: An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.)

(5) *Written affidavit.* Affidavits should ONLY be used in rare circumstances. If the documentation requirement needs to be met through affidavits, the following rules apply:

- (i) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship (the two affidavits could be combined in a joint affidavit).
- (ii) At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient.
- (iii) In order for the affidavit to be acceptable the persons making them must be able to provide proof of their own citizenship and identity.
- (iv) If the individual(s) making the affidavit has (have) information which explains why documentary evidence establishing the applicant's claim or citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well.
- (v) The State must obtain a separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained.
- (vi) The affidavits must be signed under penalty of perjury and need not be notarized.

(e) *Evidence of identity.* The following documents may be accepted as proof of identity and must accompany a document establishing citizenship from the groups of documentary evidence of citizenship in the groups in paragraphs (b) through (d) of this section.

(1) Identity documents described in 8 CFR 274a.2(b)(1)(v)(B)(1).

- (i) Driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color.
- (ii) School identification card with a photograph of the individual.
- (iii) U.S. military card or draft record.
- (iv) Identification card issued by the Federal, State, or local government with the same information included on drivers' licenses.
- (v) Military dependent's identification card.
- (vi) Certificate of Degree of Indian Blood, or other American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. Acceptable if the document carries a photograph of the applicant or recipient, or has other personal identifying information relating to the individual such as age, weight, height, race, sex, and eye color.
- (vii) U.S. Coast Guard Merchant Mariner card.

Note to paragraph (e)(1): Exception: Do not accept a voter's registration card or Canadian driver's license as listed in 8 CFR 274a.2(b)(1)(v)(B)(1). CMS does not view these as reliable for identity.

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- (2) At State option, a State may use a cross match with a Federal or State governmental, public assistance, law enforcement or corrections agency's data system to establish identity if the agency establishes and certifies true identity of individuals. Such agencies may include food stamps, child support, corrections, including juvenile detention, motor vehicle, or child protective services. The State Medicaid Agency is still responsible for assuring the accuracy of the identity determination.
- (3) At State option, a State may accept three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the individual's citizenship and the individual submitted second or third tier evidence of citizenship. The State must first ensure that no other evidence of identity is available to the individual prior to accepting such documents. Such documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity. All documents used must contain consistent identifying information. These documents include employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees and property deeds/titles.
- (f) *Special identity rules for children.* For children under 16, a clinic, doctor, hospital or school record may be accepted for purposes of establishing identity. School records may include nursery or daycare records and report cards. If the State accepts such records, it must verify them with the issuing school. If none of the above documents in the preceding groups are available, an affidavit may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent, guardian or caretaker relative (as defined in the regulations at 45 CFR 233.90(c)(v)) stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided. The affidavit is not required to be notarized. A State may accept an identity affidavit on behalf of a child under the age of 18 in instances when school ID cards and drivers' licenses are not available to the individual in that area until that age.
- (g) *Special identity rules for disabled individuals in institutional care facilities.* A State may accept an identity affidavit signed under penalty of perjury by a residential care facility director or administrator on behalf of an institutionalized individual in the facility. States should first pursue all other means of verifying identity prior to accepting an affidavit. The affidavit is not required to be notarized.
- (h) *Special populations needing assistance.* States must assist individuals to secure satisfactory documentary evidence of citizenship when because of incapacity of mind or body the individual would be unable to comply with the requirement to present satisfactory documentary evidence of citizenship in a timely manner and the individual lacks a representative to assist him or her.
- (i) *Documentary evidence.*
- (1) All documents must be either originals or copies certified by the issuing agency. Uncertified copies, including notarized copies, shall not be accepted.
 - (2) States must maintain copies of citizenship and identification documents in the case record or electronic data base and make these copies available for compliance audits.
 - (3) States may permit applicants and recipients to submit such documentary evidence without appearing in person at a Medicaid office. States may accept original documents in person, by mail, or by a guardian or authorized representative.
 - (4) If documents are determined to be inconsistent with pre-existing information, are counterfeit, or altered, States should investigate for potential fraud and abuse, including but not limited to, referral to the appropriate State and Federal law enforcement agencies.
 - (5) Presentation of documentary evidence of citizenship is a one time activity; once a person's citizenship is documented and recorded in a State database subsequent changes in eligibility should not require repeating the documentation of citizenship unless later evidence raises a question of the person's citizenship. The State need only check its databases to verify that the individual already established citizenship.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

(6) CMS requires that as a check against fraud, using currently available automated capabilities, States will conduct a match of the applicant's name against the corresponding Social Security number that was provided. In addition, in cooperation with other agencies of the Federal government, CMS encourages States to use automated capabilities to verify citizenship and identity of Medicaid applicants. Automated capabilities may fall within the computer matching provisions of the Privacy Act of 1974, and CMS will explore any implementation issues that may arise with respect to those requirements. When these capabilities become available, States will be required to match files for individuals who used third or fourth tier documents to verify citizenship and documents to verify identity, and CMS will make available to States necessary information in this regard. States must ensure that all case records within this category will be so identified and made available to conduct these automated matches. CMS may also require States to match files for individuals who used first or second level documents to verify citizenship as well. CMS may provide further guidance to States with respect to actions required in a case of a negative match.

(j) *Record retention.* The State must retain documents in accordance with 45 CFR 74.53.

(k) *Reasonable opportunity to present satisfactory documentary evidence of citizenship.* States must give an applicant or recipient a reasonable opportunity to submit satisfactory documentary evidence of citizenship before taking action affecting the individual's eligibility for Medicaid. The time States give for submitting documentation of citizenship should be consistent with the time allowed to submit documentation to establish other facets of eligibility for which documentation is requested. (See §435.930 and §435.911.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-12 The Department of Social and Health Services does not have adequate internal controls to ensure people receiving Medicaid benefits 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: None

Background

Medicaid is a jointly funded state and federal partnership providing health coverage for selected categories of people with low incomes who might otherwise go without medical care. The state of Washington Medicaid program spent more than \$6 billion during fiscal year 2007. Approximately half of Medicaid expenditures were paid with federal funds.

Federal regulations require the Department obtain a Social Security number from each individual, including children, applying for Medicaid services. Federal regulations also require the Department to verify the number given with the Social Security Administration to ensure it was issued to the individual who supplied it and whether any other number had been issued for the individual. If an applicant has not been issued a number, the Department must assist the individual in applying for one. Under these circumstances, the Department must obtain evidence to establish the age, citizenship or immigration status, and the true identity of the applicant.

The Social Security Administration provides the state with access to a computer system called the State On-line Query (SOLQ) that enables the Department to verify the validity of a Social Security number at the time of application. Department policy requires staff to verify a client-provided Social Security number using the SOLQ system.

Along with the use of SOLQ, every Social Security number entered in the Automated Client Eligibility System (ACES) is sent in an overnight batch to the Social Security Administration for verification. For those numbers that fail one or more of the matches, an electronic message or alert, is sent to the Community Service Organization indicating the numbers did not match with the Administration's information. The alerts generated are coded so workers are able to identify what caused the error.

When the Department approves an applicant for Medicaid, this information in ACES is transferred electronically into the Medical Management Information System, which the Department's Health and Recovery Services Administration uses to process claims and initiate payments.

In our audits for fiscal years 2004 through 2006, we reported findings regarding the Department's lack of controls to ensure people receiving Medicaid benefits have valid Social Security numbers

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Description of Condition

While we found improvements during the current audit, we still found deficiencies in internal controls. Key internal controls that are intended to ensure all Medicaid applicants have a valid Social Security number did not operate as designed:

- Staff does not consistently validate Social Security numbers prior to admitting clients into the Medicaid program.
- The Department could not demonstrate that staff consistently and properly resolved in a timely manner Social Security number mismatch alerts sent by the Social Security Administration.
- The Department does not have a uniform policy that requires monitoring of staff responses to Social Security number mismatch alerts.

Cause of Condition

Due to the lack of a uniform policies and procedures, the Department does not have effective monitoring in place to ensure the controls designed to validate Social Security numbers are fully implemented.

Effect of Condition

To determine the effect of the control deficiencies, we independently verified all Medicaid client Social Security numbers in the Department's claims processing system by running a computerized cross-match with the Social Security Administration's database. That process identified 723 numbers which, according to the Social Security Administration's database, have never been issued and are therefore invalid.

We provided our results to the Department for verification and follow up. The table summarizes the Department's results:

Department follow-ups	Number of Social Security numbers	Payments
The Department was not able to locate the invalid Social Security numbers we provided. The information may have been updated between the date of our audit work and the date of the Department's follow-up.	3	2,059
The Department corrected the Social Security numbers and validated them in the system.	455	521,607
Accounts have been closed.	45	23,588
Alias Social Security numbers were coded for undocumented clients	158	653,136
Alerts were set in the system for follow-ups to obtain a valid number	62	78,030
Total	723	\$1,278,420

The focus of our work was to evaluate the Department's controls over and compliance with federal requirements for verifying recipients' Social Security numbers both upon initial application and at yearly recertification for those clients that did not have a Social Security number at time of application.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Our audit work was designed to determine the effectiveness of internal controls, not to determine if recipients had valid social Security numbers or were otherwise eligible for Medicaid benefits.

Under federal laws and regulations, a disallowance of federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's Medicaid Eligibility Quality Control program, a federally mandated Medicaid eligibility review process. Because of this, and the fact that we did not perform work to determine if the clients associated with the invalid numbers were or are Medicaid-eligible, we are not questioning payments associated with the services for those clients.

Recommendations

We recommend the Department:

- Validate Social Security numbers prior to admitting clients into the Medicaid program.
- Monitor all alerts regarding Social Security numbers to ensure all alerts are being properly resolved.
- Establish a uniform policy regarding monitoring of staff responses to Social Security number mismatch alerts.

Department's Response

The department concurs with the finding.

As a result of last year's findings, SOLQ training was developed. As of December, 2006, all financial staff in the Economic Services Administration (ESA) have been trained in the use of SOLQ and are required to use SOLQ to check Social Security numbers at the time of the client's initial application for benefits in all programs.

In December 2006, ESA Supervisors also added medical cases to their monthly alerts with a focus on Social Security number mismatched alerts and the consistent use of SOLQ for Social Security number verification. Additionally, in April 2007, the Operations Support Quality Assurance unit within ESA began conducting monthly random audits on medical cases checking for consistent use of SOLQ at the time of application for benefits and at scheduled case reviews. The audit results are provided to the Division of Employment and Assistance Program (DEAP) Director and the DEAP Operations Chief for review and further action as appropriate. The audits are used to determine if there are trends or if there is a need for additional training.

On October 14, 2007, a hard edit was placed in ACES that requires workers to take action at the time of medical recertification for individuals who have had a Social Security number application pending for more than 60 days.

The department anticipates these additional measures will improve the effectiveness of ESA's internal controls.

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.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

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.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-13 The Department of Social and Health Services, Health and Recovery Services Administration's internal controls are insufficient 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 the patient per 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 that information to the Health and Recovery Services Administration. 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 develop actuarially sound capitation, or per-person, rates. From this information, the Administration determines a rate for each 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.

In fiscal years 2003 through 2006, we reported concerns regarding the Administration's controls over the accuracy of data received from providers that is used to determine the rates for its managed care program.

From July 2006 through June 2007, the state made more than \$1.1 billion in payments to managed care providers, approximately 50 percent of which was paid with federal funds. This is an increase of \$33 million over last year for the same period.

Description of Condition

During our current audit, we found no changes in the conditions that we reported in our audit of fiscal year 2006. We found the Administration relies on the providers to accurately report the data that is used to determine the rates that the managed care plans will receive and does not verify its accuracy. Although the Administration has an actuarially sound process for calculating rates, if the underlying data used is inaccurate or incomplete, the results will be inaccurate.

The federal Centers for Medicare and Medicaid Services (CMS) performed a comprehensive program review of Washington State's managed care program in April through September 2004. The review found that although the Administration had a plan for calculating rates in place that satisfied the actuarially sound requirements, the data obtained from the managed care plans and used in the Administration's calculations had shortcomings that prevented it from being used directly for rate-setting purposes. CMS recommended the State continue working with the plans to improve the accuracy of data.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Cause of Condition

The Department believed that because its calculation method is in compliance with federal requirements, no corrective action was required.

Effect of Condition

When the accuracy of data used to establish rates cannot be reasonably assumed to be correct, the risk of paying inflated rates to managed care providers is increased.

Recommendation

We recommend the Department establish and follow controls to provide reasonable assurance that the data used in rate-setting is accurate and complete.

Department's Response

The Department disagrees with this finding.

In the managed care program, health care plans provide detailed financial data directly to the department's contracted actuary. Because of concerns with the proprietary nature of this data, health care plans do not submit the data to the Department. The actuary completes a validation of the financial data received from the Healthy Options plans by comparing it with the financial statements found in the annual independent audits completed on the health care plans operations and records and submitted to the Office of the Insurance Commissioner. The actuary also reviews encounter data submitted to the Department by the health care plans. When those data sets provide a reasonable assurance to the actuary that the financial and encounter data is representative of services performed, the actuary proceeds to calculate the plan rate for the provider based upon the submitted financial and encounter data. When the data sets do not provide reasonable assurance, the actuary works with the health care plan to resolve discrepancies or inconsistencies prior to performing the rate calculation.

We do agree that CMS's 2004 audit of the Healthy Options rate setting process resulted in a finding that they, CMS, needed to conduct further review to determine whether or not the state was in compliance with the federal regulations on the use of encounter data for rate-setting. The Department responded to CMS requests for additional information, worked with CMS to clarify and strengthen our process, and continued to implement a corrective action plan required by CMS's in 2003 to ensure adequacy and accuracy of encounter data for the purposes of rate-setting for calendar year 2006. As a result of our corrective action, CMS did approve the rates developed by the actuary for the 2006 managed care contracts. In essence, by approving the rates, CMS acknowledged the methodology and the calculations utilized by the actuary to set the rates meet the federal requirements.

In response to CMS's recommendation that the Department continue to work with the Healthy Options plans to improve encounter data, the Department has amended the Healthy Options 2008 contracts. The amendment requires health care plans to provide additional encounter data elements that will improve the quality of the data used in the rate setting process. Additionally, upon implementation of Provider One at the end of 2008, staff will have additional system tools for assuring data used in rate-setting is accurate and complete.

CMS has recently completed a follow-up to their 2004 audit, and the Department anticipates receiving their draft report in January 2008. If CMS has continued findings related to the data used for rate setting, the state will work with CMS to develop an acceptable corrective action plan. Both the final report and any related corrective action plan will be shared with the State Auditor.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Auditor's Concluding Remarks

Although the Department does not agree with our finding, we appreciate its commitment to working with its federal grantor to improve controls to ensure data integrity. We will follow up during our next audit.

Applicable Laws and Regulations

OMB 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.

Title 42, Code of Federal Regulations, Section 456.3 states, in part:

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

Title 42 CFR 438.6 Contract requirements, states in parts:

(c) *Payments under risk contracts* —(1) *Terminology*. As used in this paragraph, the following terms have the indicated meanings:

(i) *Actuarially sound capitation rates* means capitation rates that—

(A) Have been developed in accordance with generally accepted actuarial principles and practices;

(B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and

(C) Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

(3) *Requirements for actuarially sound rates*. In setting actuarially sound capitation rates, the State must apply the following elements, or explain why they are not applicable:

(i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.

(4) *Documentation*. The State must provide the following documentation:

(i) The actuarial certification of the capitation rates.

(ii) An assurance (in accordance with paragraph (c)(3) of this section) that all payment rates are—

(A) Based only upon services covered under the State plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).

(B) Provided under the contract to Medicaid-eligible individuals.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-14 The Department of Social and Health Services' internal controls are insufficient to ensure compliance with 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 Control 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. These units 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 State Attorney General's Office.

The Fraud Unit investigates and prosecutes Medicaid fraud and is to review allegations of patient abuse in health care facilities that receive Medicaid payments. Residential abuse includes neglect and financial exploitation of those in residential care. The Department must report allegations of residential abuse in a timely manner to the Medicaid Fraud Control Unit.

In our audit of fiscal year 2006, we found the Department's Mental Health Division's monitoring was insufficient to ensure reporting procedures are being followed.

Description of Condition

During our current audit we found:

- Federal regulations (42CFR 455.14) state if the grantee receives a complaint of Medicaid fraud or patient abuse or identifies questionable practices, it must conduct a preliminary investigation to determine if evidence is sufficient to warrant a full investigation. We judgmentally selected nine incidents from 127 incident reports on file at Western State Hospital. The files did not include clear documentation showing that a preliminary investigation had been conducted, the results of that investigation, or whether a full investigation was deemed warranted.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

- The Department's monitoring of reporting continued to be insufficient. For example, both Eastern State Hospital and Western State Hospital have policies that require them to report allegations of abuse to the Mental Health Division and to the proper law enforcement agency as applicable. In fiscal year 2007, 268 incident reports of possible abuse were on file at the hospitals. We verified that 133 of those also were reported by the hospitals to the Washington State Patrol, however, only 111 were reported to the Mental Health Division. None were referred to the Medicaid Fraud Control Unit. During our testing, we identified five incident reports that should have been referred to the Medicaid Fraud Control Unit since they met the Western State Hospital's own definition of physical abuse.

Cause of Condition

The Department responded to the 2006 finding by stating it would update policies to ensure compliance, as well as research the feasibility of a shared reporting system to improve incident tracking. During our current audit, we found the Department had developed adequate policies but did not monitor to ensure compliance.

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 allegations of abuse of Medicaid clients, it is unable to perform its investigatory role.

Additionally, the Department's noncompliance with federal reporting requirements could jeopardize future federal funding.

Recommendations

We recommend the Department:

- Follow policies and procedures designed to ensure compliance with federal Medicaid requirements.
- Establish effective monitoring procedures to ensure reporting policies and procedures are being followed.
- Follow up with Western State Hospital regarding the incidents we identified that were not referred to the Medicaid Fraud Unit as required by the Hospital's policies.

Department's Response

The Department concurs with this finding.

In response to the 2006 audit, the Mental Health Division (MHD) implemented many changes with respect to incident reporting. Specifically, in August 2006, MHD requested and received approval and funding to create a position to develop an incident reporting and incident management infrastructure within MHD. In May 2007, MHD hired the Incident Manager who immediately began tracking and monitoring incidents using a standardized electronic incident reporting template for state hospitals and Regional Support Networks reporting to MHD. The Incident Manager worked with Assistant Attorney Generals and the Department's Health and Recovery Services (HRS), and MHD senior management to ensure that MHD's incident reporting included all elements required by the Department, including the reporting of incidents involving residential abuse. This electronic incident reporting system was fully operational and implemented in July, 2007.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

In recent contract development discussions with Regional Support Networks (RSNs) MHD clarified the 2007-2009 contract requirements related to incident reporting requirements. The Incident Manager conducted on-site visits of all 13 RSNs to evaluate their compliance with the contract terms related to incident management. The Incident Manager is following up with four RSNs. As MHD worked with state hospitals to develop an MHD wide incident management policy, the Incident Manager created a one-page, "user-friendly" flow chart for state hospitals and for RSNs to assist them in identifying incidents that required reporting to MHD.

In January 2007, the MHD Assistant Director and Federal Compliance Officer began a series of internal and external stakeholder meetings including key HRSA Systems and Monitoring Division staff in an effort to further develop the electronic incident reporting process. These meetings occurred over a 3 month period and in April 2007 the business charter was approved, funding was secured, and efforts were initiated to develop a web-based application that allowed for the information contained in the electronic incident reporting system to be relayed to MHD within a secure web-based framework. This framework allowed for administrative efficiencies such as automated notification of incidents to MHD, HRSA and other DSHS administrations and divisions as appropriate, and data storage and extrapolation that allow for pattern and trend analysis that isn't currently available within the electronic system. This secure web-based program was originally set to be fully operational in January 2008, but due to technical corrections identified in early testing it has been delayed and now has a target date of March 2008.

The Incident Manager is also responsible to monitor and oversee the electronic system and relay critical incidents through the system to appropriate DSHS management. Other duties include revising statewide policies and procedures, data analysis and training related to incident management/prevention.

The MHD Incident Manager meets regularly with the MHD Assistant Director, state hospital incident management staff, and others as needed, to finalize the incident reporting policy and ensure compliance with reporting requirements consistent with DSHS policy. MHD anticipates having the enhanced MHD Incident Reporting policy completed by March 2008.

The MHD Incident Manager will work with Western State Hospital staff and the Medicaid Fraud Control Unit to address the 5 Western State Hospital incident exceptions noted by the auditor. On an on-going basis, the MHD headquarters Incident Manager will conduct on-site reviews to assess the state hospital and contractor compliance with the division's policy for investigating, monitoring, and referring incident reports. When deficiencies are identified corrective action will be required and monitored until complete. .

MHD believes these changes and the on-site review of state hospitals by the MHD Incident Manager will improve communication and accountability with the state hospitals and provide assurance that residential abuse is being properly reported and followed up on, and that incidents of residential abuse will be referred to the Medicaid Fraud Control Unit for their investigation.

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

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.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

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.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-15 The Department of Health does not have adequate internal controls to ensure compliance with federal Medicaid requirements for hospital surveys.

Federal Awarding Agency: US 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 and home health agencies statewide received more than \$706 million in state and federal Medicaid funds in the period from July 2006 to March 2007 for services provided to Medicaid clients. Federal regulations require states to ensure health-care facilities meet prescribed health and safety standards, known as the Conditions of Participation, to be eligible for federal matching funds for reimbursements to Medicaid providers. The federal Centers for Medicare and Medicaid Services (CMS) contracts with the state Department of Health to perform Medicare validation surveys as well as licensure surveys for all hospitals and home health agencies to ensure these standards are met. The Department of Health also performs Medicare certification surveys for Critical Access Hospitals and other facilities. Surveys are required for licensure and Medicare certification.

One specific health and safety requirement included in the survey process relates to criminal background checks for home health agency employees having unsupervised access to vulnerable adults and children. Home health agencies must ensure that such employees undergo a criminal background check and make a full disclosure of any crimes committed prior to employment. Monitoring for compliance with this requirement is part of the Department's survey process.

In our audits for fiscal years 2005 and 2006, we reported the Department was not maintaining documentation to support its survey conclusions, including conclusions relating to compliance with the criminal background check requirements. The Department stated it was not required by federal regulations to maintain pre-decisional documentation, however would begin doing so as a best practice, and would implement a document retention policy. Subsequently, the federal grantor stated it agreed with our finding and that the pre-decisional survey documentation should be maintained.

Description of Condition

During our current audit we found the Department of Health had begun maintaining pre-decisional survey documentation.

However, the Department has not developed a related documentation policy that clarifies the need to maintain this documentation in keeping with federal requirements and the applicable state records retention schedules.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Cause of Condition

The Department of Health indicated that it will develop survey documentation policies, however has not yet done so. The Department initially disagreed that it was required to retain the pre-decisional documentation.

Effect of Condition

The lack of formal policies and procedures unnecessarily increases the risk that the Department's directives are not carried out and all necessary supporting documents for surveys will not be maintained according to federal requirements and applicable state records retention schedules. The Department does not have an internal control system in place to ensure that documentation requirements are accurately and consistently relayed to staff, or to monitor compliance with the requirements.

We selected seven home health agency surveys completed subsequent to the last audit for testing. For five out of the seven, the Department did not have sufficient documentation to evidence that the Department monitored home health agencies for compliance with the requirement to perform background checks and obtain disclosure statements as required by law.

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

Recommendations

We recommend the Department develop, implement and monitor survey documentation policies and procedures to ensure all records supporting the results of surveys are maintained in keeping with federal requirements and applicable state records retention schedules.

Department's Response

The Department of Health Facilities and Services Licensing office began retaining survey documentation as of December 2006. We have since received further clarification on this requirement from the Center for Medicare and Medicaid Services (CMS).

We agree that an office directive and procedure will ensure that survey documentation is retained in accordance with the clarified federal requirements.

We thank the State Auditor's Office for the professional work by their staff.

Auditor's Concluding Remarks

We appreciate the actions taken by the Department to clarify and resolve this issue. We look forward to reviewing the status of the Department's corrective action during our next audit.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Applicable Laws and Regulations

42 CFR 431.610(f) states in part:

(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.

CMS State Operations Manual (SOM), section 4801A. Provider Certification Files b.(3) states:

Survey report forms and related documents pertaining to access hospitals, nursing homes and home health agencies-Cutoff file after removal from the access category and completion of the survey. Destroy 4 years after cutoff.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-16 The Department of Health is not complying with federal requirements for time and effort reporting for the National Bioterrorism Hospital Preparedness Program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.889 National Bioterrorism Hospital Preparedness Program
Federal Award Number:	4-UHRSO5968-01-01
Applicable Compliance Component:	Allowable Costs/Cost Principles
Questioned Cost Amount:	\$31,759

Background

The Department of Health, Public Health Preparedness and Response Program, administers the federal National Bioterrorism Hospital Preparedness Program (CFDA 93.889). The National Bioterrorism Hospital Preparedness Program is designed to improve the capacity of the nation's health care system to respond to biological, chemical, and radiological outbreaks; infectious disease epidemics; and acute mass casualty events. The program focuses primarily on developing regional preparedness plans and protocols for hospitals, outpatient facilities, emergency medical systems, and poison control centers. The Department received \$10,820,068 through this program in fiscal year 2007.

Federal requirements specify how employee salaries and wages charged to the grant are to be documented. For employees who work on activities for more than one grant, payroll costs charged directly to federal awards are to be supported by monthly personnel activity reports or documentation such as time sheets. 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 solely 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

During our audit, we found six employees whose salaries and benefits were charged to the grant did not complete timesheets or maintain any type of time summary. We were told that one employee worked on the grant in a full-time capacity and therefore should have completed, at a minimum, a semi-annual certification. The Department did not provide us with information concerning the other employees' activities that would enable us to determine if timesheets or time certifications were appropriate.

Cause of Condition

The majority of employees working under the administration of the Public Health Preparedness and Response Program have kept timesheets or been accurately certified, however; we found that employees of other divisions who occasionally work for the program fail to complete timesheets and/or certifications. The Program does not have internal controls in place to ensure that non-program employees who work on the grant maintain appropriate time and effort support documentation.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

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 payroll costs of \$31,759 related to the six employees identified.

Recommendations

We recommend the Department:

- Require all employees being charged to the grant complete accurate time records
- Consult with the federal grantor to determine whether questioned costs should be repaid.

Department's Response

We concur with the finding and the recommendations of the State Auditor's Office regarding time and effort reporting. We will review our current time and effort reporting practices to ensure that the necessary documentation is consistently maintained.

We thank the State Auditor's Office for the professional work by their staff.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

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.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

(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.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

(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.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-17 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: 07-0404WADI00
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 money 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 2007, the Division spent \$26,205,305 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 2007, the Division spent \$8,984,279 for consultative evaluations.

During our state fiscal year 2005 and 2006 audits, we reported a finding in this area because the Division did not follow state law on personal service contracts. The Division disagreed with the finding in 2005, stating it believed the services were client services, which are exempt from competitive procurement requirements. The Office of Financial Management was consulted regarding the proper classification for these services and in April 2006 determined services to claimants by physicians, psychologists, and psychiatrists are to be classified as personal services and subject to competitive procurement procedures.

Based on this determination, the Department concurred with the finding in 2006 and developed a plan to ensure compliance with the requirements. Due to the number of contracts affected, the Department set a completion date for compliance of October 2007. Our current audit covered July 1, 2006 through June 30, 2007.

Description of Condition

During this audit period, 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. The Division learned of interested providers informally. Many practitioners were paid amounts that substantially exceeded the threshold of \$20,000, requiring a formal competitive procurement process.
- No written contracts for any of these services.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Cause of Condition

The Department concurred with the prior audit finding and developed a plan to address the issue. However, the time required by the Department to complete the plan extended beyond our current audit period. For the period under audit, the Department was not in compliance with contracting requirements.

Effect of Condition

The Department cannot ensure the state's resources were used in the most economical manner possible. In addition, the state may not be adequately protected when more than \$8 million in services is purchased without written contracts and terms.

Recommendation

We recommend the Department ensure its staff is following its Corrective Action Plan by:

- Properly classifying consultative evaluation contracts as personal service contracts.
- Following appropriate competitive procurement procedures.
- Preparing and maintaining contract documentation for consultative evaluations by individual medical practitioners.

Department's Response

The Department agrees with this finding. As a result of the 2006 finding the Department developed a corrective action plan for converting the evaluation contracts from client services contracts to personal services contracts by

October 1, 2007. The department issued multiple requests for qualifications for various consultative services between May and September 2007, and awarded personal service contracts to all qualifying providers willing to accept the standard fees set by the department for the respective services. Personal service contracts were executed and in place for all doctors/professionals providing consultative services by October 1, 2007, the date established in the department's corrective action plan.

Auditor's Concluding Remarks

We appreciate the efforts the Department has made to resolve this issue. We look forward to reviewing the full implementation of its corrective action during our next audit.

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.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

20 CFR Section 437.36 - Procurement.

(a) States. When procuring property and services under a grant, a State must follow the same policies and procedures it uses for procurements from its non-Federal funds.

RCW 39.29.006 states in part:

(3) "Competitive solicitation" means a documented formal process providing an equal and open opportunity to qualified parties and culminating in a selection based on criteria which may include such factors as the consultant's fees or costs, ability, capacity, experience, reputation, responsiveness to time limitations, responsiveness to solicitation requirements, quality of previous performance, and compliance with statutes and rules relating to contracts or services.

(7) "Personal service" means professional or technical expertise provided by a consultant to accomplish a specific study, project, task, or other work statement.

RCW 39.29.011 states in part:

All personal service contracts shall be entered into pursuant to competitive solicitations, except for...

- (1) Emergency contracts;
- (2) Sole source contracts;
- (3) Contract amendments;
- (4) Contracts between a consultant and an agency of less than twenty thousand dollars. However, contracts of five thousand dollars or greater but less than twenty thousand dollars shall have documented evidence of competition. Agencies shall not structure contracts to evade these requirements.

The Office of Financial Management's *State Administrative and Accounting Manual*, states in Section 15.10.10:

Personal services are to be procured and awarded by state agencies in accordance with the requirements of Chapter 39.29 RCW.

Section 15.20.30.a states:

Competitive solicitation for contracts of \$20,000 or greater requires a documented, formal solicitation process as described in the following subsections. (*Auditor's note: Following this section are detailed regulations for this process.*)

Section 20.20.20 states in part:

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

The Office of Financial Management's *Guide to Personal Service Contracting*, Section 1.3, states in part:

Personal services are professional or technical services 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.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

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 individuals the agency has statutory responsibility to serve, protect, or oversee.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

07-18 The Department of Social and Health Services is not complying with federal requirements for allocating employee salaries and wages in accordance with its Public Assistance Agency Cost Allocation Plan.

Federal Awarding Agency:	U.S. Department of Health and Human Services U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 – Vocational Rehabilitation 93.775 – Medical Assistance 93.563 – Child Support Enforcement
Federal Award Number:	Multiple
Applicable Compliance Component:	Allowable Costs/Cost Principles
Questioned Cost Amount:	\$ 162,924

Background

Federal regulations require the Department of Social and Health Services, a public welfare agency, to prepare and administer a Public Assistance Cost Allocation Plan. The Plan must provide a description of the procedures used in identifying, measuring and allocating all direct and indirect cost to each of the programs administered by state public assistance agencies. The Plan must be approved by the grantor.

All agency costs normally charged to federal awards, except those for financial assistance to recipients, medical vendor payments, and costs for services and goods provided directly to program recipients must be included in the Plan.

Cost allocation bases are used to accumulate and distribute administrative costs to the benefitting federal programs. These distributions may be based on caseloads, number of employees, employee time and activity reports, or other reasonable criteria.

An administrative cost is eligible for federal reimbursement only if the methodology used to account for and claim the cost is clearly identified as part of an approved Plan.

The Department's Financial Services Administration, Office of Accounting Services is responsible for developing and following the Plan. That Office submitted a written Plan in June of 2006 to the U.S. Department of Health and Human Services for use during fiscal year 2007. After a year of negotiations, the final plan was approved by in July 2007.

Description of Condition

The Department claimed federal reimbursement for employee salaries and benefits (administrative costs) that did not comply with the methodologies described in its approved Plan and did not comply with federal Office of Management and Budget Circular A-87 requirements regarding documentation for support of salaries and wages charged to federal awards

Specifically, we found nine employees whose salaries were distributed using an unapproved allocation base or whose salaries were charged directly to a federal grant program or programs without adequate timesheets or other documentation.

Circular A-87 requires monthly personnel activity reports such as timesheets when employees work on more than one federal program. This applies whether the employee's salary costs are charged directly to a grant, indirectly through a cost allocation process, or through a combination of methods.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Economic Services Administration (ESA)

During fiscal year 2007 we found:

- \$25,255 of the State Tribal Relations Unit Administrator's salary was directly charged to the Child Support Enforcement Program. The Plan states employee salaries in the State Tribal Relations Unit will be allocated only through cost allocation base 482. The remainder of the administrator's salary was allocated through base 482, which was allowable.
- \$22,207 of a mail clerk's salary in the Yakima Community Service Office was direct charged to the Child Support Enforcement Program. The position is shared between the Economic Services Administration and the Children's Administration and as a result, the remainder of this mail person's salary was allocated through base 590 (a Children's Administration Base) which was allowable per the Plan.

The agency stated it used pieces mailed as the basis for the allocation. However, this allocation method was not approved in the Plan for the allocation of field staff salaries in the Community Services Offices.

- \$21,029 of a truck driver's salary in the Division of Employment and Assistance Programs was direct charged to the Vocational Rehabilitation Grant. The salary was also allocated through allocation base 642 and 643 which resulted in salary costs of \$562 being charged to the Medical Assistance program. The Plan required this division's staff salaries to be allocated through Base 476.

The agency devised a special allocation methodology for this position based on an agreement between 8 DSHS Administrations to each fund a fixed portion of this position's salary. This allocation method was never approved in the Plan.

- \$2,162 of the King County Community Service Office Manager's salary was directly charged to the Vocational Rehabilitation Grant. The Plan provided that this type of position would be allocated 100% through base 476. The remainder of this person's salary was allocated through cost allocation base 476 in accordance with the Plan.

Agency management used a semi-annual analysis of building square footage as the basis for the allocation. However, this allocation method was not approved in the Plan for use in allocating Community Service Office staff costs.

Health and Recovery Services Administration (HRSA)

A special assistant's salary was allocated 50% to a state funded allocation base in the Juvenile Rehabilitation Administration and 50% to cost allocation base 805 approved for use in the by the Mental Health Administration. Allocation through base 805 resulted in salary costs of \$35,348 being charged to the Medical Assistance program for fiscal year 2007.

The agency stated that the assistant was working on policies for both the Juvenile Rehabilitation Administration and the Mental Health Administration. However, no time and effort documentation was maintained to support the allocation to the two different indirect cost activities.

Indian Policy and Support Services

From December of 2006 through June 2007, we noted the salary and benefits for the regional director of Indian Policy and Support Services were:

- Directly charged to the federal Vocational Rehabilitation Program for \$8,005, and
- Allocated through Base 571, which resulted in \$4,990 being charged to the Medical Assistance program. Use of this base was not approved for the Indian Policy and Support Services section in the Plan.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

According to the Plan, employee salaries for Indian Policy and Support should have been allocated through Base 100 which was allocated across all federal and state programs agency wide. In addition, no time and effort documentation was maintained to support the allocation to both direct and indirect cost activities.

Aging and Disability Services Administration (ADSA)

\$2,781 of an office trainee's salary in the Aging and Disability Services Administration was directly charged to the Vocational Rehabilitation Grant. According to the Plan, this position should have been allocated through cost allocation base 710, which is where the remainder of this person's salary was charged.

Because this position was shared between Region 3 ADSA and the Vocational Rehabilitation Division, program management allocated the costs between base 710 and the Vocational Rehabilitation grant using the Full-Time Equivalents disbursed method of allocation. This allocation method was not approved for use in the ADSA or Vocational Rehabilitation section of the Plan.

Research and Data Analysis Section (RDA)

According to the Plan, employee salaries in the Research and Data Analysis section may be directly charged to federal programs if appropriate, or may be charged through Base 100 which allocates costs across all federal and state programs agency wide. We noted two employees whose salary costs were allocated consistent with the methods above, however the employees did not generate time and effort documentation (i.e. timesheets) to support the charges. We noted:

- \$20,691 of one staff member's salary was charged directly to the Medical Assistance program. The remainder of the person's salary was allocated through bases 571 and 710, which resulted in \$995 being charged to the Medical Assistance program.
- \$8,715 of one staff member's salary was charged directly to the Vocational Rehabilitation Grant. The remainder was allocated through bases 571 and 710, which resulted in \$10,184 being charged to the Medical Assistance Program.

Cause of Condition

While the Office of Accounting Services is responsible for development and implementation of the Plan, it is not required to ensure each position is set up to allocate costs in accordance with the Plan. In addition, the Department's Administrative Policy 19.50.01B, "Federal Compliance with Time Certifications for Positions Charged to Multiple Funding Sources", is unclear in some areas regarding how to comply with federal requirements.

Effect of Condition and Questioned Costs

When a public assistance agency charges federal programs outside of the methods approved in the Plan, federal grantors cannot be assured costs allocated to their programs are accurate and valid.

Further, without adequate time and effort certifications, federal grantors cannot be assured salaries and wages charged to their programs are accurate and valid. This could jeopardize future federal funding.

We are questioning the following costs because they were either allocated directly to federal programs without adequate time and effort documentation and or they were allocated through cost allocation bases that were not approved for their divisions' use in the Plan.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

Questioned Costs by Division:

	ESA	HRSA	Indian Policy	ADSA	RDA	Totals
Medicaid Cluster						
Federal	\$ 281	\$ 17,674	\$ 2,495		\$ 15,935	36,385
State Match	281	17,674	2,495		15,935	36,385
Child Support Enforcement						
Federal	31,325					31,325
State Match	16,137					16,137
Vocational Rehabilitation						
Federal	18,251		6,300	2,189	6,858	33,598
State Match	4,940		1,705	592	1,857	9,094
						\$ 162,924

Recommendations

We recommend the Department require the Office of Administrative Services to approve all personnel activity reports submitted by Administrations that allocate or direct charge to more than one federal grant or allocation base.

We also recommend the Department revise its Federal Time and Effort Policy to clarify how to comply with federal requirements.

The Department should consult with its federal grantors to determine if questioned costs should be repaid.

Department's Response

The Department concurs with the finding. The Department agrees that the costs for each of the positions identified by the auditor were not distributed as required by the Public Assistance Agency Cost Allocation Plan (PACAP) or were not listed as a category of position in the PACAP. The Office of Accounting Services will work with the identified DSHS Administrations to correctly distribute the identified costs and comply with federal regulations by:

- *Updating the PACAP to identify the position and the methodology used to allocate the costs associated with that position; or*
- *Updating the account coding associated with the position so that all costs are allocated according to the PACAP; or*
- *Ensuring recorded time and effort documentation is produced and maintained to support the charges associated with the position; or*
- *Reviewing the duties of the position in question to reconfirm whether the currently identified methodology is correct or if a more appropriate methodology needs to be applied; updating the PACAP to reflect any changes made to the methodology.*

The Office of Accounting Services will also continue to work with the Administrations to accurately code positions and assist them in implementing the requirements of the PACAP.

The Department disagrees with the following statements in the finding:

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - continued

“The Department claimed federal reimbursement for employee salaries and benefits (administrative costs) that did not comply with the methodologies described in its approved Plan and did not comply with federal Office of Management and Budget Circular A-87 requirements regarding documentation for support of salaries and wages charged to federal awards”

It is the department’s position that all the methodologies used by the department are listed in the approved PACAP. However, some of the individual positions tested by the auditors were not associated with a specific category of positions included in the PACAP. These omissions were an oversight and will be corrected with the next plan update.

The Department will review Administrative Policy 19.50.01B, “Federal Compliance with Time Certifications for Positions Charged to Multiple Funding Sources” and provide clearer instructions to the administrations on documentation requirements for the distribution of salaries and wages charged to multiple programs and work with each of the federal granting agencies to determine if any of the costs questioned above are to be returned.

Auditor’s Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department’s corrective action during our next audit.

Applicable laws and Regulations

Title 45 CFR 95 section 507 reads:

Plan requirements.

(a) The State shall submit a cost allocation plan for the State agency as required below to the Director, Division of Cost Allocation (DCA), in the appropriate HHS Regional Office. The plan shall:

(1) Describe the procedures used to identify, measure, and allocate all costs to each of the programs operated by the State agency...

(4) The procedures used to identify, measure, and allocate all costs to each benefiting program and activity (including activities subject to different rates of FFP).

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.

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2007

Federal Findings and Questioned Costs - concluded

(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.

...(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.