Financial Findings Reported Under Government Auditing Standards

10-01 The State's internal controls are inadequate to ensure the Schedule of Expenditures of Federal Awards is accurately prepared, placing the state at risk of incomplete and inaccurate reporting to the federal government. This could affect the amount of federal funding the state receives in the future.

Background

As a condition of receiving federal funding, regulations require the state to prepare an annual Schedule of Expenditure of Federal Awards (SEFA) detailing the value and type of federal assistance received each year. The federal Office of Management and Budget issues instructions on how to prepare this schedule.

In Washington, the Office of Financial Management (OFM) has been delegated responsibility for the preparation of the SEFA. Each state agency receiving federal assistance is required to report the details of that assistance to OFM, which then prepares a single schedule for the state. The SEFA is a required part of the state's annual financial statement reporting package and identifies for the State Auditor's Office programs that are subject to the State of Washington Single Audit each year. Auditors are required to assess the accuracy of the schedule as part of that work.

In fiscal year 2010, the state SEFA reported total federal awards of $18,178,023,667.

Description of Condition

Our audit determined OFM's internal controls are not adequate to ensure the SEFA accurately reports all federal assistance state agencies receive. We found the following deficiencies in internal controls over the SEFA's preparation and reporting that collectively represent a material weakness:

- One employee at OFM has overall responsibility for final preparation of the SEFA. No one reviews this employee's work for accuracy. Our review of the SEFA for fiscal year 2010 found significant reporting errors by agencies and OFM that were not detected until our audit.

- Prior to 2010, OFM compiled much of the SEFA information using a data processing application. When it changed this system in 2010, it did not adequately test or monitor the new system to ensure it was working. The system was to automatically match information reported by agencies to a federal program database. Flaws in the design of this system caused incorrect information matches, creating many of the reporting errors. Because OFM does not reconcile the final SEFA to the information initially submitted by agencies, it did not identify these errors.

- More than 50 agencies report assistance information for hundreds of different federal programs each year. The decentralized nature of this process significantly increases the likelihood of errors. OFM sets requirements for federal accounting in the state accounting manual and provides additional guidance through training that references how to comply with federal guidelines.

Cause of Condition

The Legislature has delegated to OFM the responsibility for preparation of the state's financial statements, including the SEFA. OFM has not put internal controls in place to ensure the SEFA is accurate and complete. It relies on agencies to provide accurate information, but it does not review that information before preparing the SEFA.

Effect of Condition

OFM staff did not detect significant errors in the state's fiscal year 2010 SEFA. We identified reporting errors totaling approximately $1 billion.

The following three errors prevented the State Auditor's Office from correctly identifying federal programs for audit in accordance with federal regulations. This resulted in additional work late in the audit process that will cost the state approximately $14,268. It also puts the state at risk of not meeting the federally mandated audit deadline. Failure to meet the deadline could affect the state's ability to receive federal assistance:

- The Department of Health distributed $82.8 million worth of vaccines through the Immunization Grant program it did not report on the schedule.
- The Department of Health distributed $19.3 million worth of vaccines through the Public Health Emergency Preparedness program it did not report on the schedule.
- The Department of Social and Health Services reported $2.7 million of Medicaid expenditures as Children's Health Insurance Program expenditures.

The auditor also identified the following errors:

- OFM incorrectly identified "clusters" – programs that federal regulations state should be grouped and audited together due to their similarities. We identified 17 programs classified under incorrect clusters, resulting in approximately $922 million in assistance being incorrectly reported. Three significant issues identified are:
    - OFM misreported $820 million in Medicaid funds provided through the American Recovery and Reinvestment Act as Foster Grandparent/Senior Companion program funds. The state received no funding through the Foster Grandparent/Senior Companion program.
    - OFM misreported more than $34 million received through the Schools and Roads Program as Disability Insurance funding. As a result, the Schools and Roads Program was underreported.
    - OFM incorrectly identified multiple federal programs clustered together under the U.S. Department of Homeland Security in the cluster, resulting in it being underreported by $14 million.
- OFM's reporting system did not accurately identify and assign program titles, which resulted in nine programs being incorrectly titled in the SEFA.

The Department of Commerce did not correctly identify approximately $2.6 million in State Energy Program assistance provided through the American Recovery and Reinvestment Act. Federal regulations require any assistance provided through the Act to be clearly identified as such on the schedule.

- The Department of Social and Health Services did not correctly report approximately $1.8 million in Foster Care and Adoption Assistance provided through the Recovery Act.
- The Department of Social and Health Services did not correctly categorize subrecipients of the Medicaid program versus vendors and subsequently over-reported payments to subrecipients by approximately $400 million.
- The Department of Social and Health Services did not correctly identify subrecipients of the Temporary Assistance Needy Families and underreported subrecipient payments by approximately $28 million.

- The Department of Health incorrectly reported $18.7 million received through the Centers for Disease Control as Research and Development cluster grant funds.

- The Office of Superintendent of Public Instruction reported nearly $19 million in assistance received through the Commodity Supplemental Food Program under a non-existent federal award program number.

All the errors identified were provided to OFM for correction prior to it submitting the schedule to the federal government by the deadline of March 30 and releasing it to the public.

Recommendation

We recommend OFM:

- Provide knowledgeable and independent oversight of SEFA preparation and ensure staff responsible for it have the resources needed to do an effective job.
- Test and monitor systems used in SEFA preparation to ensure accurate reporting of federal assistance.
- Perform a detailed reconciliation of the federal assistance reported by the state agencies to the final schedule.
- Establish centralized reporting guidance and assistance to agencies receiving federal assistance to ensure timely, accurate and consistent information and periodically assess the effectiveness of the systems to ensure accurate reporting.

Department's Response

The Office of Financial Management (OFM) concurs that internal controls related to the preparation of the Schedule of Expenditures of Federal Awards (SEFA) need to be strengthened. To address the weaknesses noted in the finding, OFM has or will:

- *Corrected the SEFA for the discrepancies noted by the auditors prior to submitting it to the federal government and releasing it to the public.*
- *Implemented new procedures to test and monitor changes to the systems used to prepare the SEFA. The procedures include removal of discontinued CFDA numbers as appropriate.*
- *Designed procedures to ensure the quality and accuracy of the SEFA. The procedures address the assignment of cluster and program titles as well as independent oversight.*
- *Continue to provide training to agencies on federal award accounting and reporting requirements. Year end training for Fiscal Year 2011 will address discrepancies noted in this finding. Additionally, OFM is considering other tools such as a checklist or a Question & Answer document to support proper reporting by agencies.*

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

OMB Circular A-133, Section .310(b) states

(b) Schedule of expenditures of Federal awards.
The auditee shall also prepare a schedule of expenditures of Federal awards for the period covered by the auditee's financial statements. While not required, the auditee may choose to provide information requested by Federal awarding agencies and pass-through entities to make the schedule easier to use. For example, when a Federal program has multiple award years, the auditee may list the amount of Federal awards expended for each award year separately. At a minimum, the schedule shall:

(1) List individual Federal programs by Federal agency. For Federal programs included in a cluster of programs, list individual Federal programs within a cluster of programs. For R&D, total Federal awards expended shall be shown either by individual award or by Federal agency and major subdivision within the Federal agency. For example, the National Institutes of Health is a major subdivision in the Department of Health and Human Services.
(2) For Federal awards received as a subrecipient, the name of the pass-through entity and identifying number assigned by the pass-through entity shall be included.
(3) Provide total Federal awards expended for each individual Federal program and the CFDA number or other identifying number when the CFDA information is not available.
(4) Include notes that describe the significant accounting policies used in preparing the schedule.
(5) To the extent practical, pass-through entities should identify in the schedule the total amount provided to subrecipients from each Federal program.
(6) Include, in either the schedule or a note to the schedule, the value of the Federal awards expended in the form of non-cash assistance, the amount of insurance in effect during the year, and loans or loan guarantees outstanding at year end. While not required, it is preferable to present this information in the schedule.

Title 2, Code of Federal Regulations, Section 176.210, states:

(a) To maximize the transparency and accountability of funds authorized under the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) (Recovery Act) as required by Congress and in accordance with 2 CFR 215.21 "Uniform Administrative Requirements for Grants and Agreements" and OMB Circular A–102 Common Rules provisions, recipients agree to maintain records that identify adequately the source and application of Recovery Act funds. OMB Circular A–102 is available at *http://www.whitehouse.gov/omb/circulars/a102/a102.html.*

(b) For recipients covered by the Single Audit Act Amendments of 1996 and OMB Circular A–133, "Audits of States, Local Governments, and Non-Profit Organizations," recipients agree to separately identify the expenditures for Federal awards under the Recovery Act on the Schedule of Expenditures of Federal Awards (SEFA) and the Data Collection Form (SF–SAC) required by OMB Circular A–133. OMB Circular A–133 is available at *http://www.whitehouse.gov/omb/circulars/a133/a133.html.* This shall be accomplished by identifying expenditures for Federal awards made under the Recovery Act separately on the SEFA, and as separate rows under Item 9 of Part III on the SF–SAC by CFDA number, and inclusion of the prefix "ARRA-" in identifying the name of the Federal program on the SEFA and as the first characters in Item 9d of Part III on the SF–SAC.

Government Auditing Standards, July 2007 Revision – Section 5.11, requires auditors to report significant deficiencies and material weaknesses in internal control. Statement on Auditing Standards No. 115, issued by the Auditing Standards Board of the American Institute of Certified Public Accountants, defines material weakness and significant deficiency as follows:

a. Material weakness:
A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

b. Significant deficiency:
A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

10-02 The Department of Social and Health Services, Economic Services Administration, did not comply with federal regulations regarding support of salaries and wages paid to employees.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	10.551,10.561 Supplemental Nutrition Assistance Cluster 10.551,10.561 Supplemental Nutrition Assistance Cluster – American Recovery and Reinvestment Act (ARRA) 93.558 Temporary Assistance for Needy Families (TANF) 93.714 Emergency Contingency Fund for TANF State Program – American Recovery and Reinvestment Act (ARRA) 93.563 Child Support Enforcement 93.563 Child Support Enforcement – American Recovery and Reinvestment Act (ARRA) 93.575 Child Care and Development Block Grant 93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund 93.713 Child Care and Development Block Grant, American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	Multiple
Applicable Compliance Component:	Cost Principles
Questioned Cost Amount:	None

Background

Federal regulations require the Department of Social and Health Services to maintain documentation to support salaries and benefits paid to employees. It must keep a personnel activity report or equivalent documentation in order to meet this requirement. This documentation must show the employee's total activity, reflect an after-the-fact distribution of actual activity and be prepared at least monthly.

Budget estimates or other distribution percentages determined before services are performed do not qualify as support for charges to federal awards. However, budget estimates may be used for interim accounting purposes, provided they are reasonable approximations of activity performed, compared to actual activity and adjusted as needed at least quarterly if the differences are less than 10 percent, and the estimates are revised at least quarterly, if necessary, to reflect changed circumstances.

The Economic Services Administration (ESA) establishes expected time spent on programs and documents this information on Position Action Requests for each employee charging multiple awards. Employees also keep monthly timesheets to document the exact time spent on each federal program. The Department is to compare percentages on Position Action Requests to actual time documented on timesheets quarterly.

Description of Condition

ESA did not complete its comparison of Position Action Requests to timesheets quarterly for employees charging multiple federal awards. The Department's policy regarding time certifications specifies comparisons must be completed semi-annually. Each of the six regions within ESA are required to complete these reviews. We found four of the regions did not have documentation showing they did quarterly reviews.

Cause of Condition

Prior to fiscal year 2010, the Department's policy regarding time certifications for staff charging multiple federal awards directed programs to submit certifications quarterly. At the beginning of fiscal year 2010, Department management changed this policy to a semi-annual basis to reduce workload for employees. They did not understand this did not meet federal requirements.

Effect of Condition

When grantees do not follow federal requirements for documentation on salaries and benefits to multiple programs, grantors cannot ensure charges to federal grants are accurate.

Recommendation

We recommend the Department establish policies and procedures to agree with appropriate federal requirements involving the use of budget estimates for staff charging multiple federal grants.

Department's Response

The Department concurs with the finding.

DSHS Administrative Policy 19.50.01.B (Federal Compliance with Time Certifications for Positions Charged to Multiple Funding Sources or Cost Objectives) does not require a quarterly review of actual time worked compared to the Position Action Request form, so ESA will refer this issue to the DSHS Accounting Policy and Management Board (APMB) for further review and update.

Internally, ESA maintains a Business Center Process Manual for use by Community Services Division (CSD) Business Center staff. The ESA Operation Support Division (OSD) updated this manual in January 2011 to coincide with federal requirements and quarterly reviews are now a requirement. OSD also held a conference call with the CSD Regional Business Managers to reiterate this process change.

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

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

> The auditee shall:
>
> (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments* (2 CFR Part 225), states:

> Appendix B, Section 8(h) - Support of salaries and wages. These standards regarding time distribution are in addition to the standards for payroll documentation.
>
> (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.

10-03 The Department of Social and Health Services did not issue retroactive food assistance payments in accordance with federal law.

Federal Awarding Agency:	U.S. Department of Agriculture
Pass-Through Entity:	None
CFDA Number and Title:	10.551,10.561 Supplemental Nutrition Assistance Cluster 10.551,10.561 Supplemental Nutrition Assistance Cluster – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Activities Allowed/Cost Principles
Questioned Cost Amount:	$15,000 (approx.)

Background

The Economic Services Administration at the Department of Social and Health Services administers the Supplemental Nutrition Assistance Program for the state. The program provides food assistance benefits to low-income households. It paid more than $1.3 billion in benefits to eligible households in fiscal year 2010.

Federal law requires the Department to restore benefits to households that were underpaid or denied due to Department error or court action. The client is eligible for restoration of underpaid benefits for any of the 12 months prior to the month the client requests restoration or the month the Department discovers the underpayment. The Department issues a retroactive payment equal to the amount of benefits lost during that time period, regardless of the household's current eligibility status. More than 10,000 retroactive payments totaling about $2.4 million were issued during fiscal year 2010.

During our fiscal year 2008 audit, we determined the Department made $13,995 in retroactive food assistance payments to clients beyond the 12 months allowed by law. In 2009, we identified $4,460 in these inappropriate payments.

Description of Condition

We reviewed a list of all retroactive payments issued during fiscal year 2010 to identify all instances in which the payment issue date was more than 12 months beyond the first corrected month. We identified 179 such instances, and selected the 19 largest payments, representing approximately 53 percent of the total dollars at risk, for additional review. We found that all 19 included payments for time periods in excess of the 12 months allowed by law, representing more than $15,000 in unallowable benefits. Since we did not review 100 percent of the payments at risk, it is likely the total amount of inappropriate payments is higher.

Cause of Condition

Department staff responsible for issuing retroactive food assistance benefits have not been properly trained in the criterion used to calculate and document them. In response to the finding issued in fiscal year 2008, staff completed training in June 2009, and online training is available. However, training has not been required since 2008 and new staff do not complete it.

Effect of Condition and Questioned Costs

Some individuals received food assistance benefits to which they were not entitled. Inappropriate benefit payments related to the files we reviewed totaled approximately $15,000. It was not possible to establish an exact amount of questioned costs as staff did not include underpayment information for each specific month as required by Department policy.

Recommendation

We recommend the Department ensure staff are adequately trained how to calculate and document retroactive food assistance benefit payments. We further recommend the Department review all retroactive payments identified as potentially inappropriate to identify the total unallowed costs.

The Department should consult with its grantor to determine what questioned costs should be repaid.

Department's Response

The Department concurs with this finding.

The Department will retrain field staff on the proper calculation of retroactive payments. Training will focus on when a retroactive payment is indicated and allowed, and the time limitations required by law. This training will also be required for all new field staff who are responsible for issuing benefits.

The Department will review the 179 cases cited in this audit to determine the correct supplement amount for which each client was eligible. For cases where unallowable payments were made, the Department will follow existing rules and policies for establishing overpayments.

The Department will work with the respective federal agencies to determine if the costs identified need to be adjusted or repaid.

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,* Section 300, states in part:

> The auditee shall:
>
> (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

Title 7 Code of Federal Regulations Sec. 273.17 states:

> (a) Entitlement.
>
> (1) The State agency shall restore to households benefits which were lost whenever the loss was caused by an error by the State agency or by an administrative disqualification for intentional Program violation which was subsequently reversed as specified in paragraph (e) of this section, or if there is a statement elsewhere in the regulations specifically stating that the household is entitled to restoration of lost benefits. Furthermore, unless there is a statement elsewhere in the regulations that a household is entitled to lost benefits for a longer period, benefits shall be restored for not more than twelve months prior to whichever of the following occurred first:
>
> (i) The date the State agency receives a request for restoration from a household; or
>
> (ii) The date the State agency is notified or otherwise discovers that a loss to a household has occurred.
>
> (2) The State agency shall restore to households benefits which were found by any judicial action to have been wrongfully withheld. If the judicial action is the first action the recipient has taken to obtain restoration of lost benefits, then benefits shall be restored for a period of not more than twelve months from the date the court action was initiated.

When the judicial action is a review of a State agency action, the benefits shall be restored for a period of not more than twelve months from the first of the following dates:

(i) The date the State agency receives a request for restoration:

(ii) If no request for restoration is received, the date the fair hearing action was initiated; but

(iii) Never more than one year from when the State agency is notified of, or discovers, the loss.

(3) Benefits shall be restored even if the household is currently ineligible.

Washington Administrative Code 388-410-0040 states, in part:

(2) All food assistance benefits underpaid are restored when:

(a) An underpayment was caused by department error;

(b) An administrative disqualification for intentional program violation was reversed;

(c) A rule or instruction specifies restoration of unpaid benefits; or

(d) A court action finds benefits were wrongfully withheld.

(3) A client is eligible for restoration of underpaid benefits for any of the twelve months prior to:

(a) The month the client requests restoration;

(b) The month the department discovers an underpayment;

(c) The date the household makes a fair hearing request when a request for restoration of benefits was not received; or

(d) The date court action was started when the client has taken no other action to obtain restoration of benefits."

10-04 The Recreation and Conservation Office did not comply with federal cash management requirements.

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:	NA04NMF4380260, NA05NMF4381269, NA06NMF4380091, NA07NMF4380301, NA08NMF4380608, NA09NMF4380363
Applicable Compliance Component:	Cash Management
Questioned Cost Amount:	Unknown

Background

The Recreation and Conservation Office, is a small state agency that manages grant programs to create outdoor recreation opportunities, protect the best of the state's wildlife habitat and farmland, and help return salmon from extinction. The Office received more than $25 million from the U.S. Department of Commerce for salmon recovery efforts during fiscal year 2010. It passed approximately 97 percent of this money on to subrecipients such as cities, towns, counties, state agencies, special-purpose districts, non-profit organizations, Indian tribes and private landowners to fund approved projects.

Grant regulations allow the Office to receive cash advances if it spends the money within 30 days. This ensures the money is immediately put to use and prevents recipients from using it to generate interest income. Federal regulations further require the Office to ensure cash draws by subgrantees conform to similar standards of timing and expenditures. This means the Office must monitor cash advances to subrecipients to ensure they are spending money only to meet immediate needs and in a timely manner.

During our fiscal year 2009 audit, we identified instances in which the Office issued subrecipients cash advances for 90 days worth of expenditures rather than the allowed 30 days. In addition, the Office allowed subrecipients more than 120 days to provide documentation of how these cash advanced funds were spent.

Description of Condition

In response to the 2009 audit finding, the Office revised its policies and practices to restrict cash advances involving federal funds to 30 days. The revisions took effect August 14, 2010, which was not in time for the changes to be in place before the end of the 2010 fiscal year on June 30.

During our fiscal year 2010 audit we identified instances in which subrecipients were allowed more than 90 days to provide supporting documentation to show how they spent cash advances. We reviewed the cash advance lists for November 17, 2009 and June 14, 2010.

Number of Advances	Number of Days Outstanding
36	31-90
14	Over 90

At the end of our fieldwork, one subrecipient had not provided complete documentation to show it spent the money 195 days after it was received.

Cause of Condition

The Office did not complete its policy revision or change its processes prior to the end of the fiscal year due to discussions with the federal grantor regarding cash advance rules.

Effect of Condition

The Office did not ensure federal grant funds were put to immediate use. Funds not immediately used were neither earning interest for the federal government nor were they available for use by others eligible to receive them.

Recommendations

We recommend the Office ensure its policies and procedures substantially conform to the federal government's requirements to limit cash advances to the minimum funds needed for 30 days.

Office's Response

We thank the auditor for their review of the past RCO finding. RCO takes the stewardship of funds seriously. Review of RCO accounting practices by the SAO is just one way we ensure that the agency appropriately uses grant funds.

The ability to provide sponsors with a cash advance is a key component of our salmon recovery grant making process and has been since the beginning of the program. As a result of your draft finding, staff did considerable research into federal laws and policies. We attempted to negotiate a policy with our federal partner that would allow a 90 day advance period but were unsuccessful. RCO has now modified our process so that we are in compliance with rules that allow advances of federal funds to be given only for what is expected to be spent in a 30 day period.

This change was effective August 13, 2010.

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

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

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

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Section 400(d) – Pass-through entity responsibilities, states in part:

> 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 pass-through 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.

Title 15, Code of Federal Regulations, Part 24, Section 20 outlines responsibilities for entities receiving federal funds and states in part:

…(7) Cash management. Procedures for minimizing the time elapsing between the transfer of funds from the U.S. Treasury and disbursement by grantees and subgrantees must be followed whenever advance payment procedures are used. Grantees must establish reasonable procedures to ensure the receipt of reports on subgrantees' cash balances and cash disbursements in sufficient time to enable them to prepare complete and accurate cash transactions reports to the awarding agency. When advances are made by letter-of-credit or electronic transfer of funds methods, the grantee must make drawdowns as close as possible to the time of making disbursements. Grantees must monitor cash drawdowns by their subgrantees to assure that they conform substantially to the same standards of timing and amount as apply to advances to the grantees.

Title 15, Code of Federal Regulations, Part 24, Section 21 outlines responsibilities for entities receiving federal funds and states in part:

…(i)Interest earned on advances. Except for interest earned on advances of funds exempt under the Intergovernmental Cooperation Act (31 U.S.C. 6501 et seq.) and the Indian Self-Determination Act (23 U.S.C. 450), grantees and subgrantees shall promptly, but at least quarterly, remit interest earned on advances to the Federal agency. The grantee or subgrantee may keep interest amounts up to $100 per year for administrative expenses.

United States Department of Commerce, *Financial Assistance Standard Terms and Conditions*, outlines responsibilities for entities receiving federal funds and states in part:

A. Financial Requirements
.02 Award Payments
d. Advances shall be limited to the minimum amounts necessary to meet immediate disbursement needs, but in no case should advances exceed the amount of cash required for a 30-day period. Advanced funds not disbursed in a timely manner and any applicable interest must be promptly returned to DOC.

J. Code of Conduct and Subaward, Contract, and Subcontract Provisions
.02 Applicability of Award Provisions to Subrecipients
a. The recipient shall require all subrecipients, including lower tier subrecipients, under the award to comply with the provisions of the award, including applicable cost principles, administrative, and audit requirements.

10-05 The Department of Commerce, Local Government and Infrastructure Division, does not have controls to ensure it complies with reporting requirements for the Community Development Block Grant program.

Federal Awarding Agency:	U.S. Department of Housing and Urban Development
Pass-Through Entity:	
CFDA Number and Title:	14.228 Community Development Block Grant 14.225 Community Development Block Grant – American Recovery and Reinvestment Act
Federal Award Number:	B-09-DY-53-0001, B-07-DC-53-0001, B-08-DC-53-0001, B-09-DC-53-0001, B-10-DC-53-0001
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The Community Development Block Grant program provides money for local governments to use to develop housing and expanded economic opportunities for low- and moderate-income persons.

Since 1982, the state has used this grant to distribute more than $419 million from the U.S. Department of Housing and Urban Development (HUD).

During fiscal year 2010, the Department spent almost $28 million on the Community Development Block Grant program: approximately $1.4 million of which was funded through the American Recovery and Reinvestment Act.

HUD tracks how program funds provide economic opportunities to low- and very low-income persons. It collects this information annually to identify employment and training provided. It also identifies contracts awarded to businesses providing economic opportunities to low- and very low-income persons.

Description of Condition

Staff responsible for preparing the report did not have all the information needed to complete it. The Department included non-federal funds in the report and overstated the amount of funding awarded to businesses by more than $4 million. This created an overstatement of the percentage of funds awarded to businesses elsewhere in the report.

Additionally, the Department did not report the number of jobs created and training provided for low-income persons by subrecipients and contractors.

Cause of Condition

The Department misunderstood the requirements, and believed the grantor wanted all funds reported rather than only the Community Development Block Grant funds.

The Department did not collect information from its subrecipients and contractors because, it stated, the grantor did not provide it a form or other tool to collect the information.

Effect of Condition

Grantors rely on accurate reports to monitor the progress of programs and the use of federal dollars. By not submitting the reports with accurate data, the Department prevented the grantor from adequately monitoring the effects of the program. Grant conditions allow the grantor to penalize the Department for noncompliance, suspending or terminating the award, and withholding future awards.

Recommendation

We recommend the Department collect the necessary information from subrecipients and contractors to accurately and completely fill out the required report. We also recommend it work with the federal grantor for clarification on the required report information.

Department's Response

We concur with the finding. This occurred because instructions from the federal granting agency, the Department of Housing and Urban Development, (HUD), for the Section 3 report were not clear. In June 2010, HUD provided updated instructions clarifying that only the Community Development Program (CDP) portion of funding awarded to Section 3 businesses should be reported. As one of the CDP federal grantee programs, CDBG Section 3 reporting should have been separated as directed.
Commerce is taking several steps to ensure the 2010 Section 3 report due on March 31, 2011 and all future reports are accurate.

1) *We are monitoring our grant recipient's Contractor/Sub Contractor semi-annual reports to ensure only the CDBG portion of funds awarded to Section 3 businesses is reported. The Contractor/Sub Contractor reports are submitted to HUD on a semi-annual basis and are compiled and reported on the Section 3 report.*
2) *Contractor/Sub Contractor reports that include other funding will be corrected to include only the CDBG portion of funding before submitting to HUD and before being included in the annual Section 3 report.*
3) *Commerce is providing technical assistance to current grant recipients to ensure they are reporting only the CDBG portion of awards to Section 3 businesses, hiring and/or training Section 3 persons.*
4) *Commerce is updating the 2011 CDBG Management Handbook to provide clear instructions for completing the Contractor/Sub Contractor reports, documenting hiring and/or training of Section 3 persons. Our staff will provide training to the 2011 CDBG grant recipients at CDBG Management Handbook workshops on the reporting requirements in May and June 2011.*
5) *Commerce staff responsible for compiling the data will review it for completeness and accuracy and work with grant recipients to resolve any discrepancies. Commerce management will review and approve Section 3 reports before submittal to HUD and provide an explanation when any outcomes of hiring and/or training Section 3 persons are not documented in the annual Performance Evaluation Report.*

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

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

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

Title 24 Code of Federal Regulations, Section 135–Subpart E- Reporting and Recordkeeping, subsection 90 – Reporting states in part:

> Each recipient … shall submit …an annual report … for the purpose of determining the effectiveness of section 3.

Title 24 Code of Federal Regulation Section 135.32 Responsibilities of the recipient.

> Each recipient has the responsibility to comply with section 3 in its own operations, and ensure compliance in the operations of its contractors and subcontractors. This responsibility includes but may not be necessarily limited to:
>
> (f) A State or county which distributes funds for section 3 covered assistance to units of local governments, to the greatest extent feasible, must attempt to reach the numerical goals set forth in 135.30 regardless of the number of local governments receiving funds from the section 3 covered assistance which meet the thresholds for applicability set forth at 135.3. The State or county must inform units of local government to whom funds are distributed of the requirements of this part; assist local governments and their contractors in meeting the requirements and objectives of this part; and monitor the performance of local governments with respect to the objectives and requirements of this part.

HUD guidance:

> HUD ECONOMIC STIMULUS FUNDING AND THE CREATION OF JOBS, TRAINING, AND CONTRACTING OPPORTUNITIES states in part:
>
> > Section 3 is one of HUD's tools for ensuring that the expenditure of federal funds in economically distressed communities has a multiplier effect by targeting local low- and very low-income persons and qualified businesses for jobs, training, and contracting opportunities. Compliance with the requirements of Section 3 is critical.
>
> ANNUAL SECTION 3 SUMMARY REPORTING REQUIREMENTS FOR RECIPIENTS OF HUD COMMUNITY PLANNING & DEVELOPMENT FUNDING
> *TECHNICAL ASSISTANCE ON FORM HUD-60002 states in part:
>
> > Recipients that submit Section 3 reports containing all zeros, without a sufficient explanation to justify their submission, are in noncompliance with the requirements of Section 3.
> >
> > Failure to comply with the requirements of Section 3 may result in sanctions, including: debarment, suspension, or limited denial of participation in HUD programs...

10-06 The Department of Social and Health Services, Division of Behavioral and Health Services, does not ensure Justice Assistance Grant subrecipients are registered in the Central Contractor Registration database as required by federal regulation.

Federal Awarding Agency:	U.S. Department of Justice
Pass-Through Entity:	None
CFDA Number and Title:	16.738 Edward Byrne Memorial Justice Assistance Grant 16.803 Edward Byrne Memorial Justice Assistance Grant–American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	2009-SU-B9-0028
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

The Justice Assistance Grant (JAG) provides the state funding to support program areas such as law enforcement, prosecution and court, corrections and community corrections, drug treatment and enforcement, and crime victim and witness initiatives. The state Department of Commerce receives this money and passes a portion of it to other agencies.

The state was awarded approximately $22 million in JAG funds under the American Recovery and Reinvestment Act in 2009. Of that, the Department of Social and Health Services received approximately $2 million for the Division of Behavioral and Health Services Drug Courts. During fiscal year 2010, the Department paid approximately $1.5 million to counties for drug court activities.

The Act requires contractors, including subrecipients such as counties, to register in the Central Contractor Registration (CCR) database before bidding on a contract funded by the Recovery Act. This is to help ensure consistency on what contractors file regarding their financial condition and other data.

Registration also is designed to assist subrecipients in reporting accurate information to the federal government; in obtaining payment certification; and with federal tax collection.

Description of Condition

The Department could not provide documentation to show it communicated this requirement to the subrecipients it provided funding to or that it checked the CCR to ensure all were registered prior to releasing payments.

Cause of Condition

Department staff responsible for this program stated it was using state dollars, and therefore the requirements were not applicable. However the contract prepared by the Department of Commerce and signed by DSHS clearly stated the money was provided through the American Recovery and Reinvestment Act. The contract was signed by a DSHS staff member who later stated the funding was not federal. DSHS management did not place a priority on ensuring grant funds were accurately identified and monitored.

Effect of Condition

If subrecipients and contractors are not registered with the CCR, expenditure data cannot be accurately or completely reported to the federal government as required by Recovery Act regulations. This undermines one of the objectives of the Act – to ensure public transparency of the money it provides.

Recommendation

Department management should ensure all staff responsible for the acceptance, use, and monitoring of federal funds are equipped with the knowledge and resources to adequately perform those duties.

Department's Response

The Department concurs with this finding.

We agree with the analysis by the state auditor.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

U.S. Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 400 states:

> (d) Pass-through entity responsibilities. A pass-through entity shall perform the following for the Federal awards it makes:
>
> (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 pass-through 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 that performance goals are achieved.

Title 2 Code of Federal Regulations, Section 176.50

> (c) Recipients and their first-tier recipients must maintain current registrations in the Central Contractor Registration (http://www.ccr.gov) at all times during which they have active federal awards funded with Recovery Act funds. A Dun and Bradstreet Data Universal Numbering System (DUNS) Number (http://www.dnb.com) is one of the requirements for registration in the Central Contractor Registration.

10-07 The Department of Social and Health Services did not provide adequate information to its Justice Assistance Grant subrecipients, nor did it monitor subrecipients' use of those funds.

Federal Awarding Agency:	U.S. Department of Justice
Pass-Through Entity:	
CFDA Number and Title:	16.738 Edward Byrne Memorial Justice Assistance Grant 16.803 Edward Byrne Memorial Justice Assistance Grant– American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	2009-SU-B9-0028
Applicable Compliance Component:	Subrecipient Monitoring; Special Tests and Provisions
Questioned Cost Amount:	None

Background

The Justice Assistance Grant (JAG) provides the state funding to support program areas such as law enforcement, prosecution and courts, corrections and community corrections, drug treatment and enforcement and crime victim and witness initiatives. The state Department of Commerce receives the money and passes a portion of the funds to other agencies within the state.

In 2009, the state was awarded approximately $22 million in JAG funds under the American Recovery and Reinvestment Act.

The Legislature allocated approximately $2 million to the Department of Social and Health Services (DSHS) for the Division of Behavioral and Health Services' Drug Courts, which are administered by counties. During fiscal year 2010, the Department passed approximately $1.5 million of that allocation through to participating counties.

Description of Condition

The Department is required to provide its subrecipients – the counties – all identifying information and compliance requirements applicable to the grant. This includes the grant name, the federal award number, the amount of the award, and how much of that is funded through the Act. The Department did not provide this information. Instead, it used a contract developed for an unrelated grant that does not mention the JAG.

Additionally, the Department cannot show it monitored subrecipients' use of JAG funds.

Cause of Condition

Department staff responsible for this program believed it was using state dollars, and therefore the requirements were not applicable. However the contract prepared by the Department of Commerce and signed by DSHS clearly stated the money was provided through the American Recovery and Reinvestment Act. The contract was signed by a DSHS staff member who later stated the funding was not federal. DSHS management did not place a priority on monitoring the use of these grant funds.

Effect of Condition

Subreceipients were not provided the information needed to ensure proper use of Recovery Act funds.

The Department cannot ensure its subrecipients are meeting performance goals, administrative standards, financial management rules and other grant requirements. Grantors rely on subrecipient monitoring to ensure money is spent appropriately.

In addition, grant conditions allow the grantor to penalize the Department for noncompliance by suspending or terminating the award or withholding future awards.

Recommendation

Department management should ensure all staff responsible for the acceptance, use, and monitoring of federal funds are equipped with the knowledge and resources to adequately perform those duties.

Department's Response

The Department concurs with this finding.

We agree with the analysis by the state auditor.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

U.S. Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Section 400 states:

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

U.S. Office of Management and Budget Circular A-133, *Compliance Supplement*, states in part:

Section 3.N.3-
R3- Subrecipient Monitoring

Compliance Requirements- Federal Agencies must require recipients to agree to: (1) separately identify to each subreceipients and document at the time of the subaward and disbursements of funds, the Federal award number, CFDA number, and the amount of ARRA funds; and (2) require their subreceipients to provide similar identification in their SEFA and SF-SAC.

Section 3.M

Compliance Requirements- *During-the-Award Monitoring*- Monitoring the subrecipient's use of Federal awards through reporting, site visits, regular contact, or other means to provide reasonable assurance that the subrecipient administers Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

Compliance Requirements- *Pass-Through Entity Impact*- Evaluating the impact of subrecipient activities on the pass-through entity's ability to comply with applicable Federal regulations.

Title 2, Code of Federal Regulations Part 176.210 states in part

Subpart D- Single Audit Information for Recipients of Recovery Act Funds

(c) Recipients agree to separately identify to each subreceipients, and document at the time of Subaward and the time of disbursement of funds, the Federal Award number, CFDA Number and amount of Recovery Act funds. When a recipient awards funds for an existing program, the information furnished to subreceipients shall distinguish the subawards of incremental Recovery Act funds from regular subwards under the existing program.
(d) Recipients agree to require their subrecipients to include on their SEFA information to specifically identify Recovery Act funding similar to the requirements for the recipient SEFA described above. This information is needed to allow the recipient to properly monitor subrecipient expenditure of ARRA funds as well as oversight by the Federal awarding agencies, Offices of Inspector General and the Government Accountability Office.

10-08 The Employment Security Department did not comply with U.S. Department of Labor requirements for determining the accuracy of benefit payments.

Federal Awarding Agency:	U.S. Department of Labor
Pass-Through Entity:	None
CFDA Number and Title:	17.225 Unemployment Insurance 17.225 Unemployment Insurance – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	UI-19616-10-55-A-53 UI-18054-09-55-A-53
Applicable Compliance Component:	Special Tests – UI Benefit Payments
Questioned Cost Amount:	None

Background

The Employment Security Department administers the Unemployment Insurance program that provides benefits to workers for periods of involuntary unemployment. The federal government and employers in Washington State primarily fund the program. In fiscal year 2010, Employment Security paid approximately $2.5 billion in non-federal unemployment benefits and more than $2.2 billion in federal benefits.

Federal regulations require the Department to operate a Benefits Accuracy Measurement (BAM) program to estimate the number and amount of claims properly paid or denied by projecting the results from investigations of small, random samples to all claims.

The U.S. Department of Labor requires Employment Security to draw a weekly sample of payments and denied claims, review the records, and contact claimants, employers and third parties to verify information related to the claim. If a claim was incorrectly paid, the investigator determines the cause and amount of the error. For erroneously denied claims the investigator reports on the potential eligibility of the claimant; the cause of and who was responsible for the error; when the error was detected; and actions taken by the agency and employer prior to the payment or denial decision that were in error.

The Labor Department requires states to try to collect information needed for investigations using all of the following methods: in-person, telephone, facsimile or mail. Employment Security does not have to collect information from the claimant if he or she cannot be contacted or chooses not to respond. When this happens, the case is to be forwarded to a WorkSource office for a job search review to be scheduled.

The Employment Security's procedures manual directs investigators to attempt four telephone contacts with claimants at various times of the day and to follow up with at least two attempts to gather information by mail. If unsuccessful, the investigator may document the attempts and complete the investigation. The investigator is required to verify employer data, job search contacts and third-party information for each case. Federal regulations do not provide any option other than verifying the data directly and specifically states "BAM investigators must exhaust all avenues in obtaining information."

Federal guidelines require the Department to examine 480 paid claims and 450 denied claims each year. The Department received permission from the Labor Department to reduce the number of claims examined to 360 for calendar year 2009 due to increased workload coupled with reduced staffing. For 2009, the Department reported an 84 percent payment accuracy rate for paid claims and an 82 percent accuracy rate for denied claims based on the results of the Benefit Accuracy Measurement program.

We reported a finding for the fiscal year 2009 audit, noting that the Department was not complying with Department of Labor requirements for the Benefit Accuracy Measurement program. Specifically, the Department was not using all required methods to obtain information needed to complete their cases.

Description of Condition

The Department still is not using all required methods to collect data. For our audit we randomly selected 30 claims the Department had investigated and found:

- In seven cases, the investigator did not verify wage data with prior employers. When contact was not made with the employer, the case file stated that previously reported data was being used and assumed to be accurate.
- In two cases, the investigator did not verify reported job searches with potential employers.
- In two cases the investigator identified potential issues but did not perform proper follow up. In the first case, a claimant refused to complete the questionnaire and in the second an employer was contacted for employee wage data but did not provide the information requested.
- Files for seven of the cases did not document enough attempts to contact the claimant.

Cause of Condition

The Department's Corrective Action Plan issued in response to last year's finding included several procedural improvements:

- Improving record-keeping of documented attempts to contact claimant.
- Using "attention" stamps on envelopes of correspondences to encourage responses.
- Increasing the number of attempts to contact the employer from two to four.
- Establishing an internal quality control process within the Benefit Accuracy Measurement unit where the team meets monthly to review cases and give feedback that outlines successes and areas for improvement.
- Using certified mail for the letters of correspondence with claimants and employers.

With the exception of the use of certified mail, we determined these new processes were put in place throughout the audit period. However, they were not effective in reducing noncompliance. In the last audit we identified noncompliance for 43 percent of the claims we examined; this year we identified noncompliance for 40 percent of claims we examined.

Management stated after last year's finding was issued, they discussed re-starting in-person visits but determined that the Benefit Accuracy Measurement unit does not have the staff required to do this. The Department stopped doing in-person contacts in 2003.

We also determined 90 percent of the cases tested were not reviewed by a manager to ensure they were correct, complete, and performed in accordance with state and federal regulations.

Effect of Condition

The program accuracy rates are unreliable and possibly incorrect because the Department does not collect all data needed. Therefore, the Department may not be identifying potential issues with benefit claim approvals. The Department could be paying invalid claims or denying valid claims.

Recommendation

We again recommend the Department ensure all investigations performed as part of the Benefit Accuracy Measurement program include contacting the claimant, prior employers, job search contacts and third parties as required by the Department of Labor. We also recommend the Department ensure supervisory staff review completed cases to ensure proper procedures were followed.

Department's Response

The U.S. Department of Labor (USDOL) allows various methods to verify claim information. The BAM unit attempts to use all methods available to verify the validity and accuracy of audited claims. The exceptions noted by the auditor occurred during a time of significant staff and supervisory turnover in the BAM unit. Staff were learning new processes while the supervisory position was vacant which limited the availability of supervisory review and oversight of cases.

Staff performing BAM functions are now fully trained to perform these audits. The Department has hired a new supervisor with extensive BAM experience and review of the case files will be more frequent with the assistance of the Unemployment Insurance Performance Audit (UIPA) manager.

With respect to the auditor's concern about in-person contacts, these have not been conducted primarily because they are expensive and time-consuming. The Department has received conflicting guidance on in-person contacts from colleagues at the USDOL; oral advice has been inconsistent with the information that appears in written manuals. The plan for the immediate future is to seek authoritative and documented direction from USDOL regarding the requirements and expectations for in-person contacts.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 20, Code of Federal Regulations, Part 602.21 states in part:

§ 602.21 Standard methods and procedures.

Each State shall:

(a) Perform the requirements of this section in accordance with instructions issued by the Department, pursuant to § 602.30(a) of this part, to ensure standardization of methods and procedures in a manner consistent with this part;

(b) Select representative samples for QC study of at least a minimum size specified by the Department to ensure statistical validity (for benefit payments, a minimum of 400 cases of weeks paid per State per year);

(c) Complete prompt and in-depth case investigations to determine the degree of accuracy and timeliness in the administration of the State UI law and Federal programs with respect to benefit determinations, benefit payments, and revenue collections; and conduct other measurements and studies necessary or appropriate for carrying out the purposes of this part; and in conducting investigations each State shall:

(1) Inform claimants in writing that the information obtained from a QC investigation may affect their eligibility for benefits and inform employers in writing that the information obtained from a QC investigation of revenue may affect their tax liability,

(2) Use a questionnaire, prescribed by the Department, which is designed to obtain such data as the Department deems necessary for the operation of the QC program; require completion of the questionnaire by claimants in accordance with the eligibility and reporting authority under State law,

(3) Collect data identified by the Department as necessary for the operation of the QC program; however, the collection of demographic data will be limited to those data which relate to an individual's eligibility for UI benefits and necessary to conduct proportions tests to validate the selection of representative samples (the demographic data elements necessary to conduct proportions tests are claimants' date of birth, sex, and ethnic classification)

10-09 The Employment Security Department did not comply with federal cash management requirements.

Federal Awarding Agency:	U.S. Department of Labor
Pass-Through Entity:	None
CFDA Number and Title:	17.225 Unemployment Insurance
	17.225 Unemployment Insurance – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	UI-19616-10-55-A-53
	UI-18054-09-55-A-53
Applicable Compliance Component:	Cash Management
Questioned Cost Amount:	None

Background

The U.S. Department of Labor granted more than $2.2 billion to the Employment Security Department for Unemployment Insurance activities during fiscal year 2010, approximately $117 million of which was used to pay for administering the unemployment benefits program.

The Department is required to request funds only for reimbursement. In doing so, the Department must follow procedures detailed in a written agreement between the state and the federal government. The agreement states the Department is to request funds on the same day it issues payment or, in the case of warrants, the date the warrant clears the Department's account. This ensures no interest is earned on federal funds.

Description of Condition

The Department is not requesting funding for administrative expenses in accordance with the agreement. The agreement states the Department should request funds the same day warrants for administrative costs, including payroll, clear its account. We found the Department was requesting its administrative funding in advance of the dates the warrants are cleared. Specifically, the Department draws administrative funds to coincide with payroll, generally twice per month, and performs additional draws as needed. When determining the amount of the draw, the Department estimates how much it will need to keep a positive account balance until the next draw. The Office of State Treasurer manages the account in which the funds are deposited. The Treasurer's Office confirmed the account earns interest that is deposited into the state general fund.

Cause of Condition

The Department was not aware that the agreement required UI administrative funds be drawn the same day those costs cleared the state's account.

Effect of Condition

Because the Department has drawn excess federal funds, which are deposited in an interest-bearing account, it may incur an interest liability to the federal government. The state may be required to reimburse the federal government its share of interest it lost due to delays in the use of funds. This condition goes back several years. Because of this, and the fact that other funds are kept in this account, we were unable to determine the amount of interest potentially owed the federal government.

Recommendation

We recommend the Department draw administrative funds in accordance with the agreement or seek to change it.

We also recommend the Department consult with the grantor to determine if the Department owes it money.

Department's Response

The Department partially concurs with the finding. We agree that the Treasury State Agreement's draw method for Unemployment Insurance (UI) administrative funds, was incorrect for UI administrative costs. The Department requested and received federal approval to correct the agreement to reflect a more appropriate draw method. This change is effective for State Fiscal Year 2011 and aligns agency processes with the revised agreement.

The Department does not agree that excess Federal UI administrative funds have been drawn, nor has the agency incurred an interest liability. During State Fiscal Year 2010, the Department experienced a negative cash position with the U.S. Department of Labor (USDOL). This was due to Federal Notice of Obligations not being processed until after the Department's requests for funding. Additionally, if we had been using the corrected draw method, the amounts drawn would have been acceptable because our draws were expended within a day after the federal funds were received. We will coordinate with the USDOL to resolve any outstanding concerns regarding these draws.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Cash Management Improvement Act Agreement between the State of Washington and the Secretary of the Treasury, United States Department of the Treasury, submitted June 18, 2009, in effect July 1, 2009, until terminated.

> Actual Clearance ZBA Same Day Payment (ZBA-Fedwire UI Admin)
>
> The State shall request funds the same day it issues Electronic Funds Transfer (EFT) payments and Journal Voucher payments for Administrative and Reed Act costs including payroll. The State shall request funds the same day warrants for Administrative and Reed Act Costs including payroll clear the State's account. The State's request shall be made in accordance with the appropriate Federal agency cut-off time specified in EXHIBIT I. A federal agency shall deposit funds in the State account the same day as requested, if the request is made in accordance with the appropriate Federal agency cut-off time specified in EXHIBIT I. The amount of the request shall be the amount of EFT payments and Journal Voucher payments for Administrative and Reed Act costs including payroll that are issued and clear the State's account that day, and the amount of Warrants for Administrative and Reed Act costs including payroll that clear the State's account that day. This funding technique is interest neutral.

10-10 The Employment Security Department did not adequately review job search logs to ensure unemployment insurance claimants are eligible for benefits.

Federal Awarding Agency:	U.S. Department of Labor
Pass-Through Entity:	None
CFDA Number and Title:	17.225 Unemployment Insurance 17.225 Unemployment Insurance – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	UI-19616-10-55-A-53 UI-18054-09-55-A-53
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	None

Background

Washington State employers fund unemployment insurance benefits through payroll taxes. The tax collections are kept in a trust fund administered by the U.S. Department of Labor through the U.S. Department of the Treasury. In fiscal year 2010, the Washington State Employment Security Department paid more than $2.2 billion in federal unemployment benefits.

Federal law provides states flexibility in establishing requirements for job search activity by unemployment insurance claimants. Once a state establishes these requirements, it must abide by them. Washington state law requires the Employment Security Department to have a job search monitoring program to ensure claimants receiving benefits are documenting at least three job search contacts or in-person job search activities each week. Department rules outline job search requirements, including the frequency and types of activities that qualify. Claimants must document the following in order to remain eligible for benefits:

- For job search contacts, the date contact was made; the employer's name, address and telephone number; the type of contact (in-person, telephone, etc.); the name of the person contacted; and the type of work applied for.
- For in-person job search activities at a Department WorkSource office or local reemployment center, the date contact was made; a description of the services received; and/or the activities in which the claimant participated.

State law establishes penalties for claimants who do not comply with job search requirements, including a loss of benefits for those weeks during which the individual was not in compliance. The determination of the penalties applied to an individual case is made by a trained adjudicator. Claimants found to have been out of compliance after benefits had been paid are liable for repayment of those benefits.

During the Washington State Single Audit for 2009, we reported the Department was not adequately reviewing job search logs to ensure unemployment insurance claimants were eligible for benefits. We also determined the Department was applying different standards to online/internet job searches than to more traditional job search methods.

Description of Condition

In response to the 2009 audit finding, the Department developed a corrective action plan that included the following actions: revising regulations to address job search contacts; supervisory review of monthly job search log review activity in WorkSource offices; and quarterly review of job search logs to examine compliance with legal requirements. However, the revisions to the regulations addressing job search contacts did not take effect until June 12, 2010. Because job search logs are examined more than two weeks after the date the job searches occurred, no job search logs created after the new regulations went into effect were examined by the Department during the audit period.

We also found the supervisory review of monthly job search log activity took place in only one of the four WorkSource offices we examined. The rate of noncompliance at the office performing a supervisory review was 10 percent, and averaged 52 percent at the offices that did not perform the review.

We did find the Department is adequately performing the quarterly review of job search logs for compliance with legal requirements and quality in a timely manner.

We again reviewed the Department's job search log review process to determine if it ensured compliance with search requirements. We found several instances of noncompliance. Department staff:

- Continue to approve job search logs that do not meet the criteria for compliance. We found this to be the case at all four WorkSource offices we examined. Thirty of 79 job search logs we examined were missing required information including date of contact, name of employer, and employer contact information.
- Continue to approve Internet job searches that contain only a date of application, an e-mail address, a job listing number and the type of position applied for. Internet job searches are still being held to a different standard than in-person job searches. State law does not differentiate between standard searches and those performed via the Internet.
- Excused two claimants from a one-week review because the appointment notices were returned as undeliverable, and excused one from a review because he stated he had returned to work. In the latter case, the Department did not verify the claimant had returned to work and paid benefits until they ran out. According to state law, the two excused claimants should have been rescheduled for a review of their job search logs related to every week they claimed benefits. Two were not rescheduled at all and one was rescheduled for a one week review only.

Cause of Condition

The Department is not adequately reviewing for job search contact compliance by claimants. It has written guidance, but reviewers rely on use of a "standard of reasonableness" that varies among the reviewers. Supervisors at all four WorkSource offices we examined stated they received no new guidance for online/Internet job searches during the audit period.

Department management stated the supervisory review of monthly job search review activity specified in the corrective action plan was suggested but not made mandatory until after the end of the audit period.

The Department still is accepting job search contacts with less than the seven required components.

Effect of Condition

The Department is paying Unemployment Insurance benefits to claimants who may not meet eligibility requirements. Because Department staff are not identifying non-compliant job logs, the trained adjudicators do not receive the logs to determine whether the claimant should be denied benefits and, if so, to what extent. Without performing the adjudication process, payments to ineligible claimants cannot be recovered.

Recommendation

We again recommend the Department ensure all employees reviewing job search contacts are aware of eligibility requirements. We further recommend the Department consistently apply these requirements to all job search contacts, regardless of the method. The Department should monitor to ensure staff is consistently and accurately reviewing and verifying job search logs.

Department's Response

To address the issues identified in this finding regarding in-person review of job search logs, the Employment and Career Development Division (ECDD) of the Department is initiating actions to enhance and expand communications, specialized training and monitoring for the job search review program. Through these efforts staff and supervisors will be knowledgeable of program requirements, processes, and what constitutes a complete job search log and employer contact documentation. This will be an ongoing effort.

ECDD is increasing the length and frequency of staff training and holding staff accountable for the proper review of job search logs:

- *Basic Job Search Review (JSR) training was expanded from 2 ½ days to 3 days to address weaknesses identified by the auditors including proper documentation of potential issues and scheduling of all weeks reviews.*
- *JSR Refresher Training is required for staff that have not attended training in 2 years. The training will be updated by April 30, 2011 and available for scheduling in May 2011. The curriculum update will incorporate information from the audit findings, legal and program requirements, ramifications of accepting incomplete logs, processes for scheduling and rescheduling reviews, required documentation and job search log reviews, including all weeks reviews.*
- *Interactive electronic Job Search Log Review training will be developed that will focus on the required elements for a complete job search contact. The target audience is the staff performing the JSR function and the program supervisor for JSR. The training will be delivered via WebEx that combines on-line capability to present training materials and teleconferencing concurrently. Training will include agency expectations, Desk Aids and the Reemployment JSR SharePoint site. The sessions will be designed and presented no later than March 18, 2011. Additional sessions will be added as needed.*
- *Supervisory Training will expand the time used to focus on the job search log required elements and desk aids available to assist with monitoring. Modifications to the training will be complete by March 31, 2011 with training available starting in April.*

ECDD is increasing and improving its program monitoring by:

- *Following up on corrective action plans submitted by local offices at the end of November 2010 for results. All plans indicated offices will conduct a weekly review by supervisors of job search logs accepted by staff. To test the effectiveness of the reviews, ECDD UI Reemployment Services staff will conduct an intensive effort to review a sample of job search logs from all WorkSource locations. A report focusing on the completeness of the job search log and contact elements will be sent each Friday to the offices reviewed that week. If errors are found, additional corrective action will be required. Expected end date for this action is no later than May 31, 2011.*
- *Continuing to review 6 offices per quarter. The reviews are in-depth, citing the reasons why logs do not pass, including the appropriate legal references. In addition, documentation is reviewed and resolution codes evaluated for exemptions, all weeks reviews, and potential benefit eligibility issues.*
- *Revising the current JSR staff training record. The training record will be used to ensure staff performing JSR have received the appropriate program training. Offices will be notified if they have staff needing to receive training. Staff requiring training will be scheduled to attend the next available training session. Staff that have not attended training in the last 2 years will be notified. This action item will be completed by January 31, 2011. Staff will be scheduled for JSR refresher training starting in May 2011.*

Communication with staff performing JSR will be improved by:

- *Providing an ECDD SharePoint site to consolidate program information for staff involved in JSR. This site is scheduled to "go live" on January 19, 2011. A notice will be sent to all ESD staff in*

WorkSource locations of its availability. Links to all the required program information including laws, regulations, policies, program standards and desk aids will be posted.

- *Distributing a series of e-mail messages to all levels of ECDD field staff to reinforce expectations for offices to use trained, dedicated staff to perform JSR and reminding staff of JSR requirements.*

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 20 Code of Federal Regulations, section 604.5 Application—availability for work

(a) *General application.* A State may consider an individual to be available for work during the week of unemployment claimed under any of the following circumstances:
   (1) The individual is available for any work for all or a portion of the week claimed, provided that any limitation placed by the individual on his or her availability does not constitute a withdrawal from the labor market.
   (2) The individual limits his or her availability to work which is suitable for such individual as determined under the State UC law, provided the State law definition of suitable work does not permit the individual to limit his or her availability in such a way that the individual has withdrawn from the labor market. In determining whether the work is suitable, States may, among other factors, take into consideration the education and training of the individual, the commuting distance from the individual's home to the job, the previous work history of the individual (including salary and fringe benefits), and how long the individual has been unemployed.
   (3) The individual is on temporary lay-off and is available to work only for the employer that has temporarily laid-off the individual.

(b) *Jury service.* If an individual has previously demonstrated his or her availability for work following the most recent separation from employment and is appearing for duty before any court under a lawfully issued summons during the week of unemployment claimed, a State may consider the individual to be available for work. For such an individual, attendance at jury duty may be taken as evidence of continued availability for work. However, if the individual does not appear as required by the summons, the State must determine if the reason for non-attendance indicates that the individual is not able to work or is not available for work.

(c) *Approved training.* A State must not deny UC to an individual for failure to be available for work during a week if, during such week, the individual is in training with the approval of the State agency. However, if the individual fails to attend or otherwise participate in such training, the State must determine if the reason for non-attendance or non-participation indicates that the individual is not able to work or is not available for work.

(d) *Self-employment assistance.* A State must not deny UC to an individual for failure to be available for work during a week if, during such week, the individual is participating in a self-employment assistance program and meets all the eligibility requirements of such self-employment assistance program.

(e) *Short-time compensation.* A State must not deny UC to an individual participating in a short-time compensation (also known as worksharing) program under State UC law for failure to be available for work during a week, but such individual will be required to be available for his or her normal workweek.

(f) *Alien status.* To be considered available for work in the United States for a week, the alien must be legally authorized to work that week in the United States by the appropriate agency of the United States government. In determining whether an alien is legally authorized to work in the United States, the State must follow the requirements of section 1137(d) of the SSA (42 U.S.C. 1320b-7(d)), which relate to verification of and determination of an alien's status.

(g) *Relation to ability to work requirement.* A State may consider an individual available for work if the State finds the individual able to work under §604.4(b) despite illness or injury.

(h) *Work search.* The requirement that an individual be available for work does not require an active work search on the part of the individual. States may, however, require an individual to be actively seeking work to be considered available for work, or States may impose a separate requirement that the individual must actively seek work.

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

The auditee shall:

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

(c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

Revised Code of Washington (RCW) 50.20.010 states, in part:

(1) An unemployed individual shall be eligible to receive waiting period credits or benefits with respect to any week in his or her eligibility period only if the commissioner finds that:

(c) (i) With respect to claims that have an effective date before January 4, 2004, to be available for work an individual must be ready, able, and willing, immediately to accept any suitable work which may be offered to him or her and must be actively seeking work pursuant to customary trade practices and through other methods when so directed by the commissioner or the commissioner's agents.

(ii) With respect to claims that have an effective date on or after January 4, 2004, to be available for work an individual must be ready, able, and willing, immediately to accept any suitable work which may be offered to him or her and must be actively seeking work pursuant to customary trade practices and through other methods when so directed by the commissioner or the commissioner's agents. If a labor agreement or dispatch rules apply, customary trade practices must be in accordance with the applicable agreement or rules;

Revised Code of Washington (RCW) 50.20.240 states, in part:

(1) (a) To ensure that following the initial application for benefits, an individual is actively engaged in searching for work, the employment security department shall implement a job search monitoring program. Effective January 4, 2004, the department shall contract with employment security agencies in other states to ensure that individuals residing in those states and receiving benefits under this title are actively engaged in searching for work in accordance with the requirements of this section. The department may use interactive voice technology and other electronic means to ensure that individuals are subject to comparable job search monitoring, regardless of whether they reside in Washington or elsewhere.

(b) Except for those individuals with employer attachment or union referral, individuals who qualify for unemployment compensation under RCW 50.20.050 (1)(b)(iv) or (2)(b)(iv), as applicable, and individuals in commissioner-approved training, an individual who has received five or more weeks of benefits under this title, regardless of whether the individual resides in Washington or elsewhere, must provide evidence of seeking work, as directed by the commissioner or the commissioner's agents, for each week beyond five in which a claim is filed. With regard to claims with an effective date before January 4, 2004, the evidence must demonstrate contacts with at least three employers per week or documented in-person job search activity at the local reemployment center. With regard to claims

with an effective date on or after January 4, 2004, the evidence must demonstrate contacts with at least three employers per week or documented in-person job search activities at the local reemployment center at least three times per week.

(c) In developing the requirements for the job search monitoring program, the commissioner or the commissioner's agents shall utilize an existing advisory committee having equal representation of employers and workers.

(2) Effective January 4, 2004, an individual who fails to comply fully with the requirements for actively seeking work under RCW 50.20.010 shall lose all benefits for all weeks during which the individual was not in compliance, and the individual shall be liable for repayment of all such benefits under RCW 50.20.190.

Washington Administrative Code 192-180-010 states, in part:

Job search requirements – Directives

(3) What are my weekly job search requirements?

(a) At a minimum, you must:

(i) Make job search contacts with at least three employers each week; or

(ii) Participate in three approved in-person job search activities at the WorkSource office or local employment center, or any combination of employer contacts or in-person job search activities for a total of three.

(b) Based on your individual circumstances, such as your occupation, experience, or labor market area, the department may issue you a directive requiring more than three employer contacts or job search activities each week.

(c) If you are a member of a referral union you must be registered with your union, eligible for and actively seeking dispatch, and comply with your union's dispatch or referral requirements (see WAC 192-210-120). Your benefits may be denied for any weeks in which you fail to meet these requirements and you may be directed to seek work outside of your union.

(4) What is a "job search contact"? A job search contact is a contact with an employer to inquire about or apply for a job. You may use job search methods that are customary for your occupation and labor market area, including in-person, telephone, internet, or telefax contacts. The work applied for must be suitable (see RCW 50.20.100) unless you choose to look for work in a lower skill area. A contact does not count if it is made with an employer whom you know is not hiring, or if the department decides the contact is designed in whole or in part to avoid meeting the job search requirements.

(5) What is an "in-person job search activity"? This is an activity provided through the WorkSource office or local employment center that will assist you in your reemployment efforts. It includes, but is not limited to, job search workshops, training classes, or other facilitated services provided by WorkSource staff and approved by the local WorkSource administrator. For claimants residing in Washington State, an in-person job search activity must be documented in the department's services, knowledge and information exchange system (SKIES) to qualify. For interstate claimants, the activity must be documented in the one-stop system in the state in which you reside.

Washington Administrative Code 192-180-015 states, in part:

Tracking job search activities –RCW 50.20.240

(1) Do I need to keep track of my job search activities? You must keep a record or log of your job search contacts and the in-person job search activities you receive through the WorkSource office or local employment center unless you are:

(a) A member of a full referral union;

(b) Allowed benefits because you left work to protect yourself or a member of your immediate family from domestic violence or stalking as provided in RCW 50.20.050 (2)(b)(iv); or

(c) Exempt from job search requirements under WAC 192-180-010(1).

(2) What information do I need to keep in the log? Your job search log must contain at least the following information:

(a) For job search contacts, record the date contact was made; the employer's name, address and telephone number; the type of contact (in-person, telephone, etc.); the name of the person you contacted; and the type of work you applied for;

(b) For in-person job search activities at the WorkSource office or local reemployment center, record the date contact was made; and a description of the services you received or the activities in which you participated.

Washington Administrative Code 192-180-030 - Penalties.

(1) Is there a penalty if I don't look for work or fail to report for the JSR interview as directed? Benefits will be denied if you fail to:

(a) Meet the minimum job search requirements;

(b) Provide information about your job search activities and, once you have been paid five weeks of benefits, provide a copy of your job search log upon request;

(c) Comply with any job search directive issued by the department; or

(d) Report to a scheduled job search review interview.

(2) How long will my benefits be denied? Benefits will be denied for the specific week or week(s) in which you fail to act as described in subsection (1).

(3) What is the penalty if I don't attend a JSR that has been scheduled to review all weeks claimed? If you fail to appear for a review of your job search logs for all weeks claimed, fail to produce your job search logs for those weeks, or your logs fail to establish that you have met the minimum job search requirements, such failure will be treated as nondisclosure under RCW 50.20.160(3) and your benefits may be denied for any weeks at issue.

10-11 The Department of Transportation does not have adequate controls to ensure that information the American Recovery and Reinvestment Act requires to be reported for its Highway Planning and Construction program is accurate.

Federal Awarding Agency:	U.S. Department of Transportation, Federal Highway Administration
Pass-Through Entity:	None
CFDA Number and Title:	20.205 Highway Planning and Construction 20.205 Highway Planning and Construction – American Recovery and Reinvestment Act (ARRA) 20.219 Recreational Trails Program 20.003 Appalachian Development Highway System 20.003 Appalachian Development Highway System – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	0053948
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The U.S Department of Transportation provides Highway Planning and Construction grants to assist states in planning and developing transportation systems to accommodate interstate commerce and travel; to repair federal highways following disasters; to foster safe highway design; and to replace or rehabilitate bridges.

The State Department of Transportation spent nearly $785 million in federal funding related to this program during fiscal year 2010. Of this, approximately $574 million was spent through contracts with subrecipients. American Recovery and Reinvestment Act Funds accounted for $262 million of the federal spending for fiscal year 2010.

Description of Condition

Section 1512 of the American Recovery and Reinvestment Act (ARRA) requires agencies to file a quarterly report for each ARRA-funded project. The report must include the total amount received and spent. Guidance from the U.S. Department of Transportation states the total amount spent on a project should only include payments for which the Department has or will seek reimbursement.

When we reviewed the Department's March 2010 ARRA reports, we found it was incorrectly reporting the amount budgeted for each project and had combined that information with the amount spent on each project.

Cause of Condition

The Department did not monitor or adequately test the system it put in place to comply with ARRA reporting requirements. Instead of using information directly from the Department's accounting system, staff used revenue and expenditure information obtained from the Recovery Act Data System maintained by the Federal Highway Administration. The information in the Data System is updated either manually by Department staff or by a query that obtains data from several Department systems.

Effect of Condition

We reviewed 10 of the 51 ARRA reports submitted by the Department for January through March 2010. The Department over reported the actual amount spent as of March 31, 2010 on ARRA funded projects by 57% or approximately $98.7 million. Total expenditures for the 10 projects were incorrectly reported as $172.2 million, when the expenditures recorded in the Department's accounting system for the same projects were only $73.5 million.

The grantor relies on accurate reports to monitor the progress of the programs and use of federal ARRA dollars. By submitting inaccurate reports, the grantor is prevented from adequately monitoring and making informed decisions about the Department's ARRA expenditures under the Highway Planning and Construction program.

Recommendation

We recommend the Department assess its reporting process to determine why it is not working as intended, and further correct or change the system as needed. The Department should ensure individuals charged with carrying out specific activities have clear expectations and the information needed to perform those tasks. The Department should establish periodic independent monitoring to ensure that the information is being reported accurately.

Department's Response

The Department appreciates the importance of accurate ARRA reporting and goes to great lengths to identify and comply with requirements that come with ARRA funds, reviewing various changes in federal guidance on a regular basis and continually updating our procedures to ensure compliance. However, we respectfully do not agree with the statement in the audit finding about the Department not having adequate controls over ARRA reporting.

The federal ARRA reporting process was regularly evolving during the time we prepared the report which was under audit. Due to extenuating circumstances surrounding the early ARRA Federal filings and the regular updates to guidance provided on ARRA reporting requirements, misinterpretations of a data field occurred causing the error in the one quarterly reporting cycle reviewed by the State Auditor's Office. Prior to the audit, the Department identified and corrected the error reported as part of the March, 2010 quarterly reporting cycle. Since the reporting process only allowed for cumulative expenditures to be included in this ARRA report, correcting the next quarterly report for April through June 2010 was our only means of correcting the reported expenditures for January through March 2010. The Department properly reported the information in question in the Federal Fiscal Management Information System (FMIS) and Oberstar reporting systems, which are used by the grantor to manage the grant programs and by Congress and staff to monitor delivery performance.

Having stated our position above, the Department appreciates the State Auditor's review of the Department's ARRA filing process, as it has helped the Capital Program and Management Office to further strengthen internal controls to ensure proper reporting associated with the transparency reporting requirements of ARRA. We look forward to the State Auditor's staff reviewing our improvements in controls over ARRA reporting during their next audit.

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

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

The auditee shall:

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

U.S. Office of Management and Budget Circular, A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Part 3.L Reporting, American Recovery and Reinvestment Act Reporting, dated June 2010:

> Section 1512 of the Recovery Act requires reporting on the use of Recovery Act funding by recipients no later than the 10th day after the end of each calendar year quarter…Aimed at providing transparency into the use of these funds, the recipient reports are required to include the following detailed information:
>
> Total amount of funds received; and of that the total amount spent on projects and activities.

U.S. Office of Management and Budget also issued M-10-14, *Updated Guidance on the American Recovery and Reinvestment Act (*March 22, 2010), which provides information on the continuous corrections period instituted by the Recovery Accountability and Transparency Board in January 2010 under which recipients can correct reported data for the immediately preceding reporting quarter after that reporting quarter has ended and after the data is published on FederalReporting.gov.

> Total federal amount of ARRA expenditures is defined as:
>
> > Amount of Recovery Act funds received that were expended for projects or activities (federal share of expenditures). The cumulative total for the amount of federally funded expenditures. For reports prepared on the accrual basis, expenditures are the sum of cash disbursements for direct charges for property and services…

U.S. Department of Transportation Federal Highway Administration, FHWA Key 1512 Award Information, Quick Reference Card dated March 16, 2010. (FHWA is providing this document to FHWA ARRA fund recipients in response to section 1.2 of the Memorandum M-10-08, issued by the Office of Management and Budget on December 18, 2009…This document is intended to provide FHWA ARRA fund recipients with a clear definition of how to report OFM defined "key 1512 award information." The document states in part:

> Total Federal Amount of ARRA Expenditure: The cumulative total amount of payments disbursed for which the recipient has or will seek reimbursement with ARRA funds. Report all payments from February 17, 2009 through the end of the latest quarter.

10-12 The Department of Transportation did not ensure highway construction contractor invoices were supported and approved before payment.

Federal Awarding Agency:	U.S. Department of Transportation, Federal Highway Administration
Pass-Through Entity:	None
CFDA Number and Title:	20.205 Highway Planning and Construction 20.205 Highway Planning and Construction – American Recovery and Reinvestment Act (ARRA) 20.219 Recreational Trails Program 20.003 Appalachian Development Highway System 20.003 Appalachian Development Highway System – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	0053948
Applicable Compliance Component:	Activities Allowed/Cost Principles
Questioned Cost Amount:	$75,147

Background

The U.S Department of Transportation provides Highway Planning and Construction grants to assist states in planning and developing transportation systems to accommodate interstate commerce and travel; to repair federal highways following disasters; to foster safe highway design; and to replace or rehabilitate bridges.

The State Department of Transportation spent nearly $785 million in federal funding related to this program during fiscal year 2010. Of this, approximately $574 million was spent through contracts with subrecipients.

Description of Condition

During our audit, we evaluated how the Department reviews highway construction contractor invoices before processing them for payment. Our review included the Department's Tacoma field office and a high-occupancy vehicle lane project from the Port of Tacoma Road to the King County line. Total contract value of the project, which started in September 2009, was $31.02 million. We selected 30 payments, representing $5.5 million, to determine if the Department reviewed invoices and supporting documentation for appropriateness prior to payment. We selected a variety of payments for review, including ones with high dollar amounts, to determine if the review system in place was working in all situations.

We found the Department paid $449,188 to a contractor on March 18, 2010, before reviewing supporting documentation for the work performed.

Cause of Condition

The Project Engineer stated a large amount of supporting documentation was associated with this invoice. She stated staff did not review this in order to pay the contractor in a timely manner.

Department staff has a role in ensuring only allowable costs are reimbursed and adequate supporting documentation is received prior to processing a request for payment. Department management did not detect that this had not been done.

Effect of Condition and Questioned Costs

After we questioned the payment in May 2010, the Department requested additional supporting documentation from the contractor. The Department determined it overpaid the contractor $75,147 and reduced the next payment to the contractor by that amount. The overpayment included the following:

- $1,691.54 for ineligible costs, such as $553 for steel fittings and $367 for washers and small tools.
- $2,370.35 for costs incurred by the contractor on another highway construction project.
- $34,881.19 for duplicate invoices and costs.
- $36,203.49 for costs claimed by the contractor for which no supporting documentation was provided.

We reviewed all payments to the contractor between May and August of 2010, and did not identify any other unallowable costs.

Recommendation

We recommend the Department ensure all highway construction invoices are adequately reviewed before payment is made.

The Department should consult with its grantor to determine what, if any, of the questioned costs should be repaid.

Department's Response

The Department appreciates your review and recommendations regarding the construction contract mentioned in the audit finding.

As soon as the Department's project office became aware of the situation described in your finding they conducted a full reconciliation of the force account payments associated with the contract, which at the time had approximately six months remaining on the project and had only been paid approximately fifty percent of the bid amount. Overall, the inconsistencies found on the payment in question appeared to be an isolated incident due to extenuating circumstances surrounding the particular billing request by the contractor. This was confirmed when the State Auditor's extending their testing and found no other payments with similar issues. The Department has already recovered the overbilled amounts by reducing subsequent payments to the contractor. Not only does the project office now ensure that payments are made in accordance with guidance outlined in the Construction Manual, they have also worked with this particular contractor to create an informal invoice submittal process for the force account work.

In addition to the increased awareness from the particular project office involved, the WSDOT Headquarters Construction Office issued a memorandum to all project offices and construction project engineers reminding them of the importance of strong internal controls and related documentation for contractor payments, particularly force account payments. The memo also mentions the upcoming 2011 Construction Office training season, which will include contractor payments as a major topic. The Construction Office is also seeking feedback from all project offices on any suggestions, comments, or best practices related to contractor and force account payments to further improve internal control procedures.

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

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

The auditee shall:

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

Section 510:

(a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:

…(3) Known questioned costs which are greater than $10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than $10,000 for a type of compliance requirement for a major program.

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments* (2 CFR 225), states in part:

Attachment A; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
   a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
   b. Be allocable to Federal awards under the provisions of 2 CFR part 225.
   c. Be authorized or not prohibited under State or local laws or regulations.
   d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
   e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
   f. Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.
   g. Except as otherwise provided for in 2 CFR part 225, be determined in accordance with generally accepted accounting principles.
   h. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period, except as specifically provided by Federal law or regulation.
   i. Be the net of all applicable credits.
   j. Be adequately documented.

10-13 The Department of Transportation did not support over $759,000 in payroll costs in accordance with federal regulations for the Formula Grants for Other Than Urbanized Areas.

Federal Awarding Agency:	U.S. Department of Transportation, Federal Transit Administration
Pass-Through Entity:	None
CFDA Number and Title:	20.509 Formula Grants for Other Than Urbanized Areas 20.509 Formula Grants for Other Than Urbanized Areas – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	WA-18-X024, WA-18-X025, WA-18-X039, WA-18-X043, WA-18-X048, and WA-86-X001
Applicable Compliance Component:	Allowable Costs/Cost Principles
Questioned Cost Amount:	$759,869.57

Background

The Public Transportation Division of the State Department of Transportation administers the federal Formula Grants for Other Than Urbanized Areas grant to help pay for public transportation in rural areas. The Department distributes this money to public and private entities that provide these services and retains between 10 percent and 15 percent to pay its administrative costs. The Department spent $10,206,761 in this grant money in fiscal year 2010.

Grant money may be used to pay only for costs that are allowable and related to the grant's purpose. Federal regulations specify the documentation that must be kept to support employee compensation charged to federal grants. If an employee works solely on the grant program and all related payroll costs are charged to that grant, minimal documentation is required: the employee must certify, semi-annually, in writing, that he or she worked solely on that program. Requirements state that for employees who work on multiple programs or whose positions are funded by multiple sources, payroll costs must be supported by personnel activity reports or equivalent documentation, such as timesheets. These reports must:

- Reflect how much time the employee worked on each program.
- Account for the total activity for which the employee is compensated.
- Be prepared at least monthly and coincide with one or more pay periods.
- Be signed by the employee.

Payroll estimates are allowable if adjustments to actual costs are made at least quarterly.

In the fiscal year 2009 audit, we reported the Department did not support more than $740,000 in payroll costs charged to the grant in accordance with federal regulations. The Public Transportation Division administers a number of closely related federal and state programs and the work performed by administrative and program staff supports multiple programs. We determined the Division charged a portion of the payroll costs for 14 employees to the grant based on budgeted percentages. The Division did not have documentation to support the charges and they were not reconciled to actual time employees worked on programs. Additionally, we identified two employees who worked solely on the program who did not complete the semi-annual certifications.

Description of Condition

During the current audit period, the Division did not change how it allocates salaries and benefits to the Formula Grants for Other Than Urbanized Areas. The Division continued to charge a portion of the payroll costs for 14 employees to the grant based on budgeted percentages. The Division did not have documentation to support the charges and they were not reconciled to actual time employees worked on

programs. We again identified two employees who charged 100 percent of their time to the grant but did not complete the semi-annual certifications.

Cause of Condition

Public Transportation Division management responsible for allocating payroll costs stated it had not changed the method of allocating payroll costs because they have requested approval of a modified version of its current allocation method. The Division was instructed not to implement the modified allocation method until it has been reviewed and approved. The Department submitted its request to the Federal Transit Administration in June 2010.

Effect of Condition and Questioned Costs

We identified $759,869.57 in direct payroll charges to the Formula Grants for Other Than Urbanized Areas grant that were not supported in accordance with federal requirements, including $88,574.22 funded through the American Recovery and Reinvestment Act. We are questioning those costs as unallowable charges for salaries and benefits. The federal grantor could disallow these charges and require the Department to pay back the money.

Recommendations

We recommend the Department establish policies and procedures to ensure payroll charges are adequately supported until it receives approval from its grantor to use a substitute system in accordance with federal requirements.
The Department should consult with its grantor to determine what, if any, of the questioned costs should be repaid.

Department's Response

The Department appreciates the State Auditor's work regarding the Formula Grants for Other Than Urbanized Areas. At this time, we are awaiting required authorization from the federal grantor to implement our planned correction.

The Department is considered an innovative leader by the Federal Transit Administration (FTA) for its grant administration methods, which include administering a number of closely related grant programs.

After receiving a similar finding in 2009, the Department's Public Transportation Division developed and submitted a formalized direct payroll cost allocation plan, known as a substitute system, to the FTA to meet the federal regulations (OMB Circular A-87). Upon receipt of the plan, the FTA requested that the Department continue to allocate payroll costs under the current FTA approved method until such time as the new plan can be reviewed and approved. The FTA staff conducted fieldwork for their review in January 2011, and we are awaiting their results. The Department will continue to work with the FTA to receive grantor approval of the cost allocation plan. Once approved, the Public Transportation Division will allocate direct payroll costs using the new method and will incorporate the new method into its policies and procedures.

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

U.S. Office of Management and Budget Circular A-87 (2 CFR 225), *Cost Principles for State, Local and Indian Tribal Governments*, states:

Attachment B, Section 8(h):

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 8.h.(5) of this appendix unless a statistical sampling system (see subsection 8.h.(6) of this appendix) 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 8.h.(6)(c) of this appendix;
(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 8.h.(6)(a) of this appendix 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: …….the costs are equitably allocated to all related activities, including Federal awards;…..

10-14 The Department of Ecology does not have adequate internal controls to ensure it complies with suspension and debarment requirements.

Federal Awarding Agency:	U.S. Environmental Protection Agency
Pass-Through Entity:	None
CFDA Number and Title:	66.458 Capitalization Grants for Clean Water State Revolving Fund
	66.458 Capitalization Grants for Clean Water State Revolving Fund - American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	2W-96091001-1 (ARRA)
Applicable Compliance Component:	Suspension and Debarment Controls/Compliance
Questioned Cost Amount:	None

Background

The state Department of Ecology administers the Clean Water State Revolving Fund as a permanent funding source for prevention and clean up of water pollution, for technical and financial assistance for water quality projects and other water quality programs.

Federal grantors prohibit recipients of federal awards from contracting with entities that have been suspended or debarred from receiving federal funds.

The Department is responsible for determining the suspension or debarment status of any entity it provides grant funding. It must also inform those entities they are responsible for doing this if they provide funding to any lower tier contractor or subrecipient.

In fiscal year 2010, the Department spent $40 million in federal funds on the Clean Water State Revolving Fund program; approximately $22 million of this was funded through the American Recovery and Reinvestment Act of 2009.

Description of Condition

The Department determined the suspension and debarment status of its subrecipients, however it did not inform them of their responsibility to pass this requirement onto subcontractors. Instead the Department included a generic statement that subrecipients must comply with all laws and regulations.

Cause of Condition

Department staff responsible for ensuring proper language is in the contract thought the statement to subrecipients to comply with all laws and regulations was sufficient notification of the requirement.

Effect of Condition

Without adequate suspension and debarment contract language, there is risk that federal funds could be paid by the Department's subrecipients to ineligble parties. In such a case, the subrecipient would potentially have to pay these unallowable payments back to the Department.

Recommendation

We recommend the Department update its contract document to reflect current federal suspension and debarment regulations.

Department's Response

We respectfully disagree with the finding the Agency does not have adequate internal controls to ensure it complies with suspension and debarment requirements. We do agree we could update and enhance the suspension and debarment language in our contract, grant, and loan documents.

Agency contract, grant, and loan language requires subrecipients and vendors to certify they have not been suspended, debarred, or otherwise excluded from receiving federal funds. Agency contract, grant, and loan agreements also require subrecipients and vendors to ensure all their subgrantees and subcontractors comply with the terms and conditions of the agreements. We believe this language is sufficient in communicating requirements to subrecipients. This is supported by the fact that there have been no substantiated violations in payments to suspended or debarred vendors.
The agency will:

- *Include current federal suspension and debarment language in all new contracts, grants, and loans effective April 1, 2011, or later.*
- *Update all current agreements with end dates beyond June 30, 2011, to include current federal suspension and debarment language.*
- *Update all active agreements funded by American Recovery Reinvestment Act to include current federal suspension and debarment language.*

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

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

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

Title 2, Code of Federal Regulations, Section180.330 - What requirements must I pass down to persons at lower tiers with whom I intend to do business?

> Before entering into a covered transaction with a participant at the next lower tier, you must require that participant to—
>
> (a) Comply with this subpart as a condition of participation in the transaction. You may do so using any method(s), unless the regulation of the Federal agency responsible for the transaction requires you to use specific methods.
> (b) Pass the requirement to comply with this subpart to each person with whom the participant enters into a covered transaction at the next lower tier.

10-15 The Department of Health did not comply with time and effort requirements for the Capitalization Grants for Drinking Water State Revolving Fund program.

Federal Awarding Agency:	U.S. Environmental Protection Agency
Pass-Through Entity:	None
CFDA Number and Title:	66.468 Capitalization Grants for Drinking Water State Revolving Fund 66.468 Capitalization Grants for Drinking Water State Revolving Fund American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	FS-99083909, FS-99083908, FS99083907, FS-99083906, FS99083905, 2F-96087801 (ARRA)
Applicable Compliance Component:	Allowable Costs/Cost Principles
Questioned Cost Amount:	None

Background

The Department of Health administers the Drinking Water State Revolving Fund program, which provides loans and other types of financial assistance for safe drinking water projects.

In fiscal year 2010, the Department spent $30 million in federal funds on the Drinking Water State Revolving Fund program, approximately $19 million of which was provided by the American Recovery and Reinvestment Act.

Description of Condition

Federal requirements specify how employee salaries and wages charged to federal programs are to be documented. Salaries of employees who charge to multiple funding sources are to be supported by monthly personnel activity reports such as time sheets. Employees who work solely on a single federal award or cost objective must support charges for their salaries and benefits with certifications. These certifications are to be prepared at least semi-annually and signed by the employee or supervisory official having first hand-knowledge of the employee's work.

The Department certifies payroll quarterly. We selected for review time certifications for 16 employees who worked on a single cost objective for the quarters ending December 31, 2009 and June 30, 2010. The Department provided the certifications, however, we later determined the certifications provided for auditor review had been recently created and backdated to appear as if completed at the end of the quarter. The Department stated the certifications we requested had been completed but were subsequently lost, and so it recreated them for our audit.
Subsequently, the Department stated it found the certifications for the second, third and fourth quarters. However, we determined those certifications were created in November of 2010 upon request of the Grants office. They had not been completed at the end of each quarter as required.

Cause of Condition

While controls were in place at the program level, program staff stated new requirements related to the Recovery Act were considered higher priority. Due to lack of resources the certifications were not completed as required.

Effect of Condition

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.

Direct payroll charges to the Capitalization Grants for Drinking Water State Revolving Fund were not supported in accordance with federal requirements. However, we were able to gain some assurance those costs were attributable to the grant and therefore are not questioning them.

Recommendation

We recommend the Department:

- Ensure original certifications are completed and retained.
- Ensure individuals charged with carrying out specific activities know what is expected of them and that management monitor to ensure the activities are occurring.

Department's Response

We concur with the State Auditor's office assessment that time and effort records should be completed on a timely basis, but would like to emphasize that all time certifications provided to the auditors during the course of their audit were either signed by the employee or their immediate supervisor per OMB-A87 requirements.

Prior to the audit we had implemented new procedures designed to remind program staff of when their certifications are due, and to centralize the collection of the completed certifications.

We believe that the agency is now compliant with federal time and effort reporting requirements.

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

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

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

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments* (2 CFR 225):

> Appendix B, Section 8(h):

Support of salaries and wages. These standards regarding time distribution are in addition to the standards for payroll documentation.

(1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a responsible official(s) of the governmental unit.

(2) No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.

(3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having first hand knowledge of the work performed by the employee.

Department of Health Policy 11.014, Timekeeping for Federal Requirements, Effective Date April 7, 2006, states in part:

Policy Statement:

…In order to promote better fiscal accountability, the agency supports quarterly timekeeping reporting for employees funded from a single federal source.

10-16 The Energy Office of the Department of Commerce does not have controls to ensure it complies with Davis-Bacon (prevailing wage) requirements.

Federal Awarding Agency:	U.S. Department of Energy
Pass-Through Entity:	None
CFDA Number and Title:	81.041 State Energy Program 81.041 State Energy Program – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	DE-EE0000139
Applicable Compliance Component:	Davis Bacon
Questioned Cost Amount:	None

Background

The federally funded State Energy Program provides financial and technical assistance to states on energy programs, including emerging renewable energy sources and energy efficiency technologies. The Department of Commerce's State Energy Office of the Innovation and Policy Priorities Division administers the program in Washington. Funding for this program has historically been provided based on a predetermined formula, and amounted to less than $500,000 per fiscal year.

In 2009, the U.S. Department of Energy awarded Commerce approximately $60 million in State Energy Program funds under the American Recovery and Reinvestment Act (ARRA) in addition to the smaller formula grant. Of this, $38.5 million is to be used for loans and grants to public and private entities to encourage the establishment of innovative and sustainable energy industries. The remaining ARRA money is to be used for projects such as building retrofits and program administration.

In fiscal year 2010, the Department spent $3.1 million in State Energy Program money: $2.7 million in ARRA funding and approximately $400,000 in formula grant money. The Department spent approximately $3 million of its total SEP ARRA award from inception through June 30, 2010.

Description of Condition

Construction projects paid for in whole or in part by ARRA dollars are subject to the Davis Bacon Act, a federal law that requires prevailing wages to be paid on federally assisted construction projects that cost more than $2,000. Workers on-site must be paid no less than local prevailing wages and benefits for similar projects. State agencies that pay for construction projects with ARRA dollars are required to collect and review weekly certified payrolls from contractors and subrecipients to ensure prevailing wages are paid.

The Energy Office of the Department of Commerce administers the State Energy Program, and oversees grant awards and loans to subrecipients for energy-related projects. Grantees and loan recipients are required to match a portion of the total project costs with their own funding sources.

If a project includes construction, Division management requires grantees and loan recipients to use their own matching dollars to pay for the construction costs. ARRA money awarded by the Department was to be used only for non-construction costs. Therefore, program management stated, Davis Bacon Act requirements did not apply to the majority of the projects.

This is an inaccurate interpretation of the requirements of the Act. If ARRA dollars are used for any part of a construction project costing more than $2,000, even if those dollars are not spent on direct construction costs, the project is subject to the Act. U.S. Department of Energy staff stated intentionally splitting a single project into construction and non-construction activities in order to avoid Davis Bacon Act requirements is unallowable.

Cause of Condition

Department management did not ensure staff in the State Energy Program possessed the necessary understanding of Davis-Bacon requirements, nor did management have an effective system in place to identify inaccurate and inconsistent understanding and application of the regulations. We found other Department divisions understood Davis-Bacon Act requirements.

Effect of Condition

Program management initially stated no ARRA funding was spent on construction projects during fiscal year 2010. As a result of our inquiries, the Department reviewed its grant and loan files and determined Davis-Bacon requirements applied to some of the funded projects. We reviewed all invoices for the five grantees and loan recipients paid in fiscal year 2010 to determine if the Department paid for construction work without collecting certified payrolls. We found one invoice for excavating work done in June for $262,677, paid by Commerce on July 8, 2010, with ARRA dollars. Department staff confirmed that this was construction work and that certified payrolls were not collected at the time of payment. After the Department realized its error, it requested and was provided certified payrolls for the excavating work showing that prevailing wages had been paid.

The Department's ineffective controls over Davis-Bacon Act requirements in the State Energy Program increases the risk that laborers working on federally funded projects will not be paid the proper wages.

Recommendation

The Department should use the knowledgeable staff it has to establish a Department-wide monitoring system to ensure an accurate and consistent understanding of the Davis-Bacon Act, and that it complies with the Act. The effectiveness of that system should be regularly assessed by someone independent of the process.

Department's Response

We concur with the finding. When the original grants and loans were awarded, the Energy Office had many discussions with US Department of Energy (DOE) about the Davis Bacon Act requirements. Preliminary guidance from DOE indicated project costs could be split and Davis Bacon (prevailing wage) would not be applied if construction funding was not included in the ARRA award. Some of the projects undertaken are quite large and the federal contribution is a small portion of total funding. DOE reviewed each grant or loan and made determinations on which tasks required Davis Bacon compliance. This later guidance from DOE indicated that Davis Bacon would apply whenever construction was part of the project, even when construction was not funded by federal dollars.

The specific incident cited in the finding occurred because of a misunderstanding between the Energy Office Program Manager and the grant recipient regarding what constituted the start of construction. The Program Manager notified the grant recipient as early as November 2009 that Davis Bacon (prevailing wage) requirements applied and that certified payrolls for construction projects must be collected. Prior to approval of the invoice noted in the incident, the Program Manager asked if construction had begun. The grant recipient indicated that construction would begin after a ground-breaking event in July 2009.

On September 13, 2010, Commerce's Contracts Administration Unit (CAU) staff reviewed the invoices in question for Davis Bacon (prevailing wage) compliance. During the review, staff discovered the invoice for work done through June 30, 2010 included site preparation work that had been reimbursed without monitoring for Davis Bacon (prevailing wage) compliance. Commerce immediately requested certified payrolls and found a $1.41 underpayment. This took place before the next reimbursement payment was made and the underpayment was resolved on January 1, 2011.

To ensure greater control over compliance with the Davis Bacon (prevailing wage) requirements, Commerce has implemented changes to our invoice review and payment procedures. The Energy Office

staff person who made payments at that time is no longer employed by the agency. The function of invoice review and verification has been transferred to CAU. Commerce CAU staff have years of experience in processing requests for reimbursement that include Davis Bacon (prevailing wage) requirements. Experienced CAU staff members now review payment requests, collect and verify certified weekly payroll information, and process the payments.

In addition, the Energy Office is now utilizing agency-wide expertise including consultation with the Community Services and Housing Division staff members who regularly work with Davis Bacon Act requirements. In this way, we can ensure a consistent understanding of Davis Bacon requirements throughout the agency and ensure ongoing compliance.

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

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Nonprofit 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.

Section 1606 of the American Recovery and Reinvestment Act of 2009, Public Law 111–5:

> Notwithstanding any other provision of law and in a manner consistent with other provisions in this Act, all laborers and mechanics employed by contractors and subcontractors on projects funded directly by or assisted in whole or in part by and through the Federal Government pursuant to this Act shall be paid wages at rates not less than those prevailing on projects of a character similar in the locality as determined by the Secretary of Labor in accordance with subchapter IV of chapter 31 of title 40, United States Code~~.~~

10-17 The Energy Office at the Department of Commerce does not have controls to ensure it complies with reporting requirements for the State Energy Program.

Federal Awarding Agency:	U.S. Department of Energy
Pass-Through Entity:	None
CFDA Number and Title:	81.041 State Energy Program 81.041 State Energy Program – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	DE-FJ26-05R021613
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The federally funded State Energy Program provides financial and technical assistance to states on energy programs, including emerging renewable energy sources and energy efficiency technologies. The Department of Commerce's State Energy Office of the Innovation and Policy Priorities Division administers the program in Washington. Funding for this program has historically been provided based on a predetermined formula, and amounted to less than $500,000 per fiscal year.

In 2009, the U.S. Department of Energy awarded Commerce approximately $60 million in State Energy Program funds under the American Recovery and Reinvestment Act (ARRA) in addition to the smaller formula grant. Of this, $38.5 million is to be used for loans and grants to private entities to encourage the establishment of innovative and sustainable energy industries. The remaining ARRA money is to be used for projects such as building retrofits and program administration.

In fiscal year 2010, the Department spent $3.1 million in State Energy Program money: $2.7 million in ARRA funding and approximately $400,000 in formula grant money. The Department spent approximately $3 million of its total ARRA award through June 30, 2010.

Description of Condition

The grant agreement stated Commerce was to submit a financial status report to the federal grantor within 30 days after the end of each calendar quarter for the non-ARRA funding. For the July through September quarter the report was submitted on time, but did not include $45,278.80 of expenditures.

The Department's internal controls over this reporting requirement were not adequate to ensure compliance. Staff responsible for preparing the financial status report did not have all the information needed to complete it, and staff responsible for reviewing the report for accuracy did not consistently or effectively conduct that review.

Cause of Condition

Commerce did not monitor the control processes it put in place to ensure compliance with federal reporting requirements, and so did not detect that those controls were not working as intended. Similar issues were identified and communicated to Commerce management during our last audit, however it continued to place responsibility for compliance with federal reporting requirements on one individual without monitoring her performance.

Effect of Condition

Commerce did not report $45,278.80 spent during the July-September 2009 quarter on the financial status report. Grantors rely on accurate reports to monitor the progress of programs and the use of federal dollars. By submitting incomplete financial reports, Commerce prevented the grantor from adequately monitoring

the State Energy program. In addition, grant conditions allow the grantor to penalize the Department for noncompliance by withholding payments, suspending or terminating an award, withholding future awards and taking action to preclude future awards.

Recommendation

We recommend Commerce monitor and assess its internal controls to ensure they are working as intended. It should ensure individuals charged with carrying out specific control activities have clear expectations and the information needed to perform those tasks. It should establish periodic monitoring by someone not performing those tasks to ensure the activities are occurring.

Department's Response

We concur with the finding. Commerce State Energy Office submits quarterly financial reports to the US Department of Energy (DOE) electronic system with data received from Commerce's Accounting staff. Communications between program staff and accounting staff was not sufficient at that time to ensure the accounting staff was aware of a new project number for FY11 where expenditures were accumulated. As a result, accounting staff did not include charges accumulated against the new project number in the July to September 2009 quarterly report to DOE. In addition, the report was not adequately verified by the Commerce Energy Office to make sure all expenditures were accurately reflected. As a result, $45,278.80 was not reported.

The expenditure was included in the next October-December 2009 quarterly report. In 2009, no mechanism existed to revise a report once it had been submitted. Corrections had to be made in the subsequent report. With the State Energy Program's new reporting program, future corrections, if needed, can be made to the impacted quarter with a request to DOE.

Commerce has assessed its internal controls and implemented measures to ensure compliance with reporting requirements through clearly defined expectations and access to the appropriate information. Commerce Accounting updated the accounting federal reporting procedures in September 2010, adding steps to ensure all quarterly federal expenditure activity is reported. These procedures have been followed since the procedure update. Additional controls include 1) comparing federal expenditures by project code with federal report project listing; 2) supervisor review of all financial status reports or federal financial reports prior to review by Commerce Energy Office staff; and 3) communication and review with Energy Office staff prior to submitting reports.

Commerce further concurs with the Auditor's recommendation to implement periodic monitoring by personnel not performing the tasks to ensure the above activities are taking place.

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

U.S. Office of Management and Budget (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 10, Code of Federal Regulations, Part 600

Section 600.121 - Standards for financial management systems.

(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 in accordance with the reporting requirements set forth in Sec. 600.152...

Section 600.152 - Financial reporting.

(a) The following forms or such other forms as may be approved by OMB are authorized for obtaining financial information from recipients.

(1) SF-269 or SF-269A, Financial Status Report ...

State Energy Program Grant Special Terms and Conditions, Part 5a:

Failure to comply with these reporting requirements is considered a material noncompliance with the terms of the award. Noncompliance may result in withholding of future payments, suspension or termination of the current award, and withholding of future awards. A willful failure to perform, a history of failure to perform, or unsatisfactory performance of this and/or other financial assistance awards, may also result in a debarment action to preclude future awards by Federal agencies.

10-18 The Energy Office at the Department of Commerce did not adequately monitor grantees and loan recipients and paid for unallowable costs under the State Energy Program.

Federal Awarding Agency:	U.S. Department of Energy
Pass-Through Entity:	None
CFDA Number and Title:	81.041 State Energy Program 81.041 State Energy Program – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	DE-EE0000139
Applicable Compliance Component:	Activities Allowed/Cost Principles, Subrecipient Monitoring
Questioned Cost Amount:	$13,691

Background

The federally funded State Energy Program provides financial and technical assistance to states on energy programs, including emerging renewable energy sources and energy efficiency technologies. The Department of Commerce's State Energy Office of the Innovation and Policy Priorities Division administers the program in Washington. Funding for this program has historically been provided based on a predetermined formula, and amounted to less than $500,000 per fiscal year.

In 2009, the U.S. Department of Energy awarded Commerce approximately $60 million in State Energy Program (SEP) funds under the American Recovery and Reinvestment Act (ARRA) in addition to the smaller formula grant. Of this, $38.5 million is to be used for loans and grants to public and private entities to encourage the establishment of innovative and sustainable energy industries. The remaining ARRA money is to be used for projects such as building retrofits and program administration.

In fiscal year 2010, the Department spent $3.1 million in State Energy Program money: $2.7 million in ARRA funding and approximately $400,000 in formula grant money. The Department spent approximately $3 million of its total SEP ARRA award from inception through June 30, 2010.

Description of Condition

Staff in the Department of Commerce's Energy Office and Contracts Administration Unit (CAU) is responsible for monitoring State Energy Program grantees and loan recipients and ensuring all expenditures are supported and allowable under the award contract and federal guidelines.

During a review of an invoice we noted itemized charges from one loan recipient that did not appear to be allowable program expenditures. Concurrently, the Department initiated a review of all payments to that loan recipient. The Department identified $13,691 in unallowable or unsupported costs. We agreed with the Department's results. The Department subsequently disallowed $6,797 in expenditures, which it deducted from the September 2010 reimbursement to the loan recipient. Regarding the other $6,894 in potentially unallowable costs identified, the project manager stated the recipient had "reasonable explanations" for these expenditures. The Department accepted the charges as allowable without obtaining supporting documentation.

The questioned costs included:

- Unallowable travel advances and unsupported travel costs, $3,757
- Gift boxes, coffee, ice cream and alcohol, $186
- Cash payments to company employees, $1,784
- Late charges and payments owed to other vendors, $3,105
- Meals not held for business purposes, $1,697
- Credit card charges, $367

- Cell phone bills, $970
- Tax returns, $1,825

To determine if unallowable costs had been paid to other grantees, we reviewed all invoices for the five grantees and loan recipients paid during fiscal year 2010. We did not find any other invoices with unallowable costs during the fiscal year.

Cause of Condition

Department management placed reliance on an internal control system without monitoring to ensure it was working as intended. Contract staff and program staff each have a role in ensuring only allowable costs are reimbursed and adequate supporting documentation is received prior to processing a grantee's or borrower's request for payment. Contract and program staff did not perform its review for these invoices, and management did not detect the weakness in the control system.

Effect of Condition and Questioned Costs

The Department paid a loan recipient unallowable costs. Although the Department reduced subsequent payments to the loan recipient by $6,797, it is up to the federal grantor to determine if it is satisfied with the resolution of those costs. Additionally, the Department did obtain additional documentation to support the remaining $6,894. However this was done several months after the payments were made, and only in an attempt to reduce the amount we are reporting as questioned costs. Since the payments were originally made without adequate support, we are questioning them. It will be up to the federal grantor to determine if the support obtained is adequate. We are questioning the entire amount identified as unallowable or unsupported of $13,691.

Recommendation

We recommend Department management monitor its control system over State Energy Program payments to ensure that system is working as intended. The monitoring should be done by someone other than staff responsible for carrying out the control activities.

The Department should consult with its grantor to determine what, if any, of the questioned costs should be repaid.

Department's Response

We concur with the finding. Commerce authorized and paid a grant recipient's invoice for undocumented expenses. This occurred due to an inexperienced program staff member's mistake in the invoice verification and approval process.

To ensure greater control over invoice monitoring, Commerce has increased desk top monitoring. On September 1, 2010, monitoring of invoice payments on Energy ARRA contracts was transferred to Commerce's Contracts Administration Unit (CAU). CAU has experienced staff dedicated to reviewing all grant recipient requests for payments and the supporting documentation before payments are approved.

On September 20, 2010, CAU staff reviewed the grant recipient's contract file and identified $13,691 in questionable costs. Commerce staff contacted the grant recipient and requested clarification of costs and additional supporting documentation. As a result, CAU determined $6,894.41 in allowable costs was supported by the documentation. CAU also determined that $6,796.86 was unallowable. The grant recipient was notified that these costs were unallowable and the amount was deducted from the next invoice. We have received satisfactory documentation from this grant recipient for all other invoices to-date. In addition, Commerce is working with US Department of Energy to satisfy any questions regarding the approved expenses.

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

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

> A pass-through entity shall perform the following for the Federal awards it makes:
>
> (3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and those performance goals are achieved.
>
> Section 510:
>
> (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
>
> …(3) Known questioned costs which are greater than $10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than $10,000 for a type of compliance requirement for a major program.

U.S. Office of Management and Budget OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments* (2 CFR 225), Appendix A, states:

> C. Basic Guidelines
>
> *1.* Factors affecting allowbility of costs. To be allowable under Federal awards, costs must meet the following general criteria:
>
> d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
>
> j. Be adequately documented.

10-19 The Department of Commerce, Community Services and Housing Division, does not have controls to ensure it complies with subrecipient monitoring requirements for the Weatherization Assistance for Low-Income Persons program.

Federal Awarding Agency:	U.S. Department of Energy
Pass-Through Entity:	None
CFDA Number and Title:	81.042 Weatherization Assistance for Low-Income Persons 81.042 Weatherization Assistance for Low-Income Persons – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	DE-FG26-06R021685; DE-EE0000086
Applicable Compliance Component:	Subrecipient Monitoring Controls/Compliance
Questioned Cost Amount:	None

Background

The federally funded Weatherization Assistance Program provides financial assistance for low-income families making home energy efficiency improvements. The Department of Commerce's Community Services and Housing Division administers the program in Washington. Funding is passed through to 25 local agencies including community action agencies, housing authorities and municipalities that are responsible for determining client eligibility and overseeing work performed by agency crews or contractors who make energy efficiency improvements to the homes. Funding for this program has historically been less than $5 million per fiscal year for the state, determined through a formula.

In 2009, the Department was awarded approximately $60 million in weatherization funding under the American Recovery and Reinvestment Act (ARRA) in addition to the smaller formula grant. In fiscal year 2010, the Department spent $29 million on the Weatherization Assistance Program: approximately $25 million in ARRA money and $4 million in formula grant money.

The receipt of ARRA funding brought new compliance requirements for the program. In fiscal year 2010, the Department was responsible for notifying its contractors and subrecipients of their responsibility to register in the national Central Contractor Registration (CCR) system. The registration must be kept current and the Department is responsible for periodically checking the CCR to ensure subrecipients are updating their information.

Description of Condition

Program staff in the Community Services and Housing Division could not provide documentation to show this requirement was communicated to the local agencies or that it checked the CCR to ensure all agencies were registered prior to releasing payments. Department staff also could not show that it periodically checked for updates throughout the fiscal year.

Staff began checking each agency's status in the CCR after we informed them of the requirements.

Cause of Condition

Department management did not ensure Community Services and Housing Division staff had complete knowledge and understanding of how to oversee compliance with this ARRA requirement.

Effect of Condition

If subrecipients and contractors are not registered with the CCR, their ARRA expenditure data cannot be accurately or completely reported to the federal government as required by Recovery Act regulations. The Department risks paying contractors and subrecipients whose activity in the Central Contractor Registration

does not meet federal requirements. We verified that all agencies had been registered prior to payment and none had expired registrations during our audit scope, therefore we are not questioning any costs.

Recommendation

The Department should ensure all employees who oversee Central Contractor Registration compliance are trained in how to satisfy these federal requirements and document that they are met. It should monitor staff to ensure this is being done.

Department's Response

We concur with the finding. We acknowledge the oversight and have taken immediate corrective action. Since learning of the oversight, we checked the national Central Contractor Registration (CCR) system for the past quarter, completing and documenting the check on January 10, 2011. Commerce contacted three contractors to correct issues of non-compliance.

In the future, an assigned staff member will review the CCR system (https://www.bpn.gov/CCR/default.aspx) at the end of each quarter (March, June, September, December) for each contractor, noting any comments regarding missing information and documenting the information and date in a spreadsheet.

If the CCR indicates that information is missing or outdated for any contractor, the staff member assigned as liaison with the contractor will contact the contractor, requesting they go to the CCR system to review and update the entry within one week of notification. The assigned staff member will perform a follow up check on the CCR system to verify that the agency has updated or corrected its information and note the date of agency contact and correction in the CCR tracking spreadsheet. This will be implemented beginning March 31, 2011.

Commerce will include the CCR check and documentation in contracting action items or in the steps taken by Housing Improvement and Preservation staff when creating new contracts or grants, or amending existing contracts or 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

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

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

U.S. Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 400, states:

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

(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 pass-through 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 that performance goals are achieved.

Title 2 Code of Federal Regulations, Section 176.50

(c) Recipients and their first-tier recipients must maintain current registrations in the Central Contractor Registration (http://www.ccr.gov) at all times during which they have active federal awards funded with Recovery Act funds. A Dun and Bradstreet Data Universal Numbering System (DUNS) Number (http://www.dnb.com) is one of the requirements for registration in the Central Contractor Registration.

10-20 The Department of Commerce, Community Services and Housing Division, does not have controls to ensure it complies with suspension and debarment requirements for the Weatherization Assistance for Low-Income Persons program.

Federal Awarding Agency:	U.S. Department of Energy
Pass-Through Entity:	None
CFDA Number and Title:	81.042 Weatherization Assistance for Low-Income Persons 81.042 Weatherization Assistance for Low-Income Persons – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	DE-FG26-06R021685; DE-EE0000086
Applicable Compliance Component:	Suspension and Debarment
Questioned Cost Amount:	None

Background

The federally funded Weatherization Assistance Program provides financial assistance for low-income families making home energy efficiency improvements. The Department of Commerce's Community Services and Housing Division administers the program in Washington. Funding is passed through to 25 local agencies, including community action agencies, housing authorities and municipalities that are responsible for determining client eligibility and overseeing work performed by agency crews or contractors who make energy efficiency improvements to the homes. Funding for the DOE funded program has historically been less than $5 million per fiscal year for the state, as determined by a nationally-adopted formula.

In 2009, the Department was awarded approximately $60 million in weatherization funding under the American Recovery and Reinvestment Act (ARRA) in addition to the smaller formula grant. In fiscal year 2010, the Department spent $29 million on the Weatherization Assistance Program: approximately $25 million in ARRA money and $4 million in formula grant money.

Grant funds cannot be paid to entities suspended or debarred from participating in federally funded projects. If a contractor or subrecipient certifies in writing to the Department that its organization has not been suspended or debarred, the Department may rely on that certification. The Department also may check for suspended or debarred parties by reviewing the Federal Excluded Parties List (EPLS) or by including a clause in its contract with the subrecipient or vendor.

Description of Condition

In order to meet ARRA production goals, the Department supplemented local agency activity by contracting with four contractors for a total of $3.4 million to perform weatherization work on low-income, multi-family homes around the state.

Staff responsible for complying with the suspension and debarment requirement stated they checked the EPLS to ensure the vendors were not suspended or debarred. However, they did not keep any documentation, such as a screen print from the website showing the vendor was not suspended or debarred, as proof this requirement was met. The vendors did not sign suspension and debarment certifications and no clause was written into the contracts.

Cause of Condition

The Department placed responsibility for ensuring vendors were not suspended or debarred on an employee who was not adequately instructed on how to meet this federal requirement. When we spoke to the staff assigned responsibility for compliance, they informed us they typically do not participate in procurement.

Effect of Condition

The Department cannot show it complied with federal suspension and debarment requirements. However, we were able to verify that the vendors had not been suspended nor debarred and we are not questioning these costs.

Recommendation

The Department should ensure all employees who oversee suspension and debarment compliance are trained in how to meet federal requirements. It should monitor to ensure staff follows these requirements.

Department's Response

We concur with the finding. In order to ensure compliance, we designated one position, the unit contracts manager, to be responsible for ensuring that all appropriate terms are addressed in contracts, including suspension and debarment, before moving any contract forward for signatures. This is part of the contract compliance checklist. The contracts manager or other designee will check the Excluded Parties List System (EPLS) when entering into a contractual agreement with a new vendor, including documenting a print-screen of the EPLS confirmation of vendor standing and placing it in the contract file. The contracts manager will train unit members and new employees on contracting requirements and procedures. These measures will be in place and operational March 1, 2011.

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

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

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

Title 2, Code of Federal Regulations, Section 180.300

> What must I do before I enter into a covered transaction with another person at the next lower tier?
>
> When you enter into a covered transaction with another person at the next lower tier, you must verify that the person with whom you intend to do business is not excluded or disqualified. You do this by:
>
> (a) Checking the EPLS; or
> (b) Collecting a certification from that person; or
> (c) Adding a clause or condition to the covered transaction with that person.

10-21 The Department of Commerce, Community Services and Housing Division, did not comply with subrecipient monitoring requirements for the Weatherization Assistance for Low-Income Persons program.

Federal Awarding Agency:	U.S. Department of Energy
Pass-Through Entity:	None
CFDA Number and Title:	81.042 Weatherization Assistance for Low-Income Persons 81.042 Weatherization Assistance for Low-Income Persons – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	DE-FG26-06R021685; DE-EE0000086
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	$38,694 ARRA

Background

The federally funded Weatherization Assistance Program provides financial assistance for low-income families making home energy efficiency improvements. The Department of Commerce's Community Services and Housing Division administers the program in Washington. Funding is passed through to 25 local agencies including community action agencies, housing authorities and municipalities that are responsible for determining client eligibility and overseeing work performed by agency crews or contractors who make energy efficiency improvements to the homes. Funding for this program has historically been less than $5 million per fiscal year for the state, determined through a formula.

In 2009, the Department was awarded approximately $60 million in weatherization funding under the American Recovery and Reinvestment Act (ARRA) in addition to the smaller formula grant. In fiscal year 2010, the Department spent $29 million on the Weatherization Assistance Program: approximately $25 million in ARRA money and $4 million in formula grant money.

Description of Condition

Federal regulations require the Department to conduct comprehensive monitoring of each agency at least once a calendar year. This must include on-site review of client files and agency records and inspection of at least 5 percent of each agency's Department of Energy-funded completed units. This requirement applies to ARRA and formula funding. The formula grant agreement signed by Commerce states it will visit agencies once a year.

The Monitoring and Inspection Manager informed us the Department did not perform these visits in calendar year 2009. The first comprehensive monitoring visit completed in 2010 was at the end of March. By the end of June 2010, the Department had completed comprehensive reviews at nine agencies. However, it determined the monitoring process was not thorough enough and that the reports did not have enough information to allow assessment of the agencies' performance. As a result, the Department began changing its monitoring to improve the quality of information collected. We examined the reports and determined staff conducting the visits did not provide enough information to show they performed a thorough monitoring of financial and program operations.

We observed two visits in September 2010. The monitors performed only cursory reviews of files and costs with the assistance of an employee from the local agency. The monitors focused on the re-inspections of weatherized units and providing training and instruction for the local agencies, not on reviewing financial records or client files. They asked questions regarding the agency's operations and internal controls, but did not test them or verify what they were told; they relied on what the agency said without ensuring the processes were documented or followed.

In addition, we conducted our own client file reviews at five local agencies in October 2010. At one agency, we found weatherization services provided to six clients who were not eligible, Federal regulations

and Department requirements state eligibility must be re-determined if weatherization work does not begin within 15 months of the original determination date. The clients had initially been determined to be eligible, but the determinations had expired. Two of these clients received visits from Commerce inspectors who are supposed to review the client files for the units they inspect. Inspection reports for these visits did not mention eligibility issues.

Cause of Condition

Department management in the Housing Improvements and Preservation Unit did not place a priority on the financial and programmatic monitoring of the agencies. Comprehensive monitoring visits were postponed in calendar year 2009; instead, Commerce inspectors began quarterly visits to the agencies and focused on reinspecting weatherized homes to ensure work was being completed correctly. These visits did not include a review of agency expenditures or client eligibility. When comprehensive monitoring visits were reinstated in spring 2010, Department management did not have adequate controls in place to ensure these visits were conducted effectively.

Effect of Condition and Questioned Costs

The Department cannot ensure agencies are correctly determining client eligibility, and cannot ensure Weatherization funds are being used appropriately. Over $38,600 in ARRA funding was paid to weatherize the homes of the six clients whose eligibility determination was expired.

Recommendation

We recommend the Department examine and revise its monitoring process to ensure visits are thorough and effective in obtaining information from the agencies and providing guidance for their improvement. We also recommend the Department then complete its comprehensive annual monitoring visits for all subrecipients to ensure they are in compliance with laws, regulations, and the provisions of their grant agreements.

The Department should work with its grantor and subgrantee to resolve the questioned costs.

Department's Response

We concur with the finding. We acknowledge the finding and have taken immediate steps to correct and improve our monitoring and inspection protocol, checklists, consistency, and training. The failure to complete comprehensive monitoring in 2009 was a reflection of cumulative events, including preparing to receive a 10-fold increase in weatherization funding, delays in hiring and training new staff for technical positions during the time of a hiring freeze, the collapse of a community action agency, and providing direct weatherization service for the first time to meet state ARRA weatherization production goals. While these are legitimate reasons that disrupted our local agency monitoring plans, we acknowledge that program monitoring requirements were not fully satisfied.

We have always worked to refine and improve our monitoring and inspection protocol. Historically, Washington has been among a handful of states asked to share and present our monitoring and inspection policies and tools as best practices. In April 2010, we implemented the first PDF-based monitoring tool and database. It was revised in July 2010. After testing and reviewing the results, we determined the tool was not sufficient for comprehensive program monitoring. In October 2010, we implemented a revised Performance Assessment Tool, as part of a completely revised Monitoring Assessment Packet, which included fiscal review questions and a new monitoring report template.

The SAO audit highlighted areas for improvement, gaps to be filled, and internal and external training needed. The lead weatherization monitoring team met in January 2011 and outlined additional revisions to the Program Assessment Tool that consolidated fiscal and administrative monitoring into five key areas. An assigned Lead Weatherization Monitor is working closely with the Fiscal Monitor to re-design the Weatherization Program Fiscal/Admin monitoring checklist. It will be more effective, comprehensive, and

coordinated with other fiscal monitoring activities. Two additional sections of the tool are being revised to evaluate the technical and program management systems of a local agency and are targeted to be complete by the end of February 2011.

For the period July-December 2010, 15 of the 25 weatherization delivery agencies, received comprehensive monitoring, including completion of the fiscal tool checklist. The balance of agencies either did not receive the client file fiscal review or it was incomplete. By July 2011, the remaining 10 agencies will have the weatherization monitoring fiscal tool completed. We are using the state fiscal year to track monitoring schedules and completion dates to align with the program year for the US Department of Energy (DOE) weatherization program instead of the calendar year.

Over the past several months that the SAO has been present at Commerce, we have responded seriously and quickly to observations and concerns shared throughout the process. We acted immediately in October 2010, for example, when we learned that the file checklist was not applied consistently. We changed how questions are phrased to eliminate simple "yes" or "no" responses. We coached monitors and rewrote questions to probe deeper and to ask for documentation and verification. Additional weatherization monitor training is planned during regularly scheduled lead monitor meetings throughout the first quarter of 2011. These trainings will focus on Fiscal/Admin monitoring, proper use of revised evaluation tools, and the application of DOE monitoring guidelines.

We initiated planning for statewide refresher training in May 2011 for all inspectors, including local agencies and Commerce personnel. The purpose is to reaffirm inspection expectations, consistency, and accountability for immediate implementation and long-term application.

The findings attributed to King County Housing Authority (KCHA) for serving clients after their income eligibility period expired are being addressed immediately. A letter was issued to KCHA to formally disallow costs totaling $38,694 and seek refund unless supporting documentation can be provided to verify eligibility.

We issued notification on January 13, 2011 to all local agency executive directors, chief financial officers, and program managers regarding the observations and concerns received from the SAO, DOE and DOE's Inspector General. We encouraged all parties to compare current practices to concerns registered and make immediate corrections if warranted.

We updated our inspection checklist to include checking income eligibility documentation, rather than limit the review to only the in-office monitoring. Training on how to review eligibility and properly document the results is planned for all lead monitors and inspectors in February 2011. We are determining how to manage this element for large multi-family buildings when there isn't individual income verification documented.

To summarize our actions steps and target completion dates:

1. *February 2011 - Issue a finding letter to King County Housing Authority on serving households after term of eligibility;*
2. *March 2011 - Refine program monitoring tools and reinforce consistent procedures to be employed by monitors and inspectors;*
3. *May 2011 - Convene a statewide inspector refresher training;*
4. *July 2011 - Complete the weatherization monitoring fiscal tool on 10 local agencies;*

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

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

> The auditee shall:
>
> (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

U.S. Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 400, states:

> (d) Pass-through entity responsibilities. A pass-through entity shall perform the following for the Federal awards it makes:
>
> (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 pass-through 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 that performance goals are achieved.

U.S. Department of Energy Weatherization Program Guidance 10-1 Effective December 18, 2009

> 4.0 GRANTEE PROGRAM OVERSIGHT (Program Monitoring)
>
> A. ROLE: The Grantee must conduct comprehensive monitoring of each subgrantee at least once a year. The comprehensive monitoring must include review of client files and subgrantees records, as well as actual inspection of at least 5 percent of the completed units. Grantees are strongly encouraged to inspect additional "in progress" units in order to assess compliance with safe work practices, adherence to lead safe weatherization protocols, and other factors that are relevant to onsite, in progress reviews. Grantees may make as many program assessment visits as necessary and for which resources are available. By the close of the program year, the Grantee is expected to have completed a comprehensive review of each subgrantee, including review of its latest financial audit. Failure to comply with this requirement is sufficient cause to require special conditions to the grant under 10 CFR 600.212.

Department of Energy Weatherization Notice 10-18

> G. RE-CERTlFICATlON: An applicant who is deemed ineligible based on Income may be re-certified if ineligibility is due to the length of time that expired while the applicant was waiting to receive weatherization services. As a reminder, recertification of eligibility should occur at least every 12 months. The method of determining Re-Certification is to be determined by the Grantee.

Department of Commerce Weatherization Manual For Managing the Low-Income Weatherization Program

> A. Policy
>
> 1. An applicant will remain eligible for weatherization services for 12 months from the date of verified eligibility.
> 2. If weatherization work is expected to begin between 12 and 15 months from the date of verified eligibility, the household must show continued eligibility. A signed declaration of income statement for the previous three months may be used to update application if necessary.
> 3. If weatherization work has not begun after 15 months from the date of application, the household must reapply in full. Weatherization work begins on the date of initial energy audit.

10-22 The Department of the Services for the Blind is not complying with federal requirements regarding payroll costs charged to the Vocational Rehabilitation Program.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Vocational Rehabilitation Grants To States
	84.390 Vocational Rehabilitation Grants To States – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	H126A100072 (CFDA 84.126)
Applicable Compliance Component:	Allowable Costs
Questioned Cost Amount:	$947,414

Background

The Department of Services for the Blind is responsible for approximately 15.5 percent of the federal funding received by the state for the Vocational Rehabilitation Program. The program's purposes are to design, assess, plan, develop, and provide vocational rehabilitation services for individuals who are blind or have low vision, so that they may prepare for and become employed. The Department received more than $8.4 million in federal funding for this program in fiscal year 2010.

Federal regulations specify how employee salaries and wages charged to the grant are to be documented. For employees who work on multiple activities or cost objectives, payroll costs charged directly to federal awards are to be supported by monthly personnel activity reports such as time sheets. The time records are to reflect the actual hours employees work on each program and are used as a basis for requesting federal funds.

If an employee works solely on one federal activity, only semi-annual certifications signed by the employee or a supervisor are needed to meet federal requirements.

Description of Condition

Employees who provide direct services to clients complete hourly timesheets or certifications montly to meet federal time and effort requirements.

During the audit, we reviewed a random sample of payroll costs charged to the grant during the year. We reviewed salaries and benefits charged to the grant for 74 employees, 21 of which were administrative staff who did not provide direct services to clients, but who work solely on grant activities. These 21 employees did not complete semi-annual certifications during the year. Related salary and benefit expenditures totaled $947,414.

Cause of Condition

Department staff responsible for collecting semi-annual time certifications did not understand the federal requirements. Department staff incorrectly believed that only employees who provide direct services to clients were required to meet federal time and effort requirements.

Effect of Condition and Questioned Costs

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

We are questioning costs of $947,414, the amount charged to the grant that was not supported in accordance with federal requirements.

Recommendations

We recommend the Department revise its procedures and require all administrative employees who work solely on the Vocational Rehabilitation program to complete a semi-annual certification to meet federal requirements.

Additionally, we recommend the Department consult with the U.S. Department of Education to determine what, if any, costs affected by this compliance issue should be repaid.

Department's Response

The Department of Services for the Blind agrees with the audit finding and recommendations. As of March 1, 2011, a corrective action plan has been completed which included:

- *An Effort Certification form for staff working solely on a single Federal award or cost objective has been adopted into DBS procedures;*
- *Effort Certifications have been conducted on all impacted staff for the latest 6-month period of time;*
- *The Effort Certification process has been added to the agency's due dates calendar in coordination with the Federal fiscal year;*
- *DSB has contacted the US Department of Education, Rehabilitation Services Administration for their review of any costs that are to be repaid as a result of the lack of certifications.*

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

U.S. Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Section 300, states in part:

> The auditee shall:
>
> (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

The U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments* (2 CFR 225), states::

> Appendix A, Section C:
>
> 1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:…
> b. Be allocable to Federal awards under the provisions of 2 CFR 225.
> 3. Allocable costs.
> a. A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received.
>
> Appendix B, Section 8(h):
>
> Support of salaries and wages. These standards regarding time distribution are in addition to the standards for payroll documentation…

(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.

(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.

10-23 The Department of Social and Health Services is not complying with federal requirements for suspension and debarment for the federal Vocational Rehabilitation Program.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Vocational Rehabilitation Grants to States 84.390 Vocational Rehabilitation Grants to States - American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	H126A100071 (CFDA 84.126)
Applicable Compliance Component:	Suspension and Debarment
Questioned Cost Amount:	None

Background

The Department of Social and Health Services, Division of Vocational Rehabilitation, administers the federal Vocational Rehabilitation Programs. The program's purposes are to design, assess, plan, develop, and provide vocational rehabilitation services for individuals with disabilities so that such individuals may prepare for and engage in gainful employment. The Department received $54,868,671 in federal funding during fiscal year 2010, $8,872,246 of which was provided through the American Recovery and Reinvestment Act.

Federal regulations prohibit recipients of federal awards from contracting with vendors suspended or debarred from doing business with the federal government. For any purchase contract paid from federal funds that exceeds or is expected to exceed $25,000, the grantee must ensure its vendors and subrecipients are not suspended or debarred from participating in federal programs. Grantees can meet this requirement by:

(a) Checking the federal Excluded Parties List System (EPLS); or
(b) Collecting a certification from the vendor or subrecipient; or
(c) Adding a clause or condition to the covered transaction with the vendor or subrecipient.

Description of Condition

The Division contracts with vendors to provide services to the Division's clients for activities allowed under the program. Some of these are formalized through use of a Department master contract, however many are through a less formal vendor agreement, which is known as an "Authorization For Purchase" (AFP). The Division's client service tracking system automatically creates an AFP when a purchase is authorized.

We identified all vendors paid during the audit period that would be subject to the suspension and debarment requirements. We found the Division did not verify that 132 of these vendors were not suspended or debarred.

Cause of Condition

Department master contracts contain suspension and debarment clauses. However, AFP vendor agreements do not. The Division was not aware it must ensure all vendors receiving more than $25,000 in Vocational Rehabilitation grant funds are not suspended or debarred and does not check the EPLS or collect a separate certification from the vendors.

Effect of Condition

Failure to comply with grant requirements could result in repayment of grant funding or loss of eligibility for future federal awards. We examined the status of the 132 vendors in the EPLS and found none of them were debarred or suspended, therefore we are not questioning any costs.

Recommendations

We recommend the Department ensure all vendors receiving more than $25,000 in Vocational Rehabilitation grant funds have not been suspended or debarred by using one of the methods identified in federal regulations.

Department's Response

The Division of Vocational Rehabilitation (DVR) concurs with this finding.

DVR, in coordination with Central Contract Services and the Attorney General's Office, will examine current purchasing practices and identify the necessary steps to comply with the Suspension and Debarment requirements. This will be completed in conjunction with the FY 10 Accountability finding on Contract Management which noted DVR's payment for client services without contracts.

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

U.S. Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Nonprofit Organizations*, Subpart C, section 300 -- Auditee responsibilities.

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 2, Code of Federal Regulations, Section 180.220 – Are any procurement contracts included as covered transactions?

(b) Specifically, a contract for goods or services is a covered transaction if any of the following applies:
   (1) The contract is awarded by a participant in a non-procurement transaction that is covered under Sec.180.210, and the amount of the contract is expected to equal or exceed $25,000.

Title 2, Code of Federal Regulations, Section 180.300 – What must I do before I enter into a covered transaction with another person at the next lower tier?

When you enter into a covered transaction with another person at the next lower tier, you must verify that the person with whom you intend to do business is not excluded or disqualified. You do this by:

(a) Checking the EPLS; or
(b) Collecting a certification from that person ; or
(c) Adding a clause or condition to the covered transaction with that person.

10-24 The Department of Social and Health Services is not complying with federal requirements for time and effort documentation for the Vocational Rehabilitation Program.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Vocational Rehabilitation Grants To States 84.390 Vocational Rehabilitation Grants To States – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	H126A100071 (CFDA 84.126)
Applicable Compliance Component:	Allowable Costs
Questioned Cost Amount:	$662,958

Background

The Department of Social and Health Services, Division of Vocational Rehabilitation, administers the federal Vocational Rehabilitation Program. The program's purposes are to design, assess, plan, develop, and provide vocation rehabilitation services for individuals with disabilities, so that they may prepare for and engage in employment. The Department received $13,468,671 in federal funding for this program in fiscal year 2010, $8,872,246 of which was authorized and provided through the American Recovery and Reinvestment Act.

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

Description of Condition

Semi-annual payroll certifications are created by headquarters staff and verified and signed by Division supervisors to meet federal time and effort requirements.

During this year's audit, we reviewed all of the certifications for the six month period October 1, 2009 through March 31, 2010. We found 35 out of 350 Division employees did not have a certification for this period. Salary and benefit expenditures related to these exceptions totaled $662,958. Division supervisors stated that 33 of these employees worked 100 percent on the grant program; we could not determine the status of the remaining two as they no longer work for the Division.

Cause of Condition

The Division's headquarters office creates the current semi-annual certifications based on the prior certification and any communications received from the field office supervisors concerning additions or deletions of staff. However, the headquarters staff does not reconcile the certifications to accounting and payroll records to ensure semi-annual certifications are created for all employees whose salaries/benefits have been charged to the grant in the accounting records.

Additionally, some field office supervisors did not adequately review the semi-annual certifications as required.

Effect of Condition and Questioned Costs

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

We are questioning costs of $662,958, the amount charged to the grant that was not supported in accordance with federal requirements.

Recommendations

We recommend the Department:

- Revise its procedures and require headquarters staff to use salary and benefit expenditure information when creating the semi-annual certifications, and reconcile the certifications to all payroll costs charged to the grant.
- Ensure supervisors verify all of their staff members are listed on the certifications.

Additionally, we recommend the Department consult with the U.S. Department of Education to determine what, if any, costs affected by this compliance issue should be repaid.

Department's Response

The Division of Vocational Rehabilitation (DVR) partially concurs with this finding.

DVR concurs that the time certifications for the period of October 2009 to March 2010 did not include staff members who left employment any time during the certification period. DVR will revise the certification process to include salary and benefit expenditures during the semiannual certification time period and will reconcile the certifications to all payroll costs charged to the grant during the semiannual certification period. Also, we will provide VR Supervisors training to ensure all required staff members are listed on the certifications.

DVR does not concur with the questioned costs of $662,958 as each staff member can be certified they worked 100% on VR grant activities after the fact.

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 Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments* (2 CFR 225), states::

Appendix A, Section C:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:…
   b. Be allocable to Federal awards under the provisions of 2 CFR 225.
3. Allocable costs.
   b. A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received.

Appendix B, Section 8(h):

Support of salaries and wages. These standards regarding time distribution are in addition to the standards for payroll documentation…

(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 firsthand knowledge of the work performed by the employee.

(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.

10-25 The Department of Health does not monitor subrecipient expenditures of the National Bioterrorism Hospital Preparedness and Public Health Emergency Preparedness programs.

Federal Awarding Agency:	U.S. Department of Health and Social Services
Pass-Through Entity:	None
CFDA Number and Title:	93.069 Public Health Emergency Preparedness 93.889 Hospital Preparedness Program
Federal Award Number:	5UT90TP017010, 1U90TP000144, 1H75TP000369; U3RHS007562-01, U3REP070019-01, U3REP090208-01, U3REP080103-01, U3REP090228-01
Applicable Compliance Component:	Cash Management; Subrecipient Monitoring Controls/Compliance
Questioned Cost Amount:	None

Background

The Washington State Department of Health administers the Public Health Emergency Preparedness Program and the National Bioterrorism Hospital Preparedness Program. These federal grants enhance the ability of hospitals and health care systems to prepare for and respond to biological and other public health emergencies. The Department distributes money to hospitals, outpatient facilities, tribes, health centers, poison control centers, emergency management services and other healthcare partners. These entities oversee training, meetings, purchasing of supplies and equipment, and generate reports on the program. The Department spent $30.7 million in Public Health Emergency Preparedness funds and $11.4 million in Hospital Preparedness Program funds in fiscal year 2010.

Funds provided to subrecipients must be for actual costs incurred or, in the case of cash advances, to actual short- term needs. This prevents recipients from using federal funds to accumulate excess cash reserves, which is prohibited by federal regulation. It also prevents the sub-recipient from earning a profit from its grant arrangement. In all cases, only actual costs may be charged and those costs must be adequately supported.

Description of Condition

The Department of Health does not collect or review any supporting documentation for expenditures reimbursed to sub-recipients for either program. Instead, the recipients invoice the Department for a portion of their grant award each month, regardless of actual costs incurred. We found no documentation included with the invoices supporting the sub-recipient's actual costs. The Department does not request supporting documentation or perform financial reviews.

Cause of Condition

Department management felt its payment process and monitoring of sub-recipient activity were adequate to ensure costs were allowable and supported. Department management relies on finished deliverables based on the scope of work as a basis for supporting costs. However, a finished deliverable is not sufficient to determine if the amount paid to the sub-recipient was necessary, reasonable, allocable, documented, and net of any credits owed to the grantor.

Effect of Condition

The Department cannot be sure it is reimbursing its sub-recipients for allowable costs or actual costs incurred, or that its sub-recipients are not making a profit from federal dollars. The Department also cannot be sure the sub-recipient has no cash on hand and that it is operating on a reimbursement basis.

Recommendation

We recommend the Department ensure payments to sub-recipients are made in accordance with federal requirements, and that costs are adequately supported. The Department should only reimburse for actual costs incurred to avoid sub-recipients having excess cash on hand.

Department's Response

We partially concur with the State Auditor's Office finding.

We wish to emphasize however that the Department does have a regular and sustained subrecipient monitoring effort that includes on-sight monitoring of expenditures and controls for multiple grants at regular intervals.

The State Auditor's Office (SAO) recommendation represents a significant change in our business practice.

Our monitoring effort, which has been reviewed by SAO in previous audits, has here- to- for been reliant on limited testing and assessment of risks as identified through our fiscal monitoring effort. When controls or documentation has been found lacking at specific subrecipients, we typically request back up documentation to support billed expenditures for a specific period of time until we are assured that reporting problems have been resolved.

Up until the conduct of this audit we understood the Department of Health subrecipient monitoring effort to be compliant with OMB A-13.3

We will review the SAO recommendation in light of our available resources and the impact on our Public Health Partners.

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

Title 2, Code of Federal Regulations, section 215.22 (applicable to non-profits and hospitals), states:

(a) Payment methods shall minimize the time elapsing between the transfer of funds from the United States Treasury and the issuance or redemption of checks, warrants, or payment by other means by the recipients. Payment methods of State agencies or instrumentalities shall be consistent with Treasury-State CMIA agreements or default procedures codified at 31 CFR part 205.

(b) Recipients are to be paid in advance, provided they maintain or demonstrate the willingness to maintain:

  (1) Written procedures that minimize the time elapsing between the transfer of funds and disbursement by the recipient, and

  (2) Financial management systems that meet the standards for fund control and accountability as established in § 215.21. Cash advances to a recipient organization shall be limited to the minimum amounts needed and be timed to be in accordance with the actual, immediate cash requirements of the recipient organization in carrying out the purpose of the approved program or project. The timing and amount of cash advances shall be as close as is administratively feasible to the actual disbursements by the recipient organization for direct program or project costs and the proportionate share of any allowable indirect costs.

(c) Whenever possible, advances shall be consolidated to cover anticipated cash needs for all awards made by the Federal awarding agency to the recipient.
(e) Reimbursement is the preferred method when the requirements in § 215.12(b) cannot be met.

Title 45, Code of Federal Regulations, Part 92

Section 92.22 - Allowable costs.

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

Section 92.21 - Payment

(b) Basic standard. Methods and procedures for payment shall minimize the time elapsing between the transfer of funds and disbursement by the grantee or subgrantee, in accordance with Treasury regulations at 31 CFR Part 205.
(c) Advances. Grantees and subgrantees shall be paid in advance, provided they maintain or demonstrate the willingness and ability to maintain procedures to minimize the time elapsing between the transfer of the funds and their disbursement by the grantee or subgrantee.

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments* (2 CFR 225)

Appendix A, Section C.- Basic Guidelines:

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

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

Section C. Cash Management

Pass-through entities must establish reasonable procedures to ensure receipt of reports on subrecipients' cash balances and cash disbursements in sufficient time to enable the pass-through entities to submit complete and accurate cash transactions reports to the Federal awarding agency or pass-through entity.

Pass-through entities must monitor cash drawdowns by their subrecipients to ensure that subrecipients conform substantially to the same standards of timing and amount as apply to the pass-through entity.

Section M. Subrecipient Monitoring:

A pass-through entity is responsible for:

- During-the-Award Monitoring – Monitoring the subrecipient's use of Federal awards through reporting, site visits, regular contact, or other means to provide reasonable assurance that the subrecipient administers Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

10-26 The Department of Health did not support over $448,000 in payroll costs in accordance with federal regulations for the National Bioterrorism Hospital Preparedness and Public Health Emergency Preparedness Programs.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.069 Public Health Emergency Preparedness 93.889 National Bioterrorism Hospital Preparedness
Federal Award Number:	U3RHS007562-01,U3REP070019-01, U3REP090208-01, U3REP080103-01, U3REP090228-01, 5U90TP017010-10, 1H75TP000369-01, 1U90TP000144-01
Applicable Compliance Component:	Allowable Costs/Cost Principles
Questioned Cost Amount:	$448,344.90

Background

The state Department of Health administers the Public Health Emergency Preparedness Program and the National Bioterrorism Hospital Preparedness Program. These federal grants enhance the ability of hospitals and health care systems to prepare for and respond to biological and other public health emergencies. The Department distributes this money to public and private entities that provide these services and retains a portion to pay administrative costs. The Department spent $30.7 million in Public Health Emergency Preparedness funds and $11.4 million in National Bioterrorism Hospital Preparedness funds during fiscal year 2010.

Grant money may be used to pay only for costs that are allowable and related to the grant's purpose. Federal regulations specify the documentation that must be kept to support employee compensation charged to federal grants. If an employee works solely on the grant program and all related payroll costs are charged to that grant, minimal documentation is required: the employee must certify, semi-annually, in writing, that he or she worked solely on that program. Requirements state that for employees who work on multiple programs or whose positions are funded by multiple sources, payroll costs must be supported by personnel activity reports such as timesheets. These reports must:

- Reflect how much time the employee worked on each program.
- Account for the total activity for which the employee is compensated.
- Be prepared at least monthly and coincide with one or more pay periods.
- Be signed by the employee.

Payroll charges based on an estimate are allowable if the estimate of time worked is reconciled to actual work activity at least quarterly.

Description of Condition

During the audit period, the Department charged a portion of the payroll costs for five managers to multiple grants based on budgeted percentages. Although these managers worked on and were charged to multiple programs, they did not maintain timekeeping or other personnel activity reports as required.

Cause of Condition

Department staff misinterpreted federal requirements and believed the personnel activity reports were not required for these managers.

Effect of Condition and Questioned Costs

We identified $253,669.70 in direct payroll charges to the Public Health Emergency Preparedness Program grants and $194,675.20 in direct payroll charges to the National Bioterrorism Hospital Preparedness Program grants that were not supported in accordance with federal requirements. We are questioning those costs as unallowable charges for salaries and benefits. The federal grantor could disallow these charges and require the Department to pay back the money.

Recommendations

We recommend the Department ensure all employee salaries and benefits charged to a federal grant meet the documentation requirements of federal regulations.

The Department should consult with its grantor to determine what, if any, of the questioned costs should be repaid.

Department's Response

Subsequent to the completion of the State Auditor's Office field work, agency staff located time and effort documentation in the form of time sheets for all but one of the managers whose documentation was reviewed during the audit. All but one of the managers began keeping time sheets in March of 2009 in addition to completing quarterly time certifications.

We will work with the federal grantor to demonstrate how the affected program managers' time was distributed directly among the federal funding sources, and to resolve the questioned costs.

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

Auditor's Concluding Remarks

We thank the Department for its response. We reviewed a sample of the time sheets located by the Department. Although time sheets were completed during the audit period, payroll charges were not charged to the grant based on the hours worked as reported on the time sheets. Rather, we found payroll was charged to the grant based on budgeted percentages within the payroll system and hours were not reconciled to the time sheets.

We affirm our finding and will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

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

> The auditee shall:
>
> (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

U.S. Office of Management and Budget Circular A-87 (2 CFR 225), *Cost Principles for State, Local and Indian Tribal Governments*, states:

> Appendix B, Section 8(h):
>
> 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 8.h.(5) of this appendix unless a statistical sampling system (see subsection 8.h.(6) of this appendix) 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 8.h.(6)(c) of this appendix;
(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 8.h.(6)(a) of this appendix 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: …the costs are equitably allocated to all related activities, including Federal awards;….

10-27 The Department of Commerce does not ensure the Temporary Assistance for Needy Families funding it provides to subrecipients is reported and audited in accordance with federal regulations.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.558 Temporary Assistance for Needy Families 93.714 Emergency Contingency Fund for TANF State Program – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	1-910896842-A1
Applicable Compliance Component:	Subrecipient Monitoring Controls/Compliance
Questioned Cost Amount:	None

Background

The Temporary Assistance for Needy Families **(**TANF) program provides time-limited assistance to low-income families with children so that the children can be cared for in their own homes or in the homes of relatives. The program served approximately 41,000 households each month and spent more than $518 million in fiscal year 2010.

The Department of Social and Health Services administers most of the funds. The Department of Commerce uses a smaller portion to provide sub-grants to organizations that help clients with job skills and placement. During fiscal year 2010, Commerce paid more than $28 million to 15 of these organizations.

Federal regulations require Commerce to monitor the grant-funded activities of subrecipients. This includes ensuring the organizations receive an audit of these funds in accordance with the federal Office of Management and Budget Circular A-133. This requirement is fundamental to good subrecipient monitoring activities, and helps ensure that federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements. Grant awards are also required to be reported by the subrecipients on a Schedule of Expenditures of Federal Awards. This schedule forms the basis for selecting federal funds to audit pursuant to these requirements. The results of all such audits, along with the schedule, must be submitted to a federal clearing house within nine months of the organizations' fiscal year end. This process is the basis of the monitoring and accountability system for federal grants.

Description of Condition

The Department of Commerce does not ensure subrecipients receive an audit in accordance with federal regulations The Department is not ensuring subrecipients are reporting the TANF funds in their Schedule of Expenditures of Federal Awards as required.

Cause of Condition

The Department stated it has no responsibility to ensure its subrecipients have had an audit in accordance with federal regulations or to ensure federal awards it passes through are properly reported. The Department stated it includes a clause in its award contract that states the subrecipient is to obtain an audit if required, and that having this language in the contract absolves the Department of any further responsibility.

Effect of Condition

Almost half of the TANF funds passed through from Commerce to subrecipient organizations were not audited or reported. Of the 15 subrecipients, we found concerns with five:

- Commerce had no evidence an audit of the federal funds was conducted on three subrecipients. Total TANF funds received were $3,797,482.
- Two subrecipients did not report the TANF grant on their Schedule of Expenditures of Federal Awards. Because of this, even though an audit appears to have been done, it did not include the TANF funds. Total TANF funds received were $6,347,228.

In addition, the audit conducted for one subrecipient appeared to have significant deficiencies based on a cursory review:

- We could find no evidence the audit had been submitted to the federal clearing house; and
- The audit report included misinformation indicating the audit was not conducted in accordance with federal requirements.

We identified $10,144,710 in funds received by subrecipients that were not audited as required by OMB Circular A-133.

Audits are designed to provide transparency to the public about how tax dollars are spent and to ensure federal grantors know that funds are being spent appropriately.

Recommendation

We recommend the Department take appropriate action to ensure its subrecipients receive audits as required. For those subrecipients who did not have an audit or did not report the TANF funds, we recommend the Department take appropriate action, up to and including recovery of the funds provided.

Department's Response

We partially concur with the finding. We agree that not all subrecipients submitted audit reports as required and we did not catch the oversight. Terms and conditions of contracts with the subrecipients identify the requirement that organizations receiving in excess of $500,000 in federal funds must have a Circular A-133 audit. Commerce is satisfied that program funds expended during this period were appropriate and correct through the monthly invoice verification process, the required documentation and on-site monitoring conducted for each subrecipient.

In the future, based on direction from our funding source, we will consider the WorkFirst contractors as vendors, thus negating the requirements for Circular A-133 audit reports.

Commerce does not agree that it is our responsibility to ensure that subrecipient audits are conducted in accordance with Circular A-133. We do not believe we should be required to re-audit an audit report prepared by the auditee's Certified Public Accountant. Generally accepted accounting principles and federal regulations enumerate many financial statement disclosure requirements and to expect us to review the reports for all of those requirements is not possible. That is the responsibility of the auditee and their auditor and we cannot be expected to take on that responsibility. Also, if the State Auditor's Office has concerns about the quality of an audit report, there are procedures for notifying the State Board of Accountancy of those concerns. Commerce does not have the expertise to make those judgments and that is not a responsibility we will assume.

Auditor's Concluding Remarks

We thank the Department for its response. Contrary to the Department's position, federal regulations (cited below) clearly state it is the Department's responsibility to ensure sub-recipients receive audits in accordance with OMB Circular A-133. During our audit, we looked at three criteria to determine if the Department complied with A-133: Did the Department receive an audit report from its sub-recipient; did it look at the report to see if it appeared to include the basic components of an A-133 audit; and did it look at the report to ensure the TANF funds provided were accurately reported. The Department did none of these.

We affirm our finding and will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-133. *Audits of States, Local Governments, and Non-Profit Organizations*, Section .400, states in part:

(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.

(6) Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.

10-28 The Department of Social and Health Services requested federal grant funding in excess of its immediate needs.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.563 Child Support Enforcement 93.563 Child Support Enforcement – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	G-1004WA4004
Applicable Compliance Component:	Cash Management
Questioned Cost Amount:	N/A

Background

Federal regulations require agencies to minimize the time elapsing between receipt and payment of federal grant funds to prevent interest from accruing on unspent money. Rules governing the transfer of funds from the U.S. Treasury Department to the state for the Child Support Enforcement grant are spelled out in the Cash Management Improvement Act agreement, which allows the Department of Social and Health Services to request reimbursement for program expenditures only after they have been incurred. Requesting funds in advance could result in the Department incurring interest that it would have to pay to the federal government.

Program staff track eligible expenditures and the Department's Office of Accounting Services requests the reimbursement from the grantor. During fiscal year 2010, the Department requested more than $112 million in reimbursement for expenditures related to the Division of Child Support.

Description of Condition

The Department claimed $112 million for federal reimbursement for the Child Support Enforcement Grant, but had only incurred $80 million in eligible expenditures. The Department requested and was reimbursed $32 million for expenditures it had not yet incurred.

Cause of Condition

The Division of Child Support used incorrect account coding when it adjusted expenditure and revenue records during fiscal year 2010. Because of this, the Department did not correctly identify expenditures eligible for reimbursement, resulting in the Department requesting reimbursement for the same expenditures multiple times. The Department does not reconcile expenditures to revenue to ensure it draws the appropriate amount. The Department only identified the error when it was denied reimbursement because it had overdrawn the grant funds for the period.

Effect of Condition

The Department requested reimbursement of more than $32 million in Child Support Enforcement expenses it had not incurred. The state may owe interest to the federal government for this amount.

The Department identified the overdrawn funds and returned them to the federal government during fiscal year 2011.

Recommendation

We recommend the Department strengthen controls over the recording and tracking of expenditure and revenue accounts to ensure it requests money based on accurate accounting information. We further

recommend the Department consult with its grantor and the state Office of Financial Management to determine if any interest is owed to the federal government.

Department's Response

The Department concurs with the finding.

The errors occurred as a result of ARRA funds adjustments which caused inadvertent "draw downs" of federal funds over a four quarter period. The draw downs were not immediately identified because the DSHS Grants Management System (GMS) does not interface with the federal Payment Management System (PMS). ESA fiscal staff do not have access to the PMS. By obtaining quarterly PMS reports from the DSHS Office of Accounting Services (OAS) a reconciliation process will be implemented.

The errors were corrected and all inappropriately received federal funds were returned, in October of *2010.*

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,* Section 300, states in part:

> The auditee shall:
> (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

Title 31, Code of Federal Regulations, Section 205.1.

> What Federal assistance programs are covered by this part?
>
> (a) This part prescribes rules for transferring funds between the Federal government and States for Federal assistance programs. This part applies to:
> (1) All States as defined in § 205.2; and
> (2) All Federal program agencies, except the Tennessee Valley Authority (TVA) and its Federal assistance programs.
> (b) Only programs listed in the Catalog of Federal Domestic Assistance, as established by Chapter 61 of Title 31, United States Code (U.S.C) are covered by this part.
> (c) This part does not apply to:
> (1) Payments made to States acting as vendors on Federal contracts, which are subject to the Prompt Payment Act of 1982, as amended, 31 U.S.C. 3901 et seq., 5 CFR part 1315, and 48 CFR part 32; or
> (2) Direct loans from the Federal government to States.

Title 31, Code of Federal Regulations, Section 205.10

> How do you document funding techniques?
>
> The Treasury-State agreement must include a concise description for each funding technique that a State will use. The description must include the following:
> (a) What constitutes a timely request for funds;
> (b) How the State determines the amount of funds to request;

(c) What procedures are used to project or reconcile estimates with actual and immediate cash needs;
(d) What constitutes the timely receipt of funds; and
(e) Whether a State or Federal interest liability accrues when the funding technique, including any associated procedure for projection or reconciliation, is properly applied.

Cash Management Improvement Act Agreement between The State of Washington and The Secretary of the Treasury, United States Department of the Treasury, states:

6.2.1 The following are terms under which standard funding techniques shall be implemented for all transfers of funds to which the funding technique is applied in section 6.3 of this agreement.

Modified Payment Schedule – Bi-Weekly (Semi-Monthly Drawdown on Payday)
These are negotiated drawdowns scheduled to be received by the State on the day after payday. These drawdowns represent payroll costs, other administrative costs, or direct benefit/program costs incurred by the State. The request shall be made in accordance with the appropriate Federal agency cut-off time specified in EXHIBIT I. The amount of the request shall be the sum of the payments paid for benefits, payroll, and administrative costs accumulated since the last draw. This funding technique is interest neutral.

6.3.2 Programs

93.563 Child Support Enforcement
Recipient: 300 --- Department of Social & Health Services----------DSHS
% of Funds Agency Receives: 100
Component: Administrative and Payroll Costs
Technique: Modified Payment Schedule – Bi-Weekly (Semi-Monthly Drawdown on Payday)
Clearance Pattern: 0 days

10-29 The Department of Commerce, Community Services and Housing Division, did not comply with subrecipient monitoring requirements for the Community Services Block Grant program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	
CFDA Number and Title:	93.569 Community Services Block Grant 93.710 Community Services Block Grant – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	08B1WACOSR, 09B1WACOSR, 10B1WACOSR, 0901WACOS2
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

The Community Services Block Grant program assists community-based organizations in providing programs and services to low-income communities, individuals and families. These include 26 non-profits and four local government agencies.

During fiscal year 2010, the Department spent almost $15.3 million on the Community Services Block Grant Program, approximately half of which was provided through the American Recovery and Reinvestment Act (ARRA) of 2009.

Description of Condition

Federal regulations require the Department monitor each organization it provides funding, including onsite reviews at least once every three years to determine conformity with performance goals, administrative standards, financial management rules, and other requirements. The Department performed the required onsite reviews for 28 of the organizations within the three years. It did not review two of the organizations onsite for at least five years. These two organizations received more than $1.2 million in block grant funding during fiscal year 2010.

Cause of Condition

The Department assigned two employees to monitoring the 30 organizations. It did not review the tracking schedule to ensure they performed all required onsite visits.

In July 2009, the Department reassigned the monitoring. The new staff updated the tracking schedule and discovered the two onsite reviews had not been done. Because they already established a monitoring schedule, the reviews of those two took place 10 and 16 months after the discovery.

Effect of Condition

The Department cannot ensure organizations are meeting performance goals, administrative standards, financial management rules and other grant requirements. Grantors rely on subrecipient monitoring to ensure money is spent appropriately.
In addition, grant conditions allow the grantor to penalize the Department for noncompliance by suspending or terminating the award or withholding future awards.

Recommendation

We recommend the Department follow the monitoring schedule and ensure all onsite visits are performed timely and the organizations are in compliance with laws, regulations, and the provisions of the grant agreements.

We recommend the Department ensure individuals charged with carrying out specific activities know what is expected of them and that management monitor to ensure the activities are occurring.

Department's Response

We concur with the finding. When a staff member assumed program management responsibilities for the Community Service Block Grant (CSBG) in July 2009, she noted that two subrecipients had not received onsite monitoring within the required three year period. In the summer and fall of 2009, the upcoming monitoring schedule was updated, but since the schedule was already set for 2009, the two subrecipients were not added to the schedule. With only two employees monitoring approximately 10 subrecipients per year, and the addition of American Reinvestment and Recovery Act funding awards in the spring of 2009, it was difficult to add the two subrecipients to the monitoring schedule for 2009. The entire grant process—from application to award, from tracking expenditures to assessing risk, from additional fiscal monitoring to state and federal reporting—had to be ramped up under significantly constrained staffing conditions. Monitoring visits are typically scheduled March or April through October, to a) avoid hazardous driving conditions in the winter, and b) because the annual application and reporting processes consume most of staff's time from October through March.

Both subrecipients were contacted on March 11, 2010 when the 2010 monitoring schedule was being prepared for that year. Monitor dates were arranged for May and November 2010.

At present, the monitoring schedule has been adjusted so that 10 subrecipients will be monitored on-site each year, to ensure that all 30 subrecipients are monitored on-site every three years. Any additional on-site monitor visits triggered by a risk assessment, request by the subrecipient, or poor performance will be added to the normal three-year rotation schedule.

In addition to on-site monitoring, other monitoring activities are performed by Commerce staff that yield information about the performance of the subrecipients:

- *Annual application process—includes review of their annual plan, community needs assessment, strategic planning documents, and budget*
- *Monthly review and processing of requests for reimbursement—yields a picture of their spend-down of the grant, and adherence to expenditures based on their stated plan*
- *Periodic phone calls—includes technical assistance*
- *Desk monitoring—fiscal documents for ARRA grants mailed to Commerce by grant subrecipients were reviewed at Commerce*
- *Twice-yearly reporting—subrecipients send mid-year and yearly data to Commerce for review (Aug. 15th and Feb. 15th). Reports indicate whether they are following their plan for spending resources in planned areas and obtaining expected outcomes, with explanations of variances from outcome targets*

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

U.S. Office of Management and Budget (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.
(c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

Section 400:

(d) Pass-through entity responsibilities. A pass-through entity shall perform the following for the Federal awards it makes:
  (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 pass-through 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 that performance goals are achieved.

United States Code, Title 42, Section 9914, states:

a) In general
In order to determine whether eligible entities meet the performance goals, administrative standards, financial management requirements, and other requirements of a State, the State shall conduct the following reviews of eligible entities:
(1) A full onsite review of each such entity at least once during each 3-year period

10-30 The Department of Commerce, Community Services and Housing Division, did not comply with period of availability requirements for the Community Services Block Grant program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	
CFDA Number and Title:	93.569 Community Services Block Grant 93.710 Community Services Block Grant – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	08B1WACOSR
Applicable Compliance Component:	Period of Availability
Questioned Cost Amount:	$55,593.11 non-ARRA

Background

The Community Services Block Grant program assists organizations in providing programs and services to low-income communities, individuals and families. These organizations include 26 non-profits and four local government agencies.

During fiscal year 2010, the Department spent almost $15.3 million on the Program, approximately half of which was provided through the American Recovery and Reinvestment Act (ARRA) of 2009.

Description of Condition

Federal regulations allow the Department two years from the time of award to spend the block grant money. Funds awarded for the 2008 grant had to be spent by September 30, 2009. We identified five expenditures totaling $55,593.11 in October 2009 that were charged to the 2008 grant.

Cause of Condition

Department fiscal staff did not properly review costs transferred from one grant year to another grant year to ensure they were within the proper period of availability. Fiscal staff did not consult program staff when transferring costs between grant years.

Effect of Condition and Questioned Costs

The Department charged $55,593.11 in costs to the grant after the grant's period of availability ended, resulting in federal questioned costs.
When the Department does not adequately monitor expenditures to ensure only expenditures within the period of availability are paid for, grant conditions allow the grantor to penalize the Department for noncompliance by suspending or terminating the award or withholding future awards.

Recommendation

We recommend the Department properly review costs transferred between grants to ensure only expenditures made during the proper period of availability are charged to grants. We further recommend that fiscal staff consult program staff when transferring costs between grants.

The Department should work with its grantor to determine what, if any, of the questioned costs should be repaid**.**

Department's Response

We concur with the finding. Commerce did not properly review costs transferred from one grant year to another grant year to ensure costs were within the proper period of availability. Fiscal staff did not clarify nor consult with program staff when program staff requested cost transfers between grant years. Fiscal staff reviewing the work of newly hired staff did not properly verify backup documentation for the transfer. As a result, $55,593.11 transferred was not properly identified within the period of availability.

In January 2011, fiscal and program staff reviewed and corrected the original October 2009 $55,593.11 costs transfer between grant years. Appropriate costs within the period of availability were identified and transferred.

Commerce concurs with the Auditors recommendation that fiscal staff consult with program staff when transferring costs between grant years. Commerce has assessed its internal controls and implemented the following measures to ensure proper review of costs transfer through clearly defined expectations and responsibilities. Program and Fiscal staff have updated the transfer / correction request form to include identification of specific items to transfer and provided training to fiscal and program staff. Fiscal has reiterated document review and approval expectations with supervisors and lead works.

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

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

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

United States Department of Health and Human Services, Community Services Block Grant Terms and Conditions outlines responsibilities for entities receiving federal funds and states in part:

13) If the grantee is on an accrual accounting system, services must be provided on or before September 30, 2009; and liquidated on or before December 29, 2009;
14) Grantees shall adhere to a provision of law under the Consolidated Appropriations Act of 2005 which requires that to the extent FY 2008 CSBG funds are distributed by a State to an eligible entity, and have not been expended by such eligible entity, they shall remain with such eligible entity for carryover and expenditure into the next fiscal year. If FY 2008 funds are carried forward by such eligible entity into FY 2009, those funds must be fully expended and services provided on or before September 30, 2009.

10-31 The Department of Early Learning and the Department of Social and Health Services 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:	93.575 Child Care and Development Block Grant 93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund 93.713 Child Care and Development Block Grant, American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	G-1101 WACCDF
Applicable Compliance Component:	Activities Allowed or Unallowed
Questioned Cost Amount:	None

Background

The state Department of Early Learning (DEL) administers the federal Child Care and Development program to assist eligible working families in paying for child care. In fiscal year 2010, the Department paid approximately $261 million to child care centers and providers through the Working Connections Child Care Program.

The Department of Social and Health Services (DSHS) performs many functions related to the grant under an agreement with DEL, including processing payments to child care providers.

Our audits of fiscal years 2005-2009 reported the Departments did not adequately monitor direct payments made to child care providers. Payments are made through the Social Services Payment System (SSPS) maintained by DSHS. Monitoring is critical to ensure payments are allowable.

Description of Condition

In response to the 2009 audit finding, the Departments expanded its review of child care payments, selecting a sample to reconcile to provider attendance records to determine if payments were supported by documentation. In addition, the Departments trained providers on proper billing procedures. The Departments documented their own responsibilities in a Service Level Agreement.

Each month, DSHS randomly selects payment files for licensed child care centers and licensed family homes. DEL sends a written request to the providers for attendance records and provides them to DSHS to reconcile with the payment. If a provider fails to provide attendance records or a discrepancy is found, DSHS follows DEL policy and records it as an overpayment.

We found DSHS requested attendance records and reconciled them to child care payments. The Department performed reconciliations for 54 children during the months of July 2009 through April 2010; three from three centers from each of its six regions. When overpayments were identified for a child at one center, the Department did an expanded review to determine if that provider had additional unsupported payments. However, additional review is difficult as the provider is permitted to edit the attendance sheet and block out information on other possible overpayments. DSHS stopped performing reconciliations in May 2010, even though they were required by the service level agreement.

We reviewed documentation that showed the Department reviewed $365,305.60 in payments for child care for fiscal year 2010, less than .14 percent of the total payments. The Department found variances in 77 percent of the payments it reviewed, totaling $188,866.25. The variances were for such reasons as invalid parent signatures, no attendance records, incorrect number of children claimed, etc.

The number of attendance records reviewed by the Department was inadequate to address the risk of inappropriate claims. The inadequate monitoring of direct payments, specifically the lack of reconciliation between attendance records and payment requests submitted by providers, has not been resolved.

Cause of Condition

Although the Departments reached an agreement regarding their roles and responsibilities as they relate to child care payment reconciliations, they did not define what would constitute adequate reconciliation of direct payments, resulting in minimal efforts to identify and collect overpayments.

In addition, DSHS stopped performing reconciliations, stating that available staff was assigned to work on the Improper Payment Information Act audit. DSHS stated it does not have adequate staff to do both.

DEL stated the monthly reconciliations are a separate requirement that DSHS should be performing according to the service level agreement. The Improper Payment Act is related to a federal audit of child care payments that is performed every three years.

Effect of Condition

The lack of controls results in a high risk that providers will be overpaid and those overpayments will not be identified or recovered. The Departments are aware of overpayments and that providers are claiming more than authorized amounts.

While we recognize the improvements both Departments have made over the monitoring of child care payments, noted above under the description, the inadequacy of the system for reconciling payments to source documentation is a significant weakness that leaves the program vulnerable to abuse.

Recommendation

We recommend the Departments establish and follow detailed monitoring procedures for provider payments to include adequate reconciliation of provider attendance records to payments made to ensure expenditures are allowable. When exceptions are found, the Departments should expand their review to determine if additional costs could be recovered.

Departments' Response

The Departments does not concur with this finding. In July 2008, the Department of Early Learning and the Department of Social and Health Services implemented a process to reconcile child care payment to attendance records to determine if the payments were supported by appropriate documentation.

On a monthly basis, payment files are randomly selected from child care center and family child care homes by DSHS. The attendance records are requested from the providers and received by DSHS to monitor for correct payments. Overpayments and underpayments are written by DSHS if found during the monitoring.

This reconciliation occurred through the State Fiscal Year 2010 audit period. Because of the lag between service month and payment period, the last month of service was May which would have corresponding payments records in June or later.

When DSHS audits attendance records, if they find issues with a provider, they expand their review to determine if there are more overpayments or underpayments.

During State Fiscal Year 2010 approximately 64,000 children receive subsidized child care through WCCC from approximately 11,300 licensed providers. The Department of Social and Health Services audit reviewed:

- *483 providers*
- *786 cases*
- *$365,305 payments (including expanded audits)*

DSHS also conducted expanded reviews on 11 providers that provided care for 32 children, with corresponding payments of $36,890.

The audit work completed represented 1.2% of all children who received subsidized care and 4.3% of all licensed providers who billed for care.

Auditor's Concluding Remarks

We thank the Department for its response. This response was the first indication that the Department did not agree with our finding. Neither the Chief Financial Officer nor the Child Care Administrator disputed the findings when we discussed it with them previously.

Providers are to submit subsidized care claims to the Department monthly. Auditing one monthly claim for one child is not sufficient for the Department to assert it audited all payments on behalf of that child. Similarly, auditing one monthly claim at one provider is not sufficient for the Department to make a conclusion about the accuracy of all claims submitted by that provider. Using the Department's numbers, 11,300 providers would have submitted approximately 135,000 monthly claims. Auditing 483 provider claims equates to approximately 0.35 percent of these claims. Monthly attendance for 64,000 children equates to approximately 768,000 months of child care. Auditing 786 monthly child care subsidies equates to approximately 0.1 percent. The percentage of audit coverage we identify in our finding relates to dollars – not children or providers. The Department paid out over $261 million for subsidized child care, and audited only 0.14 percent of those dollars.

Additionally, staff at DSHS responsible for conducting the audits were the ones who informed us that no reconciliations occurred for any period after May of 2010 due to staffing restrictions. We informed the Department's Chief Financial Officer when we learned of this.

We affirm our finding.

Applicable Laws and Regulations

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

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

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments.*

> Attachment A, Section C, <u>Basic Guidelines</u>, states in part:
>
> 1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria: …
>
> j. Be adequately documented.

Washington Administrative Code 170-295-7030 states in part:

(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 in part:

(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.

Service Level Agreement (Interagency Agreement No. 0661-00799)

Attendance reconciliation:
"In addition to this work, additional reviews will be performed to reconcile provider payments. This work will involve QA pulling a random sample of Working Connections Child Care cases to compare child care authorizations to attendance records and the payments issued. ESA staff correct errors when identified and establish an overpayment when warranted. DEL will provide policy interpretation to DSHS if issues arise."

10-32 The Department of Social and Health Services, Children's Administration, is not ensuring the eligibility of clients receiving adoption assistance payments.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.659 Adoption Assistance 93.659 Adoption Assistance - American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	N/A
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	$61,918 (Actual); $537,457 (Projected)

Background

The federal Adoption Assistance program provides money to states for parents who adopt children with special needs. The Children's Administration of the Department of Social and Health Services administers the state program from six regional offices with staffing from an adoption support program specialist. The Department paid approximately $97.5 million in adoption assistance in fiscal year 2010 for support of almost 12,000 children.

In our audits of fiscal years 2008 and 2009, we reported the Department was not following control processes designed to ensure the eligibility of clients receiving adoption assistance payments. In response, the Department stated it would train all adoption support staff on how to determine eligibility.

Description of Condition

To follow up on the concerns noted in prior audits, we randomly selected 40 payments made during fiscal year 2010 from one regional office for the support of children over 18 years of age. To be eligible, adopted children over 18 must be in school. Our prior audit found exceptions in these cases, particularly when associated with one region. We identified the adoptee related to each payment selected and reviewed the case files to determine if they contained evidence that eligibility requirements were met and that payments were properly supported. Eight of forty did not include support showing the adopted children were still in school and entitled to receive adoption support assistance. Payments associated with these selections totaled $12,835.

In addition, we randomly selected 40 payments from all adoption support payments made during the fiscal year for review. We again reviewed case files to determine if they contained evidence to support the adoptees' eligibility. For these 40 payments, case files showed eligibility requirements were met and all payments were properly supported.

State law prohibits support payments for any adoptee once they reach age 21. We reviewed all adoption payments for fiscal year 2010 to determine if any were made for adoptees over the age of 21. We identified 18 adoptees over 21 who received a total of 71 payments during the year, totaling $49,083.

Cause of Condition

The Department stated the region with the high error rate experienced significant employee turnover in July of 2006. The Department since has instituted quarterly spot checks of adoption payments by regional managers, however the frequency of monitoring payments and updating case files has not improved.

Regarding payments to recipients over the age of 21, the Department does not have an automated process to ensure that no payments to recipients over the age of 21 occur, and relies on manual identification of adoptees aging out of the program.

Effect of Condition and Questioned Costs

We identified $537,457 in assistance payments that were unsupported or unallowable, and question that amount. In our review of children over the age of 18 served out of one particular region, we used a sampling method that allows us to project our results to the entire population of children over 18 served out of that region. Projected questioned costs are $488,374. Unallowable payments made for adoptees over age 21 totaled $49,083.

Recommendation

We recommend the Department:

- Follow established internal controls for monitoring case files to ensure eligibility is met and payments are fully supported, for recipients between the ages of 18 and 21.
- Communicate with the federal grantor to determine whether questioned costs need to be repaid.

Department's Response

The Department concurs with this finding.

Control procedures are in place to avoid payments for adopted children over ages 18 and 21, but are based on manual processes that generate reports. These reports must be reviewed to identify cases to be addressed. This process works very well in most regions across the state. The Department will evaluate why the process has not worked in the region where exceptions were found.

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

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

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

Revised Code of Washington (RCW) 74.13.031 Duties of department — Child welfare services — Children's services advisory committee (as amended by 2009 c 235). (Effective until October 1, 2010.)

> The department shall have the duty to provide child welfare services and shall:
>
> (11) Within amounts appropriated for this specific purpose, have authority to provide continued foster care or group care and necessary support and transition services to youth ages eighteen to twenty-one years who are enrolled and participating in a posthigh school academic or vocational program. A youth who remains eligible for such placement and services pursuant to department rules may continue in foster care or group care until the youth reaches his or her twenty-first birthday.

Washington Administrative Code (WAC) 388-27-0135 What are the eligibility criteria for the adoption support program?

For a child to be eligible for participation in the adoption support program, the department must first determine that adoption is the most appropriate plan for the child. If the department determines that adoption is in the child's best interest, the child must:

(1) Be less than eighteen years old when the department and the adoptive parents sign the adoption support agreement;
(2) Be legally free for adoption;
(3) Have a "special needs" factor or condition according to the definition in this rule (see WAC 388-27-0140); and
(4) Meet at least one of the following criteria:
    (a) Is in state-funded foster care or child caring institution or was determined by the department to be eligible for and likely to be so placed (For a child to be considered "eligible for and likely to be placed in foster care" the department must have opened a case and determined that removal from the home was in the child's best interest.); or
    (b) Is eligible for federally funded adoption assistance as defined in Title IV-E of the Social Security Act, the Code of Federal Regulations, the U.S. Department of Health and Human Services establishing guidelines for states to use in determining a child's eligibility for Title IV-E adoption assistance.

Washington Administrative Code (WAC) 388-27-0210 Under what circumstances would the adoption support agreement be terminated?

The adoption support agreement is terminated according to the terms of the agreement or if any one of the following events occurs:

(1) The child reaches eighteen years of age; (if a child is at least eighteen but less than twenty-one years old and is a full-time high school student or working full time toward the completion of a GED (high school equivalency) certificate and continues to receive financial support from the adoptive parent(s), the department may extend the terms of the adoption support agreement until the child completes high school or achieves a GED. Under no circumstances may the department extend the agreement beyond the child's twenty first birthday.) Adoption support benefits will automatically stop on the child's eighteenth birthday unless the parent(s) requests continuation per this rule and have provided documentation of the child's continuation in school. To prevent disruption in services the parent should contact the adoption support program at least ninety days prior to the child's eighteenth birthday if continued services are to be requested.
(2) The adoptive parents no longer have legal responsibility for the child;
(3) The adoptive parents are no longer providing financial support for the child;
(4) The child dies; or
(5) The adoptive parents die. (A child who met federal Title IV-E eligibility criteria for adoption assistance will be eligible for adoption assistance in a subsequent adoption.)

Children’s Administration Operations Manual

13100. RECORDS MANAGEMENT AND SECURITY

State law requires that CA maintain records for services to children and their families as well as for licensed or approved providers and for persons who apply and are subsequently denied licensure or approval for service. RCW 13.34.130; RCW 13.50.010; RCW 26.33.330; RCW 26.44.030

CA will maintain these records in two formats:

- Automated format in the State of Washington's State Automated Child Welfare Information System (SACWIS) called FamLink.
- Paper records linked to cases in the FamLink system.

The following table identifies tasks and procedures to be completed in FamLink and staff responsible for their completion. The table will be updated as needed to reflect changes in FamLink.

Title IV-E Desk Guide: Documentation

Eligibility: Age
To be eligible for title IV-E, a child must be under age 18, or if 18 years old, must be in high school, GED or equivalent program full-time and is expected to complete the program before age 19, or the youth is ineligible for the entire placement episode.
Documentation: File Construction
At a minimum, assemble completed hard copy documentation as follows, affixed to the right hand side of the financial revenue file from top to bottom:

- Colored sheet of paper separating each eligibility review/eligibility determination
- Title IV-E Summary Report (or DSHS 14-293, -297, and -298)
- Voluntary placement agreement or flagged court order that contains the initial required contrary to welfare and reasonable efforts language highlighted
- Flagged court order that contains the required reasonable efforts to finalize the permanency plan in effect language highlighted
- Computer printouts used to support eligibility decision (ACES, SEMS, etc.) annotated as needed so the reader can understand the meaning of each printout
- Other documentation used to support the eligibility/reimbursability decision annotated as needed so the reader can understand the meaning of each document
- DSHS Family Face Sheet and DSHS 14-281 if still in use in your region

At a minimum, assemble completed hard copy documentation as follows, affixed to the left side of the financial revenue file from top to bottom:

- DSHS 14-319 IV-E Eligibility Determination for an Adoption Support Application (if applicable)
- 14-319A IV-E Eligibility Determination for R-GAP, Relative Guardianship Assistance Program (if applicable)
- Legal history and placement history printouts
- Case Notes pertaining to the federal funding determination(s)
- Licensing information for each licensed placement
- DSHS 14-434 Title IV-E Requirements for Out of State Foster Care

10-33 The Department of Social and Health Services spent approximately $2.7 million of federal Children Health Insurance Program (CHIP) money on unallowable administrative activities.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.767 Children's Health Insurance Program
Federal Award Number:	
Applicable Compliance Component:	Activities Allowed/Allowable Costs
Questioned Cost Amount:	$2,708,627.53

Background

The state and federal government pay for the Children's Health Insurance Program (CHIP), which provides medical assistance for children through age 18 who reside in households with incomes between 200 percent and 300 percent of the federal poverty level. The CHIP spent more than $43 million during state fiscal year 2010; approximately $34 million was paid with federal funds.

The Department contracts with local health jurisdictions and community-based organizations to provide outreach and application activities. The contractors identify families who have children likely to be eligible for the program and assist them in enrolling. Contractors receive $150 for each child approved for coverage.

The federal grantor will only reimburse costs related to activities that are specified in a state plan for CHIP that it has approved. Changes to the plan must be approved by the grantor before they take effect.

Description of Condition

The Department paid its contractors for outreach administrative costs, such as salaries and benefits, that were not allowable because the activities were not in the approved state plan.

Cause of Condition

Staff responsible for managing outreach was not aware the plan needed to be amended. Outreach program staff authorized changes to allowable outreach activities, but did not notify the staff responsible for plan amendments. As a result, the Department did not submit an amendment request to the grantor that would have made these costs allowable if approved before the end of the fiscal year.

Effect of Condition and Questioned Costs

The Department paid for unallowable activities with CHIP funds. We are questioning the unallowable payments totaling $2,708,627.53

Recommendation

We recommend the Department ensure changes in the operation of the program are communicated between appropriate parties. Additionally, we recommend the Department provide oversight to ensure all federal funds are spent for allowable activities covered in the State Plan.

We recommend the Department consult with its grantor, the U.S. Department of Health and Human Services to determine what questioned costs should be repaid.

Department's Response

The Department (MPA) concurs with this finding.

The Department (MPA) has developed internal financial procedures and monthly fiscal reports to monitor the Children's Health Insurance Program (CHIP) expenditures to ensure the Department (MPA) does not exceed the administrative cap.

The Department (MPA) has implemented a process for the full recovery of the CHIP funds from the Local Health Jurisdictions (LHJ) and will coordinate with the Center for Medicaid and Medicare Services (CMS) to repay the federal portion.

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

U.S. Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments* (2 CFR Part 225), states:

> Appendix A
> C. Basic Guidelines
> 1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:…
> d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items….

Title 42, Code of Federal Regulations, Section 457.50 State Plan, states:

> The State plan is a comprehensive written statement, submitted by the State to CMS for approval, that describes the purpose, nature, and scope of the State's SCHIP and gives an assurance that the program is administered in conformity with the specific requirements of title XXI, title XIX (as appropriate), and the regulations in this chapter. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

Title 42, Code of Federal Regulations, Section 457.60 Amendments, states:

> A State may seek to amend its approved State plan in whole or in part at any time through the submission of an amendment to CMS. When the State plan amendment has a significant impact on the approved budget, the amendment must include an amended budget that describes the State's planned expenditures for a 1-year period. A State must amend its State plan whenever necessary to reflect—
> (a) Changes in Federal law, regulations, policy interpretations, or court decisions that affect provisions in the approved State plan;
> (b) Changes in State law, organization, policy, or operation of the program that affect the following program elements described in the State plan:
> (1) Eligibility standards, enrollment caps, and disenrollment policies as described in §457.305.
> (2) Procedures to prevent substitution of private coverage as described in §457.805, and in §457.810 for premium assistance programs.
> (3) The type of health benefits coverage offered, consistent with the options described in §457.410.

(4) Addition or deletion of specific categories of benefits covered under the State plan.
(5) Basic delivery system approach as described in §457.490.
(6) Cost-sharing as described in §457.505.
(7) Screen and enroll procedures, and other Medicaid coordination procedures as described in §457.350.
(8) Review procedures as described in §457.1120.
(9) Other comparable required program elements.

(c) Changes in the source of the State share of funding, except for changes in the type of non-health care related revenues used to generate general revenue.

Title 42, Code of Federal Regulations, Section 457.65 Effective date and duration of State plans and plan amendments, states in part:

(3) A State plan amendment that takes effect prior to submission of the amendment to CMS may remain in effect only until the end of the State fiscal year in which the State makes it effective, or, if later, the end of the 90-day period following the date on which the State makes it effective, unless the State submits the amendment to CMS for approval before the end of that State fiscal year or that 90-day period.

Children's Health Insurance Program State Plan, Section 5. Outreach (Section 2102(c))

8. Increase in contract payments beginning in October 1st, 2008 from $75/per approved child to $150/per approved child. This increase is based on a pilot of a performance based "Application Agent" model where payment is made based on specific application assistance. Applications are barcode labeled to identify and track the agent involved. The contractor will also be responsible for providing a health literacy component to their outreach efforts. <u>The state will only seek federal match for $75/per approved child under this model.</u>

10-34 The Department of Social and Health Services does not have adequate procedures to ensure compliance with earmarking requirements for the Children's Health Insurance Program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.767 Children's Health Insurance Program
Federal Award Number:	
Applicable Compliance Component:	Earmarking
Questioned Cost Amount:	$98,754

Background

The state and federal government pay for the Children's Health Insurance Program (CHIP), which provides medical assistance for children through age 18 who reside in households with incomes between 200 percent and 300 percent of the federal poverty level. The CHIP spent more than $43 million during state fiscal year 2010; approximately $34 million was paid with federal funds.

Federal regulations limit expenditures not directly related to providing CHIP assistance services, such as administration, children's health quality improvement activities and outreach activities. The limit is determined by a formula described in the regulation.

Description of Condition

During our audit, we found the Department was not monitoring CHIP expenditures to ensure the program's non-benefit costs were within the limit. Rather than monitor actual non-benefit expenditures throughout the fiscal year, the Department relied on an annual budget report.

Cause of Condition

The Department stated since it had not historically reached the limit, it relied on the budget as evidence of compliance.

Effect of Condition and Questioned Costs

We reviewed the CHIP expenditure report for the federal fiscal year 2010 to identify all expenditures and non-benefit costs which were subject to the limit. Based on the formula specified in the federal regulation, the maximum allowable non-benefit costs were $5,400,559 for the fiscal year 2010. However, the Department charged the grant $5,499,312 in non-benefit costs, exceeding the limit by $98,754. We are questioning that amount.

Recommendation

We recommend the Department regularly monitor actual CHIP expenditures throughout the fiscal year to ensure they do not exceed the limit.

The Department should consult with its grantor to determine whether the federal portion in excess of the limit should be repaid.

Department's Response

The Department (MPA) concurs with this finding.

The Department (MPA) has developed internal financial procedures and monthly fiscal reports to monitor the Children's Health Insurance Program (CHIP) expenditures to ensure the Department (MPA) does not exceed the administrative cap.

The Department (MPA) has implemented a process for the full recovery of the CHIP funds from the Local Health Jurisdictions (LHJ) and will coordinate with the Center for Medicaid and Medicare Services (CMS) to repay the federal portion.

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, United States Code, Part 1397ee states, in parts:

(a) Payments
  (1) In general
    Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this subchapter, from its allotment under section 1397dd of this title, an amount for each quarter equal to the enhanced FMAP (or, in the case of expenditures described in subparagraph (D)(iv), the higher of 75 percent or the sum of the enhanced FMAP plus 5 percentage points) of expenditures in the quarter—
    (A) for child health assistance under the plan for targeted low-income children in the form of providing medical assistance for which payment is made on the basis of an enhanced FMAP under the fourth sentence of section 1396d (b) of this title;
    (B) [reserved]
    (C) for child health assistance under the plan for targeted low-income children in the form of providing health benefits coverage that meets the requirements of section 1397cc of this title; and
    (D) only to the extent permitted consistent with subsection (c) of this section—
      (i) for payment for other child health assistance for targeted low-income children;
      (ii) for expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children);
      (iii) for expenditures for outreach activities as provided in section 1397bb (c)(1) of this title under the plan;
      (iv) for translation or interpretation services in connection with the enrollment of, retention of, and use of services under this subchapter by, individuals for whom English is not their primary language (as found necessary by the Secretary for the proper and efficient administration of the State plan); and
      (v) for other reasonable costs incurred by the State to administer the plan.

(c) Limitation on certain payments for certain expenditures
  (2) Limitation on expenditures not used for medicaid or health insurance assistance
    (A) In general
      Except as provided in this paragraph, the amount of payment that may be made under subsection (a) of this section for a fiscal year for expenditures for items described in paragraph (1)(D) of such subsection shall not exceed 10 percent of the

total amount of expenditures for which payment is made under subparagraphs (A), (C), and (D) of paragraph (1) of such subsection.

Title 42, Code of Federal Regulations, Part457 - ALLOTMENTS AND GRANTS TO STATES Subpart f - PAYMENTS TO STATES

457.618 - Ten percent limit on certain State Children's Health Insurance Program expenditures.

(a) Expenditures.

(1) Primary expenditures are expenditures under a State plan for child health assistance to targeted low-income children in the form of a standard benefit package, and Medicaid expenditures claimed during the fiscal year to the extent Federal payments made for these expenditures on the basis of the enhanced FMAP described in sections 1905(b) and 2105(b) of the Act that are used to calculate the 10 percent limit.

(2) Non-primary expenditures are other expenditures under a State plan. Subject to the 10 percent limit described in paragraph (c) of this section, a State may receive Federal funds at the enhanced FMAP for 4 categories of non-primary expenditures: (i) Administrative expenditures; (ii) Outreach; (iii) Health initiatives; and (iv) Certain other child health assistance.

(b) Federal payment. Federal payment will not be available based on a State's non-primary expenditures for a fiscal year which exceed the 10 percent limit of the total of expenditures under the plan, as specified in paragraph (c) of this section.

(c) 10 Percent Limit. The 10 percent limit is (1) Applied on an annual fiscal year basis; (2) Calculated based on the total computable expenditures claimed by the State on quarterly expenditure reports submitted for a fiscal year.Expenditures claimed on a quarterly report for a different fiscal year may not be used in the calculation; and (3) Calculated using the following formula: L10% = (a1+ u2+ u3)/9; L10% = 10 Percent Limit for a fiscal year a1 = Total computable amount of expenditures for the fiscal year under section 2105(a)(1) of the Act for which Federal payments are available at the enhanced FMAP described in Section 2105(b) of the Act; u2 = Total computable expenditures for medical assistance for which Federal payments are made during the fiscal year based on the enhanced FMAP described in sections 1905(b) and 2105(b) of the Act for individuals described in section 1905(u)(2) of the Act; and u3 = Total computable expenditures for medical assistance for which Federal payments are made during the fiscal year based on the enhanced FMAP described in sections 1905(b) and 2105(b) of the Act for individuals described in section 1905(u)(3) of the Act.

(d) The expenditures under section 2105(a)(2) of the Act that are subject to the 10 percent limit are applied (1) On an annual fiscal year basis; and (2) Against the 10 percent limit in the fiscal year for which the State submitted a quarterly expenditure report including the expenditures. Expenditures claimed on a quarterly report for one fiscal year may not be applied against the 10 percent limit for any other fiscal year.

(e)(1) The 10 percent limit for a fiscal year, as calculated under paragraph (c)(3) of this section, may be no greater than 10 percent of the total computable amount (determined under paragraph (e)(2) of this section) of the State allotment or allotments available in that fiscal year. Therefore, the 10 percent limit is the lower of the amount calculated under paragraph (c)(3) of this section, and 10 percent of the total computable amount of the State allotment available in that fiscal year.

(2) As used in paragraph (e)(1) of this section, the total computable amount of a State's allotment for a fiscal year is determined by dividing the State's allotment for the fiscal year by the State's enhanced FMAP for the year. For example, if a State allotment for a fiscal year is $65 million and the enhanced FMAP rate for the fiscal year is 65 percent, the total computable amount of the allotment for the fiscal year is $100 million ($65 million/.65). In this example, the 10 percent limit may be no greater than a total computable amount of $10 million (10 percent of $100 million).

U.S. Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Nonprofit Organizations*, section 300 -- Auditee responsibilities.

> 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.

10-35 The Department of Social and Health Services did not have adequate internal controls to accurately identify and claim all eligible Children's Health Insurance Program expenditures.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.767 Children's Health Insurance Program
Federal Award Number:	
Applicable Compliance Component:	Activities Allowed/Cost Principles & Reporting
Questioned Cost Amount:	None

Background

The state and federal government pay for the Children's Health Insurance Program (CHIP), which provides medical assistance for children through age 18 who reside in certain low-income households. Eligibility for the program is based on net income. The state used approximately $34 million in federal money to pay for its $43 million CHIP program during state fiscal year 2010. The rest was state money.

States are required to pay CHIP expenditures and may seek reimbursement from the federal government for eligible costs. States typically are reimbursed for approximately 65 percent of their CHIP expenditures.

Certain Medicaid expenditures also may be eligible for CHIP funding. As they do under CHIP, states pay Medicaid costs and then seek reimbursement from the federal government. Prior to 2009, the reimbursement rate for these expenditures was approximately 50 percent. The American Recovery and Reinvestment Act of 2009 increased this rate to approximately 62 percent.

When states identify eligible Medicaid expenditures, they may claim the higher CHIP reimbursement rate. If the Medicaid costs already have been claimed and reimbursed, the state still can claim the difference between the Medicaid and CHIP rates.

The grantor awards states an annual CHIP allotment. States must return any unused amounts. The average CHIP allotment for the state for the last three years was approximately $91 million; the state spent and was reimbursed approximately $40 million each year, returning the excess $51 million. During fiscal year 2010, approximately $8 million of the CHIP money received were through the identification of qualifying Medicaid expenditures.

Description of Condition

When the Department identified Medicaid expenditures it could transfer to the CHIP program and claim the higher reimbursement rate, it incorrectly used gross income rather than net income to determine eligibility. Federal regulations say the same income criteria used to determine eligibility for Medicaid clients should be used to identify Medicaid expenditures that are eligible for the additional CHIP funds. The Department uses net income to determine eligibility for Medicaid.

We also noted the Department did not account for all Medicaid expenditures that might qualify for additional CHIP funds. When the Department calculated Medicaid expenditures that are eligible for additional CHIP funds, it accounted only for expenditures processed through its Medicaid payment system. Claims also are processed through the Department's Social Service Payment System (SSPS) and manual invoices.

Cause of Condition

The Department had been using gross income to determine eligible Medicaid expenditures for CHIP for several years and assumed it was proper to do so.

Prior to 2009, states could use only up to 20 percent of their CHIP allotment for additional reimbursements for eligible Medicaid expenditures. The Department had been able to identify enough eligible Medicaid expenditures in the Medicaid payment system to claim that 20 percent. In 2009, a change in federal regulation eliminated the 20 percent limit on these types of costs. The Department continued to look only to its Medicaid payment system to identify costs eligible for transfer to CHIP, even though it did not have enough expenditures in that system to claim the entire amount of CHIP money available.

The Department did not effectively communicate CHIP information among administrations. The Aging and Disability Services Administration, which administers programs for children with developmental disabilities, was not aware that the Medicaid claims processed through the SSPS could be eligible for additional CHIP funds, nor did the Department assess claims processed through manual invoices for eligible costs.

Effect of Condition

Because the Department did not identify all eligible Medicaid costs, it did not claim all available CHIP funds available to the state. The Department does not have an automated process that identifies CHIP eligible Medicaid expenditures in its SSPS or invoice systems.

It is currently in the process of identifying Medicaid clients and expenditures that qualify for additional CHIP funds and determining the amount of additional CHIP funds it can claim. It has two years from payment date to submit these claims for the additional reimbursement.

Additionally, because the Department used incorrect criteria to determine income eligibility for Medicaid costs it transferred to CHIP, it cannot ensure those costs were eligible for transfer and the higher reimbursement rate.

Recommendation

We recommend the Department:

- Identify all prior Medicaid costs eligible for CHIP and claim them before the opportunity is lost.
- Use the correct income criteria in determining Medicaid expenditures eligible for CHIP money. Review CHIP funds claimed and work with the U.S. Department of Health and Human Services to determine if it must refund any costs charged to CHIP because it used incorrect criteria.
- Ensure it has a system to identify all Medicaid costs eligible for CHIP reimbursement.
- Evaluate regulation changes that affect its ability to claim CHIP funds.
- Communicate information on CHIP money availability among its administrations.

Department's Response

The Medicaid Purchasing Administration (MPA) and Aging and Disability Services Administration (ADSA) both concur with this finding.

MPA and ADSA will work together to establish a workgroup to communicate the availability of CHIP funding, regulation changes, and develop a system to identify CHIP eligible costs.

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

U.S. Office of Management and Budget Circular 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.

Sec. 2105. [42 U.S.C. 1397ee] (g) Authority for qualifying States to use certain funds for medicaid expenditures, states:

> (1) State option.—
>
> (A) In general.—Notwithstanding any other provision of law subject to paragraph (4)[67], a qualifying State (as defined in paragraph (2)) may elect to use not more than 20 percent of any allotment under section 2104 for fiscal year 1998, 1999, 2000, 2001, or 2004, 2005, 2006, 2007, or 2008[68] (insofar as it is available under subsections (e) and (g) of such section) for payments under title XIX in accordance with subparagraph (B), instead of for expenditures under this title.
>
> (B) Payments to states.—
>
> (i) In general.—In the case of a qualifying State that has elected the option described in subparagraph (A), subject to the availability of funds under such subparagraph with respect to the State, the Secretary shall pay the State an amount each quarter equal to the additional amount that would have been paid to the State under title XIX with respect to expenditures described in clause (ii) if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)).
>
> (ii) Expenditures described.—For purposes of this subparagraph, the expenditures described in this clause are expenditures, made after the date of the enactment of this subsection and during the period in which funds are available to the qualifying State for use under subparagraph (A), for medical assistance under title XIX to individuals who have not attained age 19 and whose family income exceeds 150 percent of the poverty line.
>
> (iii) No impact on determination of budget neutrality for waivers.—In the case of a qualifying State that uses amounts paid under this subsection for expenditures described in clause (ii) that are incurred under a waiver approved for the State, any budget neutrality determinations with respect to such waiver shall be determined without regard to such amounts paid. …
>
> (2) Qualifying state.—In this subsection, the term "qualifying State" means a State that, on and after April 15, 1997, has an income eligibility standard that is at least 184 percent of the poverty line with respect to any 1 or more categories of children (other than infants) who are eligible for medical assistance under section 1902(a)(10)(A) or, in the case of a State that has a statewide waiver in effect under section 1115 with respect to title XIX that was first implemented on August 1, 1994, or July 1, 1995, has an income eligibility standard under such waiver for children that is at least 185 percent of the poverty line, or, in the case of a State that has a statewide waiver in effect under section 1115 with respect to title XIX that was first implemented on January 1, 1994, has an income eligibility standard under such waiver for children who lack health insurance that is at least 185 percent of the poverty line, or, in the case of a State that had a statewide waiver in effect under section 1115 with respect to title XIX that was first implemented on October 1, 1993, had an income eligibility standard under such waiver for children that was at least 185 percent of the poverty line and on and after July 1, 1998, has an income eligibility standard for children under section 1902(a)(10)(A) or a statewide waiver in effect under section 1115 with respect to title XIX that is at least 185 percent of the poverty line.

(3) Construction.—Nothing in paragraphs (1) and (2) shall be construed as modifying the requirements applicable to States implementing State child health plans under this title.

(4) [69] Option for allotments for fiscal years 2009 through 2013.—

(A) Payment of enhanced portion of matching rate for certain expenditures.—In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State's allotment made under section 2104 for any of fiscal years 2009 through 2013 (insofar as the allotment is available to the State under subsections (e) and (m) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under title XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)).

(B) Expenditures described.—For purposes of subparagraph (A), the expenditures described in this subparagraph are expenditures made after the date of the enactment of this paragraph and during the period in which funds are available to the qualifying State for use under subparagraph (A), for the provision of medical assistance to individuals residing in the State who are eligible for medical assistance under the State plan under title XIX or under a waiver of such plan and who have not attained age 19 (or, if a State has so elected under the State plan under title XIX, age 20 or 21), and whose family income equals or exceeds 133 percent of the poverty line but does not exceed the Medicaid applicable income level.

10-36 The Department of Social and Health Services, Aging and Disability Services Administration, Home and Community Based Services Division, does not have adequate controls to ensure Medicaid recipients have received the services for which Medicaid is billed.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Utilization Control and Program Integrity
Questioned Cost Amount:	None

Background

Federal regulations require state Medicaid agencies to have a process to verify with Medicaid clients that they received the services billed to Medicaid by providers. This process is intended to identify potential fraud or abuse of the Medicaid program.

The Medicaid program is the major source of public funding for long-term care services. The Home and Community Based Services waiver program permits states to furnish long-term care services to Medicaid beneficiaries in home and community settings, avoiding institutionalization. The client or agencies working on behalf of the client choose these service providers.

The Department of Social and Health Services, Aging and Disability Services Administration (ADSA), administers long-term services and support and is responsible for instituting and following the recipient verification process.

In our audit of state fiscal years 2008 and 2009, we reported findings regarding the Department's lack of adequate controls to ensure Medicaid payments to in-home service providers are allowable and supported.

ADSA paid approximately $580 million for in-home services during fiscal year 2010.

Description of Condition

During our current audit, we found no changes in the conditions we reported in our previous two audits. The Administration does not have procedures to verify with home- and community-based service Medicaid clients whether services billed by providers were received.

Cause of Condition

The Department states it plans to use a feature available in the new Medicaid payment system, ProviderOne, that will automatically send selected clients an explanation of services billed by providers in order to verify those services were received. This system is scheduled for implementation in 2012. The Department does not believe putting an interim automated solution in place is prudent or cost-effective.

Effect of Condition

The lack of appropriate, required verification increases the risk of fraudulent provider claims being paid and not being detected in a timely manner, if at all.

Recommendation

We recommend the Department develop and follow a process for verifying directly with recipients that they have received the services for which Medicaid is being billed.

Department's Response

The Department concurs with this finding. We agree we do not have a process that provides Medicaid clients with information on the number of hours billed to the Department by individual providers (IP).

The Department has plans to implement the Provider Compensation System (PCS) by the end of 2012 which will allow for an automated review process. PCS will be a sub-system of Provider One and is designed to generate intermittent, random notices to clients informing them how many hours were paid to the provider on their behalf during the previous month. The clients will be instructed to notify the Department if they notice a discrepancy in the hours provided versus the hours billed.

Until PCS is implemented the Department will rely on the following controls that are currently in place:

- *Case managers complete an assessment that results in an authorization of hours that cannot be exceeded by a provider invoice.*
- *Clients receive a copy of the service summary that tells them the number of hours of service they are eligible to receive. Clients are advised they can choose when those hours are provided and direct the individual provider when to provide them. Case Managers also advise clients to contact them if they are not receiving the hours (or care) for which they are eligible.*
- *Clients are expected to keep copies of timesheets for their individual providers. Case managers periodically review these time sheets and verify with the client that authorized services have been provided. Case managers are instructed to document the review of time sheets and the discussion of service verification in a Service Episode Record.*
    - *In the 12 month period ending October 2010, staff reviewed a revised "Acknowledgement of My Responsibilities as the Employer of My Individual Providers" with all clients who employ an individual provider. This form must be distributed and reviewed with new clients who select an IP and with current clients who switch to an IP from a homecare agency or residential setting.*
    - *In April 2010, all Individual Providers delivering personal care services received a written reminder of their obligation to keep a record of the date/time that in-home services are provided to ADSA clients and complete and retain copies of their timesheets.*
    - *In August of 2010 ADSA began auditing a randomly selected sample of Individual Provider timesheets to ensure that services billed for are consistent with timesheet documentation submitted.*
- *The Department, through its Payment Review Program, runs algorithms to detect possible fraudulent claims. Overpayments are initiated and referrals are made to the Medicaid Fraud Control Unit as indicated by findings.*
- *The Social Service Payment System will not process payments in excess of hours authorized. A provider is therefore unable to claim and be reimbursed for hours that exceed those authorized by the case manager.*

Auditor's Concluding Remarks

We thank the Department for its response and assistance throughout the audit, and will review this area 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 455 states in part:

> § 455.1 Basis and scope.
>
> This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control.
>
> (a) Under the authority of sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act, Subpart A provides State plan requirements for the identification, investigation, and referral of suspected fraud and abuse cases. In addition, the subpart requires that the State—
>
> (1) Report fraud and abuse information to the Department; and
>
> (2) Have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients.
>
> (b) Subpart B implements sections 1124, 1126, 1902(a)(36), 1903(i)(2), and 1903(n) of the Act. It requires that providers and fiscal agents must agree to disclose ownership and control information to the Medicaid State agency.
>
> (c) Subpart C implements section 1936 of the Act. It establishes the Medicaid Integrity Program under which the Secretary will promote the integrity of the program by entering into contracts with eligible entities to carry out the activities of subpart C.
>
> [51 FR 34787, Sept. 30, 1986, as amended at 72 FR 67655, Nov. 30, 2007]
>
> § 455.20 Recipient verification procedure.
>
> (a) The agency must have a method for verifying with recipients whether services billed by providers were received.
>
> (b) In States receiving Federal matching funds for a mechanized claims processing and information retrieval system under part 433, subpart C, of this subchapter, the agency must provide prompt written notice as required by §433.116 (e) and (f).

10-37 The Department of Social and Health Services does not have an adequate process to identify ineligible Medicaid expenditures for nonqualified aliens at the time of payment, resulting in $187,557 in questionable costs.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) - American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Activities Allowed or Unallowed
Questioned Cost Amount:	$ 149,965.40 Non ARRA $ 37,591.93 ARRA

Background

State and federal dollars pay for the Medicaid program, which provides coverage for low-income individuals who otherwise might go without medical care. The state's Medicaid program spent more than $6.9 billion during fiscal year 2010.

Under federal law, all U.S. citizens and certain legal immigrants who meet Medicaid's financial and non-financial eligibility criteria may receive Medicaid. Nonqualified aliens are not eligible to receive general Medicaid benefits, but may be eligible for care and services necessary in an emergency medical situation not related to an organ transplant.

Federal law requires the state to have an Alien Emergency Medical program for these emergency situations for nonqualified aliens who meet all Medicaid program requirements with the exception of immigration status. This program covers low-income families, children and adults who are aged, blind or disabled.
The program defines emergency medical conditions as the sudden onset of a medical condition (including labor and delivery) whose symptoms are acute and severe (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

With the passage of the American Recovery and Reinvestment Act (ARRA), the amount the federal government will pay for most Medicaid expenditures increased from approximately 50 percent to more than 60 percent of costs. The state can elect to pay for non-emergency services for nonqualified aliens. The federal government will not share the cost of those services.

Description of Condition

In our current audit, we identified services provided to 130 nonqualified aliens totaling $570,359.92. To determine whether the services were allowable, we reviewed detailed transactions associated with those services. We found services provided to 34 of those clients totaling $272,366.06 were allowable because they were related to a medical emergency or transferred to state only funds.

We also determined medical services provided to 96 clients were not allowable because they did not relate directly to a medical emergency. The table below summarizes unallowable services we found in our review of Medicaid expenditures for July 1, 2009 through May 30, 2010:

Service Description	Questioned Costs	Federal Share		State Share
		Non-ARRA	ARRA*	
Long-term care	$231,845.29	$116,676.14	$29,247.28	$85,921.87
Behavioral rehabilitation services	$27,439.86	$13,809.10	$3,461.54	$10,169.21
Managed care insurance premiums	$31,185.47	$15,694.09	$3,934.05	$11,557.33
Dental services	$5,108.87	$2,571.04	$644.48	$1,893.35
Other services including physician visits, prescription drugs, family planning , vision and disability medical evaluation	$2,414.37	$1,215.03	$304.58	$894.77
Total	**$297,993.86**	**$149,965.40**	**$37,591.93**	**$110,436.53**

*The non- ARRA federal shares are calculated by using 50.325 percent, which is the average of the federal reimbursement percentages in fiscal years 2009 and 2010.

*The ARRA federal shares are calculated by using 12.615 percent, which is the average of the reimbursement increase authorized by ARRA s in fiscal years 2009 and 2010.

Cause of Condition

As we have reported in past audits, the Department does not have an adequate process to identify ineligible expenditures for nonqualified aliens at the time of payment. It generally charges costs to Medicaid first and then reviews the payments to identify non-emergency services. When it identifies them, the Department removes the payments from Medicaid and charges them to state funds only. However, the Department does not identify all unallowable expenditures because the review does not cover all nonqualified alien clients.

Additionally, we found the Department had incorrectly categorized some clients as a citizens or legal aliens. We randomly selected five clients whose services were paid for through the Medicaid payment system. In all cases, the Department incorrectly categorized the clients: in four cases, Department staff relied on the clients' self-declaration instead of verifying proof of citizenship or legal status and for the other, the Department determined a client had provided a false immigration document, stopped benefits and is seeking repayment.

In December 2010, the U.S. Department of Health and Human Services Office of the Inspector General released a report: Review of Washington State's Medicaid Claims for Nonqualified Aliens[i]. As in our audit, the Inspector General found the Department had been claiming non-emergency expenditures for nonqualified aliens. An additional cause identified by the Inspector General was that the Medicaid services card provided to clients and the Medicaid payment system were ineffective at preventing ineligible services or payments for nonqualified aliens.

Effect of Condition and Questioned Costs

The Department paid $297,993.86 for services that are not eligible for federal money. We are questioning $187,557.33, which is the federal portion of the expenditures.

Recommendation

We recommend the Department:

- Strengthen procedures to verify Medicaid clients' citizenship status.

- Establish and follow adequate procedures to ensure that Medicaid services provided to nonqualified aliens are restricted only to emergency services.
- Follow up on the non-emergency services provided to 96 nonqualified aliens and work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid funds must be reimbursed.

Department's Response

This finding involved the Aging and Disability Services Administration (ADSA) and the Medicaid Purchasing Administration (MPA). Each administration responded individually.

Aging and Disability Services Administration

ADSA concurs with this finding.

Medicaid funds were used to serve non-qualified alien clients who were otherwise Medicaid eligible. These clients should have received services through state-funded programs. ADSA is establishing new state only SSPS codes for these clients and training case managers to ensure undocumented clients are charged correctly in the future.

Medicaid Purchasing Administration

The Medicaid Purchasing Administration concurs with this finding.

During the audit period in question, MPA did not have an accounting process that moved non-emergent Medicaid paid claims to state-only for documented non-citizen clients with invalid Social Security Numbers. As a result, such claims, as identified in the audit, would have been paid with Medicaid dollars.

MPA is developing a methodology to move these claims from Medicaid to state-only. The process will entail periodic identification of non-citizens with invalid Social Security Numbers. This list would then be passed to financial staff, who will identify the non-emergent Medicaid claims data from ProviderOne and perform an accounting adjustment to shift these dollars to state-only funds.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

Title 42, Code of Federal Regulations, Part 435

Section 435.139 Coverage for certain aliens states:

The agency must provide services necessary for the treatment of an emergency medical condition, as defined in §440.255(c) of this chapter, to those aliens described in §435.406(c) of this subpart.

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

(a) FFP for services. FFP is available for services provided to aliens described in this section which are necessary to treat an emergency medical condition as defined in paragraphs (b)(1) and (c) or services for pregnant women described in paragraph (b)(2).
(b) Legalized aliens eligible only for emergency services and services for pregnant women. Aliens granted lawful temporary resident status, or lawful permanent resident status under sections 245A, 210 or 210A of the Immigration and Nationality Act, who are not in one of the

exempt groups described in §§435.406(a)(3) and 436.406(a)(3) and who meet all other requirements for Medicaid will be eligible for the following services—

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

(2) Services for pregnant women which are included in the approved State plan. These services include routine prenatal care, labor and delivery, and routine post-partum care. States, at their option, may provide additional plan services for the treatment of conditions which may complicate the pregnancy or delivery.

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

(1) The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
   (i) Placing the patient's health in serious jeopardy;
   (ii) Serious impairment to bodily functions; or
   (iii) Serious dysfunction of any bodily organ or part, and

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

Title 42, Code of Federal Regulations, Section 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.

(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.

Washington Administrative Code (WAC) 388-500-0005, Medical definitions, states in part:

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

*Placing the patient's health in serious jeopardy;
*Serious impairment to bodily functions; or
*Serious dysfunction of any bodily organ or part.

Emergency Rule WSR 09-22-055, Effective November 1, 2009, states:

(1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 388-438-0110 is eligible for the alien emergency medical program's scope of covered services described in this section if the person meets (a) and (b) below, or (c) below:
   (a) The department's health and recovery services administration (HRSA) determines that the primary condition requiring treatment meets the definition of an emergency medical condition as defined in WAC 388-500-0005, and the condition is confirmed through review of clinical records; and
   (b) The person's qualifying emergency medical condition is treated in one of the following hospital settings:
      (i) Inpatient;
      (ii) Outpatient surgery;
      (iii) Emergency room services, which must include an evaluation and management (E&M) visit by a physician; or
   (c) An Involuntary Treatment Act (ITA) or voluntary inpatient community hospital psychiatric admission prior authorized by the department's inpatient mental health designee.

(2) If a person meets the criteria in subsection (1), the department will cover and pay for all related medically necessary health care services and professional services provided during this specific emergency room visit, outpatient surgery or inpatient admission. These services include, but are not limited to:
   (a) Medications;
   (b) Laboratory, x-ray, and other diagnostics and the professional interpretations;
   (c) Medical equipment and supplies;
   (d) Anesthesia, surgical, and recovery services;
   (e) Physician consultation, treatment, surgery, or evaluation services;
   (f) Therapy services;
   (g) Emergency medical transportation; and
   (h) Non-emergency ambulance transportation to transfer the person from a hospital to a long term acute care (LTAC) or an inpatient physical medicine and rehabilitation (PM&R) unit, if that admission is prior authorized by the department as described in subsection (3) of this section.

(3) The department will cover admissions to an LTAC facility or an inpatient PM&R unit if:
- (a) The original admission to the community hospital meets the criteria as described in subsection (1) of this section;
- (b) The person is transferred directly to this facility from the community hospital; and
- (c) The admission is prior authorized according to LTAC and PM&R program rules (see WAC 388-550-2590 for LTAC and WAC 388-550-2561 for PM&R).

(4) The department does not cover any services, regardless of setting, once the person is discharged from the hospital after being treated for a qualifying emergency medical condition authorized by the department under this program. Exception: Pharmacy services prescribed on the same day and associated with the qualifying visit or service (as described in subsection (1) of this section) will be covered and retrospectively reimbursed according to pharmacy program rules.

(5) Inpatient psychiatric care must be prior authorized by the department's inpatient mental health designee according to the requirements in WAC 388-550-2600.

(6) There is no precertification or prior authorization for eligibility under this program.

(7) Under this program, certification is only valid for the period of time the person is receiving services under the criteria described in subsection (1) of this section.
- (a) For inpatient care, the period of eligibility is only for the period of time the person is in the hospital, LTAC, or PM&R facility - the admission date through the discharge date. Upon discharge the person is no longer eligible for coverage.
- (b) For an outpatient surgery or emergency room service the period of eligibility is only for the date of service. If the person is in the hospital overnight, the eligibility period will be the admission date through the discharge date. Upon release from the hospital, the person is no longer eligible for coverage.

(8) Under this program, any visit or service not meeting the criteria described in subsection (1) of this section is not within the scope of covered services as described in WAC 388-501-0060. This includes, but is not limited to:
- (a) Hospital services, care, surgeries, or inpatient admissions to treat any condition which is not considered by the department to be a qualifying emergency medical condition, including but not limited to:
  - (i) Laboratory x-ray, or other diagnostic procedures;
  - (ii) Physical, occupational, speech therapy, or audiology services;
  - (iii) Hospital clinic services; or
  - (iv) Emergency room visits, surgery, or hospital admissions.
- (b) Any services provided during a hospital admission or visit (meeting the criteria described in subsection (1) of this section), which are not related to, or consistent with best practices in treating, the qualifying emergency medical condition;
- (c) Organ transplants, including preevaluations and post operative care;
- (d) Services provided outside the hospital settings described in subsection (1) of this section, including but not limited to:
  - (i) Office or clinic-based services rendered by a physician, an ARNP, or any other licensed practitioner;
  - (ii) Prenatal care, except labor and delivery;
  - (iii) Laboratory, radiology, and any other diagnostic testing;
  - (iv) School-based services;
  - (v) Personal care services;
  - (vi) Physical, respiratory, occupational, and speech therapy services;
  - (vii) Waiver services;
  - (viii) Nursing facility services;
  - (ix) Home health services;
  - (x) Hospice services;
  - (xi) Vision services;
  - (xii) Hearing services;
  - (xiii) Dental services;
  - (xiv) Durable and non durable medical supplies;
  - (xv) Non-emergency medical transportation;

(xvi) Interpreter services; and

(xvii) Pharmacy services, except as described in subsection (4).

(9) The services listed in subsection (8) of this section are not part of the scope of covered services for this program and therefore the exception to rule process is not available.

(10) Providers must not bill the department for visits or services that do not meet the qualifying criteria described in this section. The department will identify and recover payment for claims paid in error.

10-38 The Department of Social and Health Services, Medicaid Purchasing Administration[1], does not have adequate controls to ensure controlled substances prescribed for Medicaid clients are authorized and allowable.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Activities Allowed/Cost Principles
Questioned Cost Amount:	$ 119,829.99 (Non-ARRA) $ 30,037.85 (ARRA)

Background

The federal Drug Enforcement Administration (DEA) classifies all controlled substances as scheduled drugs ranging from level 1-5; the number represents the potential risk of abuse the drug poses to the client. Schedule 1 drugs, such as heroin, are illegal. The rest are considered legitimate for medical use and range from drugs such as morphine (schedule 2), to cough syrup with codeine (schedule 5).

Federal regulations require individuals who prescribe controlled substances to register with the DEA. These individuals must have an active medical license in the state in which they practice. This registration allows the DEA to track all prescribers of controlled substances in a national database and to monitor all prescriptions. The DEA assigns all registrants an identification number. All Medicaid providers are required to have a National Provider Identifier (NPI) number issued by the U.S. Department of Health and Human Services, regardless of whether they prescribe scheduled drugs.

Pharmacies submit claims for Medicaid client prescriptions through an electronic point-of-sale system that processes requests for payment through a series of criteria (edits) within the system. Prescribers can use either their DEA numbers or NPI numbers as identification; the system will accept either, even when processing a scheduled drug claim. Claims are paid if the prescriber passes all edits.

Federal grant regulations require the Department to have adequate controls to ensure that Medicaid expenditures are allowable. These expenditures must be supported, authorized and allowable under federal, state laws or regulations. Controlled substances are allowable expenditures for Medicaid only when prescribed by prescribers with valid DEA numbers.

The Department paid $18,518,770 in claims for schedule 2-5 drugs between July 1, 2009 and June 30, 2010.

Description of Condition

In our audit for fiscal year 2009, we reported the Department's controls over payments for schedule 2-5 prescription drug claims were inadequate. The Department since has improved procedures to verify the DEA numbers for schedule 2 drugs. It now requires pharmacists to include the prescriber's DEA or NPI number, which can be cross-matched with the DEA database, on claims that it verifies using the DEA database.

[1] Formerly Health and Recovery Services Administration (HRSA)

The Department, however, does not have similar requirements for schedule 3-5 drugs. Claims for these medications are paid without assurance that the prescriber has proper DEA authorization.

Without adequate controls to validate prescriber's DEA number for scheduled drugs, the Department is unable to ensure all expenditures related to the claims are properly authorized and allowable.

Cause of Condition

The Department stated it does not believe it is responsible for verifying DEA numbers of prescribers for any scheduled drugs. It believes this responsibility lies with medical licensing authorities and the dispensing pharmacies. However, it stated it validates DEA numbers for schedule 2 drugs because of the risk of abuse associated with these narcotics.

Effect of Condition and Questioned Costs

We reviewed pharmaceutical claims processed through the point-of-sale system and identified 14,017 for scheduled drugs 2-5, totaling $238,112.28, that were paid even though the Department did not verify the prescriber had a valid DEA number. We separated the transactions into two categories:

Transactions with an invalid DEA number
We found prescribers submitted 4,071 pharmaceutical claims using 354 DEA numbers that were not valid at the time of the transaction, as shown in the table below:

Schedule	Transactions with invalid DEA number	
	Transactions	Expenditures
Schedule 2	1,228	$ 31,621.07
Schedule 3	1,202	$ 8,081.58
Schedule 4	1,516	$ 13,614.93
Schedule 5	125	$ 6,022.95
Total	4,071	$ 59,340.53

The Department paid $59,340.53 for these claims. We are questioning $37,348.92, which is the federal portion of the expenditures.

Transactions with an NPI number

We found 9,946 transactions involving controlled substances for which prescribers used NPI numbers. When we asked the Department to provide the DEA numbers for the transactions with NPI numbers, it stated it uses a manual process to cross-match the NPI number to a DEA number. It stated it does not have the resources to give us DEA numbers for those transactions.
Since the Department would not provide DEA numbers for those transactions, we were not able to determine whether controlled substances were prescribed by individuals who are legally authorized to do so, as shown in the table below:

Schedule	Transactions with NPI numbers	
	Transactions	Expenditures
Schedule 2	1,775	$ 81,746.23
Schedule 3	4,106	$ 34,097.60
Schedule 4	3,711	$ 39,330.74
Schedule 5	354	$ 23,597.18
Total	9,946	$ 178,771.75

The Department paid $178,771.75 for these claims. We are questioning $112,518.92, which is the federal portion of the expenditures.

In total we identified $238,112.28 paid for scheduled drugs to prescribers without a valid DEA number on record. The federal portion of these payments was $149,867.84.

Recommendation

We recommend the Department:

- Ensure prescribers of controlled substances have valid DEA numbers that demonstrate they are authorized to provide this service in accordance with federal requirements.
- Consult with the U.S. Department of Health and Human Services to determine if any questioned costs must be repaid to the federal government.

Department's Response

The Department (MPA) does not concur with the finding.

There are no federal or state statutes that require a payer (e.g. state) to validate the Drug Enforcement Administration (DEA) number of a prescriber. Therefore, the Department (MPA) disagrees that the lack of an edit that validates DEA for Schedule 2-5 drugs constitutes inadequate internal controls or that the lack of such validation renders the payment unallowable.

The Department (MPA) believes that responsibility for compliance with controlled substance requirements lies with the prescribing provider and the dispensing pharmacies. The Controlled Substance Act (21 USC Sec. 821) and the State Uniform Controlled Substance Act (RCW 69.50) do not regulate payment for controlled substances and there are no provisions in either that could be interpreted as a requirement relating to payment of claims for controlled substances. Title 21 CFR Section 1306.04 clearly states that the prescribing practitioner is responsible for assuring that the prescription conforms in all essential respects to the law and regulation:

> *(a) A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. <u>The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription.</u>"*

This finding indicates that since the previous 2009 finding, the Department (MPA) has developed procedures to verify DEA for Schedule 2 drugs. That statement is incorrect. The automated edit procedure has been in place since 2002 when the Department (MPA) implemented a pharmacy Point of Sale (POS) edit for the purpose of validating the DEA of the prescribing physician for Schedule II drugs. The Department (MPA) considered this to be an essential POS validation because Schedule II drugs are subject to the highest risk of abuse. The Department (MPA) considered it prudent to provide this additional validation to guard against the potential for fraud and abuse.

The Department (MPA) implemented a new pharmacy Point of Sale (POS) in October 2008. The POS design allowed us to require and utilize the National Provider Identifier (NPI) as the prescriber identifier. The POS was designed to utilize a national file that associated the NPI to the DEA number, theoretically allowing a match of the NPI to DEA that enforces the Schedule II edit. However, at implementation it was discovered that the national file that associated NPI to DEA was not complete and did not meet the business needs of matching NPI to DEA. As a result, the Schedule II edit in POS is based on a work-around. The POS maintains a "prescriber network" of known NPI/DEA associations, and it is updated by state staff as new associations become known. The work-around includes manual updates to a "blocked prescriber list" that identifies prescriber DEAs prevented from prescribing Schedule II drugs.

There continues to be no complete external source of data that provides the NPI to DEA crosswalk. As a result, the work-around within the POS does not provide any external data file that can be utilized for analysis or that allows us to query the data and match DEA with NPI. So while the POS automatically associates the NPI with DEA for adjudication, external review of the NPI/DEA associations requires manual lookup to document the association. The Department (MPA) performed the following detailed claims analysis and responded to SAO as follows:

- *Transactions with an invalid DEA number (4,071 records): The Department (MPA) reviewed the first 100 records in POS and found 100% were active in the POS prescriber file with valid DEA. The prescriber file does not currently include DEA end dates.*
- *Transactions with an NPI number (9,946 records): A manual review of 50 records found 47 associations of NPI to valid DEA. In three instances, only the NPI was in the Prescriber Network file. These three claims paid because the NPI was not on the blocked Schedule II list.*
- *SAO reviewers were provided with access to the POS as well as instruction on the screens showing how the NPI/DEA associations could be located.*

In addition to the POS edit that validates the DEA for Schedule II drugs; the Department (MPA) has a set of robust Program Integrity activities including pharmacy utilization review, pharmacy rules-based algorithms that identify improper payments, and data mining activities that identify patterns outside the norm. In the absence of any requirement to validate DEA for controlled substances, the Department (MPA) believes this set of Program Integrity activities provide adequate controls to ensure that controlled substances are authorized and allowable.

The Department (MPA) continues to research the availability of a complete external file that accurately and completely associates NPI to DEA. Other states are faced with similar difficulties in utilizing the NPI for prescriber identifier.

Auditor's Concluding Remarks

We thank the Department for its response.

We agree the Department does not have a regulatory role over controlled substance prescribers. However, the Department does have a responsibility to ensure that services provided to Medicaid clients are allowable. In order for a controlled substance prescription to be an allowable Medicaid service, it must be prescribed by a provider with a valid DEA number.

The Department indicates that the automated edit procedure validating the DEA of the prescribing providers has been working since it was implemented in 2002. However, evidence we collected during our 2009 audit suggested otherwise. The Department (MPA) implemented a new pharmacy Point of Sale (POS) in October 2008. After the implementation of the POS, the Department discovered that the new POS did not have a system edit for schedule 2 drugs and was allowing claims to be processed without verifying the validity of the provider's DEA number. The Department has since developed a work-around procedure to verify DEA numbers for prescribers of schedule 2 drugs.
We will review this area during our next audit.

Applicable Laws and Regulations

U.S. Office of Management and Budget, Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section 300 Auditee responsibilities, 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 Budget Circular A-87: *Cost Principles for State, Local and Indian Tribal Governments*; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
   k. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
   l. Be allocable to Federal awards under the provisions of 2 CFR part 225.
   m. Be authorized or not prohibited under State or local laws or regulations.
   n. 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.
   o. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
   p. Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.
   q. Except as otherwise provided for in 2 CFR part 225, be determined in accordance with generally accepted accounting principles.
   r. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period, except as specifically provided by Federal law or regulation.
   s. Be the net of all applicable credits.
   t. Be adequately documented.

Title 21, Code of Federal Regulations, Section 1306 states in part:

§1306.03 Persons entitled to issue prescriptions.

(a) A prescription for a controlled substance may be issued only by an individual practitioner who is:
   (1) Authorized to prescribe controlled substances by the jurisdiction in which he is licensed to practice his profession and
   (2) Either registered or exempted from registration pursuant to §§1301.22(c) and 1301.23 of this chapter.

(b) A prescription issued by an individual practitioner may be communicated to a pharmacist by an employee or agent of the individual practitioner.

§ 1306.21 Requirement of prescription**.**

(a) A pharmacist may dispense directly a controlled substance listed in Schedule III, IV, or V which is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act, only pursuant to either a written prescription signed by a practitioner or a facsimile of a written, signed prescription transmitted by the practitioner or the practitioner's agent to the pharmacy or pursuant to an oral prescription made by an individual practitioner and promptly reduced to writing by the pharmacist containing all information required in §1306.05, except for the signature of the practitioner.

(b) An individual practitioner may administer or dispense directly a controlled substance listed in Schedule III, IV, or V in the course of his/her professional practice without a prescription, subject to §1306.07.

(c) An institutional practitioner may administer or dispense directly (but not prescribe) a controlled substance listed in Schedule III, IV, or V only pursuant to a written prescription signed by an individual practitioner, or pursuant to a facsimile of a written prescription or order for medication transmitted by the practitioner or the practitioner's agent to the institutional practitioner-pharmacist, or pursuant to an oral prescription made by an individual practitioner and promptly reduced to writing by the pharmacist (containing all information required in Section 1306.05 except for the signature of the

individual practitioner), or pursuant to an order for medication made by an individual practitioner which is dispensed for immediate administration to the ultimate user, subject to §1306.07.

§ 1306.22 Refilling of prescriptions.

(a) No prescription for a controlled substance listed in Schedule III or IV shall be filled or refilled more than six months after the date on which such prescription was issued. No prescription for a controlled substance listed in Schedule III or IV authorized to be refilled may be refilled more than five times.

(b) Each refilling of a prescription shall be entered on the back of the prescription or on another appropriate document or electronic prescription record. If entered on another document, such as a medication record, or electronic prescription record, the document or record must be uniformly maintained and readily retrievable.

(c) The following information must be retrievable by the prescription number:

(1) The name and dosage form of the controlled substance.

(2) The date filled or refilled.

(3) The quantity dispensed.

(4) The initials of the dispensing pharmacist for each refill.

(5) The total number of refills for that prescription.

(d) If the pharmacist merely initials and dates the back of the prescription or annotates the electronic prescription record, it shall be deemed that the full face amount of the prescription has been dispensed.

(e) The prescribing practitioner may authorize additional refills of Schedule III or IV controlled substances on the original prescription through an oral refill authorization transmitted to the pharmacist provided the following conditions are met:

(1) The total quantity authorized, including the amount of the original prescription, does not exceed five refills nor extend beyond six months from the date of issue of the original prescription.

(2) The pharmacist obtaining the oral authorization records on the reverse of the original paper prescription or annotates the electronic prescription record with the date, quantity of refill, number of additional refills authorized, and initials the paper prescription or annotates the electronic prescription record showing who received the authorization from the prescribing practitioner who issued the original prescription.

(3) The quantity of each additional refill authorized is equal to or less than the quantity authorized for the initial filling of the original prescription.

(4) The prescribing practitioner must execute a new and separate prescription for any additional quantities beyond the five-refill, six-month limitation.

(f) As an alternative to the procedures provided by paragraphs (a) through (e) of this section, a computer application may be used for the storage and retrieval of refill information for original paper prescription orders for controlled substances in Schedule III and IV, subject to the following conditions:

(1) Any such proposed computerized application must provide online retrieval (via computer monitor or hard-copy printout) of original prescription order information for those prescription orders that are currently authorized for refilling. This shall include, but is not limited to, data such as the original prescription number; date of issuance of the original prescription order by the practitioner; full name and address of the patient; name, address, and DEA registration number of the practitioner; and the name, strength, dosage form, quantity of the controlled substance prescribed (and quantity dispensed if different from the quantity prescribed), and the total number of refills authorized by the prescribing practitioner.

(2) Any such proposed computerized application must also provide online retrieval (via computer monitor or hard-copy printout) of the current refill history for Schedule III or IV controlled substance prescription orders (those authorized for refill during the past six months). This refill history shall include, but is not limited to, the name of the controlled substance, the date of refill, the quantity dispensed, the identification

code, or name or initials of the dispensing pharmacist for each refill and the total number of refills dispensed to date for that prescription order.

(3) Documentation of the fact that the refill information entered into the computer each time a pharmacist refills an original paper, fax, or oral prescription order for a Schedule III or IV controlled substance is correct must be provided by the individual pharmacist who makes use of such an application. If such an application provides a hard-copy printout of each day's controlled substance prescription order refill data, that printout shall be verified, dated, and signed by the individual pharmacist who refilled such a prescription order. The individual pharmacist must verify that the data indicated are correct and then sign this document in the same manner as he would sign a check or legal document (*e.g.*, J.H. Smith, or John H. Smith). This document shall be maintained in a separate file at that pharmacy for a period of two years from the dispensing date. This printout of the day's controlled substance prescription order refill data must be provided to each pharmacy using such a computerized application within 72 hours of the date on which the refill was dispensed. It must be verified and signed by each pharmacist who is involved with such dispensing. In lieu of such a printout, the pharmacy shall maintain a bound log book, or separate file, in which each individual pharmacist involved in such dispensing shall sign a statement (in the manner previously described) each day, attesting to the fact that the refill information entered into the computer that day has been reviewed by him and is correct as shown. Such a book or file must be maintained at the pharmacy employing such an application for a period of two years after the date of dispensing the appropriately authorized refill.

(4) Any such computerized application shall have the capability of producing a printout of any refill data that the user pharmacy is responsible for maintaining under the Act and its implementing regulations. For example, this would include a refill-by-refill audit trail for any specified strength and dosage form of any controlled substance (by either brand or generic name or both). Such a printout must include name of the prescribing practitioner, name and address of the patient, quantity dispensed on each refill, date of dispensing for each refill, name or identification code of the dispensing pharmacist, and the number of the original prescription order. In any computerized application employed by a user pharmacy the central recordkeeping location must be capable of sending the printout to the pharmacy within 48 hours, and if a DEA Special Agent or Diversion Investigator requests a copy of such printout from the user pharmacy, it must, if requested to do so by the Agent or Investigator, verify the printout transmittal capability of its application by documentation (*e.g.*, postmark).

(5) In the event that a pharmacy which employs such a computerized application experiences system down-time, the pharmacy must have an auxiliary procedure which will be used for documentation of refills of Schedule III and IV controlled substance prescription orders. This auxiliary procedure must ensure that refills are authorized by the original prescription order, that the maximum number of refills has not been exceeded, and that all of the appropriate data are retained for online data entry as soon as the computer system is available for use again.

(g) When filing refill information for original paper, fax, or oral prescription orders for Schedule III or IV controlled substances, a pharmacy may use only one of the two applications described in paragraphs (a) through (e) or (f) of this section.

(h) When filing refill information for electronic prescriptions, a pharmacy must use an application that meets the requirements of part 1311 of this chapter.

§ 1306.23 Partial filling of prescriptions. The partial filling of a prescription for a controlled substance listed in Schedule III, IV, or V is permissible, provided that:

(a) Each partial filling is recorded in the same manner as a refilling,

(b) The total quantity dispensed in all partial fillings does not exceed the total quantity prescribed, and

(c) No dispensing occurs after 6 months after the date on which the prescription was issued.

§ 1301.11 Persons required to register; requirement of modification of registration authorizing activity as an online pharmacy.

(a) Every person who manufactures, distributes, dispenses, imports, or exports any controlled substance or who proposes to engage in the manufacture, distribution, dispensing, importation or exportation of any controlled substance shall obtain a registration unless exempted by law or pursuant to §§1301.22 through 1301.26. Except as provided in paragraph (b) of this section, only persons actually engaged in such activities are required to obtain a registration; related or affiliated persons who are not engaged in such activities are not required to be registered. (For example, a stockholder or parent corporation of a corporation manufacturing controlled substances is not required to obtain a registration.)

(b) As provided in sections 303(f) and 401(h) of the Act (21 U.S.C. 823(f) and 841(h)), it is unlawful for any person who falls within the definition of "online pharmacy" (as set forth in section 102(52) of the Act (21 U.S.C. 802(52)) and §1300.04(h) of this chapter) to deliver, distribute, or dispense a controlled substance by means of the Internet if such person is not validly registered with a modification of such registration authorizing such activity (unless such person is exempt from such modified registration requirement under the Act or this chapter). The Act further provides that the Administrator may only issue such modification of registration to a person who is registered as a pharmacy under section 303(f) of the Act (21 U.S.C. 823(f)). Accordingly, any pharmacy registered pursuant to §1301.13 of this part that falls within the definition of an online pharmacy and proposes to dispense controlled substances by means of the Internet must obtain a modification of its registration authorizing such activity following the submission of an application in accordance with §1301.19 of this part. This requirement does not apply to a registered pharmacy that does not fall within the definition of an online pharmacy set forth in §1300.04(h). Under the Act, persons other than registered pharmacies are not eligible to obtain such a modification of registration but remain liable under section 401(h) of the Act (21 U.S.C. 841(h)) if they deliver, distribute, or dispense a controlled substance while acting as an online pharmacy without being validly registered with a modification authorizing such activity.

10-39 The Department of Social and Human Services, Aging and Disability Services Administration, did not ensure the level of in-home care services for some clients was evaluated at least annually.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Utilization Control and Program Integrity
Questioned Cost Amount:	$36,372.24 Non-ARRA $ 9,117.45 ARRA

Background

The Department of Social and Health Services, Aging and Disability Services Administration, requires all clients who seek Medicaid assistance to meet eligibility criteria to receive services. Eligibility is determined in part through an assessment of the client's level of ability to perform daily living tasks.

The Department uses the Comprehensive Assessment Reporting Evaluation system to determine the type and level of services the client needs. The Department's Home and Community Services perform an initial evaluation; it contracts with case managers at one of the 13 Area Agency on Aging offices across the state for the annual re-evaluations.

The annual re-evaluation is designed to determine whether the level of care is appropriate and whether clients are still eligible for assistance. Evaluations are considered complete and the client is authorized to receive services once the client has reviewed the results of his or her assessment and has either verbally agreed to or given a signature of approval for the services.

If an assessment is not completed in a timely manner, the client is notified that the assessment must be completed in order to continue receiving benefits.

In fiscal year 2010, the Department provided approximately $570 million in funding for services to more than 19,000 clients.

Description of Condition

The Department did not monitor to ensure staff was completing evaluations in a timely manner. During our audit, we identified 662 clients whose assessment was at least 30 days late. Case managers are given until the last day of the month in which the previous assessment occurred. This means some case assessments may not be performed until nearly 30 days after the standard 12-month period. We acknowledge the extended time case managers are allowed and only considered those assessments occurring more than 30 days late as an audit exception.

The table below summarizes the assessments we identified in our review as being completed after the annual re-evaluation due date:

Duration of Time Exceeding Annual Assessment Date	**Number of Assessments**
One Month	320
Two Months	143
Three Months	108
Four Months	81
Five Months	1
Six Months or Greater	9
Total	**662**

Cause of Condition

Department personnel stated most late assessments related to the difficulties in establishing contact with the client and high workloads.

Effect of Condition and Questioned Costs

When services are provided without authorization, expenditures are not allowable. Additionally, ineligible clients may receive benefits that could be available for eligible clients. We reviewed payments for services for 10 clients whose assessment was at least five months late. Total payments after the re-evaluation due date for these clients were $72,274.69. We are questioning $45,489.69, which is the federal portion of the expenditures.

Recommendation

We recommend the Department:

- Monitor to ensure the level of care assessment for clients receiving in-home care is performed at least once every twelve months.
- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid funds must be reimbursed.

Department's Response

The Department partially concurs with this finding.

Department analysis determined that 2 of the 10 clients reviewed by the auditors did have annual assessments within the required time frames but computer anomalies coded these assessments as late. Both clients had notations in the Service Episode Record documenting this issue. Total payment for these two clients was $9,455.16 and the federal portion of this expenditure was $5,951.08.

A review of the remaining 8 clients identified by the auditors as having assessments at least 5 months late determined that all 10 clients (this includes the two mentioned above)remained eligible for services received during the time frame that assessments were out of date. In addition, each client's services were provided with authorizations generated by case managers.

Due to significant workload the Department was not able to complete a line by line review of all 662 questioned assessments. There are routine reasons that an assessment may not be completed on time. Examples of these reasons include the client's inability to meet with the case manager to do the assessment, delays in locating a provider of personal care, and delays caused by bids for specialized medical equipment or environmental modifications. A client may also have been admitted to a nursing facility or hospital or had a break in service nullifying the annual assessment due date.

During this audit cycle, the Department completed 59,570 assessments. If the 662 assessments identified by the auditors were actually late, this amounts to a compliance rate of 98.9% which is well within an acceptable threshold given the routine reasons why an assessment could be late. The Department has set a benchmark of 90% for compliance with assessment timeliness. This benchmark is measured during each quality monitoring cycle and was surpassed during this audit period when 98% compliance was achieved.

Actions planned by the Department:

- *The Department will review the tool used in the current Quality Assurance cycle to make certain that monitoring is conducted to ensure the level of care assessment for clients receiving in-home care is performed at least once every twelve months.*

- *The Department will work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid funds must be reimbursed. The Aging and Disability Services Administration does not believe there are any questioned costs because all clients were eligible for services received.*

Auditor's Concluding Remarks

We appreciate the cooperation and assistance provided by the Department throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

Community Options Program Entry System (COPES) Waiver Version 06-95 states in part:

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE
The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in the Executive Summary of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION
The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):
_____ Discharge planning team
_____ Physician (MD or DO)
X Registered nurse, licensed in the state
_____ Licensed social worker
_____ Qualified mental retardation professional, as defined in 42 CFR 483.430(a)
X Other (specify):
Social Workers, Case Managers

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE
Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (specify):
_____ Every 3 months
_____ Every 6 months
X Every 12 +months
X Other (specify):

As indicated by a significant change in the client's condition or situation

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS
Check one:
X The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.
_____ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for all individuals performing reevaluations of level of care (specify):
_____ Physician (MD or DO)
_____ Registered nurse, licensed in the state
_____ Licensed social worker
_____ Qualified mental retardation professional, as defined in 42 CFR 483.430(a)
_____ Other (specify):
_____

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS
The state will employ the following procedures to ensure timely reevaluations of level of care (check below):
_____ "Tickler" file Edits in computer system
_____ Component part of case management
X Other (specify):

Quality assurance monitoring staff from ADSA headquarters conducts annual reviews of case management services provided by the Home and Community Services Division (HCS), Area Agencies on Aging (AAA) and Managed Care Organizations (MCO). Each HCS region ,AAA office and MCO is monitored. At the regional and local levels, HCS and AAA case management supervisors also conduct regular quality reviews of their case management staff.
42 C.F.R. 441.302 State assurances.

Unless the Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted:

(a) Health and Welfare —Assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include—
(1) Adequate standards for all types of providers that provide services under the waiver;
(2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and
(3) Assurance that all facilities covered by section 1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
(b) Financial accountability— The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.
(c) Evaluation of need. Assurance that the agency will provide for the following:
(1) Initial evaluation. An evaluation of the need for the level of care provided in a hospital, a NF, or an ICF/MR when there is a reasonable indication that a recipient might need the services in the near future (that is, a month or less) unless he or she receives home or

community-based services. For purposes of this section, “evaluation” means a review of an individual recipient's condition to determine—

(i) If the recipient requires the level of care provided in a hospital as defined in §440.10 of this subchapter, a NF as defined in section 1919(a) of the Act, or an ICF/MR as defined by §440.150 of this subchapter; and

(ii) That the recipient, but for the provision of waiver services, would otherwise be institutionalized in such a facility.

(2) Periodic reevaluations. Reevaluations, at least annually, of each recipient receiving home or community-based services to determine if the recipient continues to need the level of care provided and would, but for the provision of waiver services, otherwise be institutionalized in one of the following institutions:

(i) A hospital;

(ii) A NF; or

(iii) An ICF/MR.

(d) Alternatives —Assurance that when a recipient is determined to be likely to require the level of care provided in a hospital, NF, or ICF/MR, the recipient or his or her legal representative will be—

(1) Informed of any feasible alternatives available under the waiver; and

(2) Given the choice of either institutional or home and community-based services.

(e) Average per capita expenditures. Assurance that the average per capita fiscal year expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made in the fiscal year for the level of care provided in a hospital, NF, or ICF/MR under the State plan had the waiver not been granted.

(1) These expenditures must be reasonably estimated and documented by the agency.

(2) The estimate must be on an annual basis and must cover each year of the waiver period.

(f) Actual total expenditures. Assurance that the agency's actual total expenditures for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to recipients under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals, absent the waiver, in—

(1) A hospital;

(2) A NF; or

(3) An ICF/MR.

(g) Institutionalization absent waiver. Assurance that, absent the waiver, recipients in the waiver would receive the appropriate type of Medicaid-funded institutional care (hospital, NF, or ICF/MR) that they require.

(h) Reporting. Assurance that annually, the agency will provide CMS with information on the waiver's impact. The information must be consistent with a data collection plan designed by CMS and must address the waiver's impact on—

(1) The type, amount, and cost of services provided under the State plan; and

(2) The health and welfare of recipients.

(i) Habilitation services. Assurance that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver, are—

(1) Not otherwise available to the individual through a local educational agency under section 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730); and

(2) Furnished as part of expanded habilitation services, if the State has requested and received CMS's approval under a waiver or an amendment to a waiver.

(j) Day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness. Assurance that FFP will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are—

(1) Age 22 to 64;
(2) Age 65 and older and the State has not included the optional Medicaid benefit cited in §440.140; or
(3) Age 21 and under and the State has not included the optional Medicaid benefit cited in §440.160.
[50 FR 10026, Mar. 13, 1985, as amended at 59 FR 37717, July 25, 1994; 65 FR 60107, Oct. 10, 2000]

Washington Administrative Code (WAC)388-106-0025

How do I apply for long-term care services?

To apply for long-term care services, you must request an assessment from the department and submit a Medicaid application.

Washington Administrative Code (WAC) 388-106-0050

What is an assessment?

(1) An assessment is an in-person interview in your home or your place of residence that is conducted by the department to inventory and evaluate your ability to care for yourself. The department will assess you at least annually or more often when there are significant changes to your ability to care for yourself.
(2) Between assessments, the department may modify your current assessment without an in-person interview in your home or place of residence. The reasons that the department may modify your current assessment without conducting an in-person interview in your home or place of residence include but are not limited to the following:
    (a) Errors made by department staff in coding the information from your in-person interview;
    (b) New information requested by department staff at the time of your assessment and received after completion of the in-person interview (e.g. medical diagnosis);
    (c) Changes in the level of informal support available to you; or
    (d) Clarification of the coding selected.
(3) When the department modifies your current assessment, it will notify you using a Planned Action Notice of the modification regardless of whether the modification results in a change to your benefits. You will also receive a new service summary and assessment details.

Washington Administrative Code (WAC) 388-106-0055

What is the purpose of an assessment?

The purpose of an assessment is to:

(1) Determine eligibility for long-term care programs;
(2) Identify your strengths, limitations, and preferences;
(3) Evaluate your living situation and environment;
(4) Evaluate your physical health, functional and cognitive abilities;
(5) Determine availability of informal supports and other nondepartment paid resources;
(6) Determine need for intervention;
(7) Determine need for case management activities;
(8) Determine your classification group that will set your payment rate for residential care or number of hours of in-home care;
(9) Determine need for referrals; and
(10) Develop a plan of care, as defined in WAC 388-106-0010.
(11) In the case of New Freedom consumer directed services, the purpose of an assessment is to determine functional eligibility and for the participant to develop the New Freedom spending plan, as defined in WAC 388-106-0010.

Washington Administrative Code (WAC) 388-513-1315 states in part:

Eligibility for long-term care (institutional, waiver, and hospice) services.

This section describes how the department determines a client's eligibility for institutional, waiver, or hospice services under the categorically needy (CN) program and institutional or hospice services in a medical institution under the medically needy (MN) program. Also described are the eligibility requirements for these services under the general assistance (GA) program in subsection (12) and the alien emergency medical programs described in subsection (11).

(1) To be eligible for long-term care (LTC) services described in this section, a client must:
   (a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a) through (f);
   (b) Attain institutional status as described in WAC 388-513-1320;
   (c) Meet functional eligibility described in chapter 388-106 WAC for waiver and nursing facility coverage; and

DSHS Long-Term Care Manual Chapter 3 states in part:

Completing a CARE Assessment – Developing the Plan of Care

Background
Clients are able to choose from options for personal and healthcare services that are governed by eligibility criteria, payment source requirements, coverage options, and provider qualifications. Twenty-four hour, paid care is available only in residential or medical facility settings, so case managers must work with clients to maximize all available resources, both paid and unpaid, in order to develop a plan of care that addresses the health and safety needs of the client. The state identifies the essential tasks to be performed by formal providers in the care plan. How and when they are performed is determined by the client.

The state has an obligation to educate clients, family members, support systems, and other service providers, informing them that a plan of care is developed based on the resources available and that meeting all needs and providing all services is an expectation that neither the client, family, support system, or case manager may be able to achieve.

How do I get approval on the plan of care from the client?
Before authorizing services, you must obtain the client's approval on the plan of care.

How do I distribute the plan of care to the client/representative?
Distribute the Service Summary and CARE Results to the client along with a Planned Action Notice (PAN). Distribute Assessment Details if requested by the client/representative.

How and when do I distribute the plan of care to the provider(s)?
Mail or fax the Service Summary and Assessment Details prior to authorizing/reauthorizing services and document in the SER. Review the plan of care with the provider when the client has special or extraordinary needs due to cognitive issues. Distribute the Service Summary and Assessment Details to:

- Individual providers;
- Agency providers;
- Nursing services staff, if applicable;
- Residential providers;
- The nursing facility, if the client is placed there on Medicaid funding only;
- Adult Day Services providers;
- Nurse delegators.

Document in the SER when you distributed the documents and to whom.

How do I authorize services?

Complete all authorizations in CARE once the client has approved the plan of care. For:

· Initial assessments, the begin date may not precede the date the assessment was moved to Current status.

· Significant Change assessments, if extending services for one year, terminate the current line or lines (for example, if participation is also authorized) and create a new line(s) on the same authorization. Do not change the begin date on a current line since changing the begin date creates a risk of canceling outstanding payments or prevents invoicing from occurring. If there are not enough lines left on the authorization, open a new authorization.

· Annual assessments, you may not extend services beyond one year from the last day of the month in which it was moved to Current. A face-to-face assessment must occur and the assessment must be moved to Current prior to reauthorization of services.

10-40 The Department of Social and Health Services, Medicaid Purchasing Administration[2], does not comply with state law and the federal Deficit Reduction Act of 2005, thereby increasing the likelihood that the state is paying claims that should have been paid by liable third parties.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Activities Allowed or Unallowed and Allowable Costs/Cost Principles
Questioned Cost Amount:	None

Background

Medicaid is the "payer of last resort", meaning the Department should identify other payment sources 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 Medicaid coverage. The function of third-party liability within the Medicaid program is to ensure non-Medicaid resources are the primary source of payment. Federal regulations require states to have processes to identify third parties liable for payment of services before Medicaid dollars are used.

The federal Deficit Reduction Act of 2005 requires health insurers to provide states with eligibility and coverage information that will enable Medicaid agencies to determine whether Medicaid recipients have third-party coverage. The Act directs states, as a condition of receiving Medicaid money, to have laws requiring health insurers doing business in that state to provide the eligibility and coverage information upon the request of the state.

To comply with this requirement, the state Legislature passed a law (RCW 74.09A) in 2007 that requires the Department to provide Medicaid client eligibility and coverage information to insurers doing business in the state. The insurers, in turn, are required to use that information to identify Medicaid clients with third-party coverage, and provide those results to the Department. The law requires this process to be performed no less than twice per year. The law, if followed, would provide a comprehensive identification of potential third-party payers.

In our audits for fiscal years 2008 and 2009 we reported findings regarding the Department's noncompliance with the state law.

The state had Medicaid expenditures of approximately $6.9 billion in fiscal year 2010, more than $4.4 billion of which was federal dollars.

Description of Condition

The Department has not performed the semi-annual data share with insurers as required by state law.

[2] Formerly Health and Recovery Services Administration (HRSA)

Cause of Condition

Although the Department initially disagreed with our finding, during this audit period it took steps toward establishing routine client eligibility and coverage information exchanges with third-party health insurers. The Department signed agreements with health insurers regarding information sharing, put in place a new Medicaid payment system with more data share functionality than the prior system, and received established data sharing formats from its grantor to be used when sharing eligibility and benefit information. However, the Department has not completed all necessary steps nor are all systems fully operational to effect the data share as required by law.

Effect of Condition

When Medicaid-eligible individuals with third-party liability coverage are not identified, Medicaid is no longer the payer of last resort and the Department is paying claims that should have been paid by liable third parties.

Recommendation

We recommend the Department complete all necessary steps to provide routine and periodic computerized information to health insurers regarding client eligibility and coverage information and receive joint beneficiaries information in order to better identify all third parties liable for Medicaid beneficiary claims.

Department's Response

The Department (MPA) does not concur with this finding.

The Department (MPA) continues to believe that it is in compliance with the Deficit Reduction Act of 2005. The Department (MPA) meets this standard by making data available to all insurers to use for Third Party Liability (TPL) reporting and by matching data directly with those insurers most likely to provide third party coverage to Medicaid recipients.

The Department's (MPA) position was corroborated by an independent review conducted by Health Management Systems (HMS) in March 2010. That review stated, "HMS's review of the DSHS confirms a strong Medicaid TPL program…" This report also noted areas of industry best practices that the Department (MPA) could explore to enhance its cost avoidance and recovery. The Department (MPA) is exploring these recommendations and has submitted a budget request for the 11/13 biennium to enhance its TPL activities.

Although the Department (MPA) is in compliance with applicable state and federal law, the Deficit Reduction Act (DRA) of 2005 requires that the Secretary of Health and Human Services specify a manner in which the state Medicaid agencies and health plans may exchange eligibility and coverage data. In June 2010, the Department (MPA) was finally notified that CMS had published the recommended format called for by the DRA. This new format serves as a tool to enable all states and all payers to use to comply with the DRA data exchange requirements. The Department (MPA) is moving forward to incorporate this tool into its system to enhance our cost avoidance and recovery activities.

Auditor's Concluding Remarks

We thank the Department for its response. However, it does not conduct the semi-annual data share with insurers as required by state law. We affirm our finding.

Applicable Laws and Regulations

Title 42, United States Code, Part 1396a(a)(25).states:

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 1167(1) of Title 29), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including--
  (i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and
  (ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396*o* of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396*o* of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396*o* of this title), exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall--
  (i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and
  (ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall--
  (i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and
  (ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is

eligible for or is provided medical assistance under a plan under this title for such State, or any other State;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to--

(i) provide, with respect to individuals who are eligible (and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with subsection (e)(13)(D) of this section) for, or are provided, medical assistance under the State plan under this subchapter (and, at State option, child health assistance under subchapter XXI of this chapter), upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if-

(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

Revised Code of Washington (RCW) 74.09A.005 states:

The legislature finds that:

(1) Simplification in the administration of payment of health benefits is important for the state, providers, and health insurers;

(2) The state, providers, and health insurers should take advantage of all opportunities to streamline operations through automation and the use of common computer standards;

(3) It is in the best interests of the state, providers, and health insurers to identify all third parties that are obligated to cover the cost of health care coverage of joint beneficiaries; and

(4) Health insurers, as a condition of doing business in Washington, must increase their effort to share information with the department and accept the department's timely claims consistent with 42 U.S.C. 1396a(a)(25).

Therefore, the legislature declares that to improve the coordination of benefits between the department of social and health services and health insurers to ensure that medical insurance benefits are properly utilized, a transfer of information between the department and health insurers should be instituted, and the process for submitting requests for information and claims should be simplified.

Revised Code of Washington (RCW) 74.09A.020 states:

Computerized information — Provision to health insurers.

(1) The department shall provide routine and periodic computerized information to health insurers regarding client eligibility and coverage information. Health insurers shall use this information to identify joint beneficiaries. Identification of joint beneficiaries shall be transmitted to the department. The department shall use this information to improve accuracy and currency of health insurance coverage and promote improved coordination of benefits.
(2) To the maximum extent possible, necessary data elements and a compatible database shall be developed by affected health insurers and the department. The department shall establish a representative group of health insurers and state agency representatives to develop necessary technical and file specifications to promote a standardized database. The database shall include elements essential to the department and its population's health insurance coverage information.
(3) If the state and health insurers enter into other agreements regarding the use of common computer standards, the database identified in this section shall be replaced by the new common computer standards.
(4) The information provided will be of sufficient detail to promote reliable and accurate benefit coordination and identification of individuals who are also eligible for department programs.
(5) The frequency of updates will be mutually agreed to by each health insurer and the department based on frequency of change and operational limitations. In no event shall the computerized data be provided less than semiannually.
(6) (6) The health insurers and the department shall safeguard and properly use the information to protect records as provided by law, including but not limited to chapters 42.48, 74.09, 74.04, 70.02, and 42.56 RCW, and 42 U.S.C. Sec. 1396a and 42 C.F.R. Sec. 43 et seq. The purpose of this exchange of information is to improve coordination and administration of benefits and ensure that medical insurance benefits are properly utilized.
(7) The department shall target implementation of this section to those health insurers with the highest probability of joint beneficiaries.

Washington Administrative Code (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:
    (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.

10-41 The Department of Social and Health Services did not ensure all Medicaid providers were eligible to participate in the 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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Suspension and Debarment
Questioned Cost Amount:	$ 8,379.59 Non-ARRA $ 2,100.52 ARRA

Background

The Department of Social and Health Services contracts with businesses and individuals to provide services to Medicaid clients. Federal regulations prohibit grant recipients from using federal money to pay contractors or subcontractors who have been suspended, debarred or excluded from doing business with the federal government.

The U.S. Office of Inspector General has authority under the Social Security Act to exclude individuals and businesses from being paid with Medicaid funds to provide services. The Office maintains the List of Excluded Individuals/Entities database that shows parties that are excluded.

Grant recipients are responsible for verifying that the business or individual with whom they intend to do business is not excluded or debarred. The Department's Aging and Disability Services Administration (ADSA) is responsible for this verification and requires providers to sign a contract that contains a clause stating the provider is not suspended, debarred or excluded.

Description of Condition

We compared all the Department's providers to the database to determine if any were federally excluded. We identified one provider that had been excluded and that received $17,126.15 in Medicaid funds that it should not have been paid.

Cause of Condition

The Department runs a data match between its provider list and the database, but this procedure is not identifying all exceptions.

Effect of Condition and Questioned Costs

Medicaid payments to an excluded party are unallowable.

Upon receiving a notification from the State Auditor's Office in January 2010, the Department terminated this provider from participation in the Medicaid program in February 2010. We are questioning $10,480.11, which is the federal portion of the expenditures during fiscal year 2010 prior to the provider being terminated.

Recommendation

We recommend the Department:

- Review its data match process to determine why the excluded provider was not identified, and make adjustments or corrections to the process as necessary to prevent future occurrences.
- Refund $10,480.11 to the federal government.

Department's Response

The Department concurs with this finding.

Medicaid dollars were used to reimburse an excluded party who happened to be a parent provider. The excluded party (parent provider) provided the client services as authorized, and was paid for those services. During the audit period, parent providers were exempt by rule (RCW 74.15.030 (3)) from background checks. This exemption will change in 2012, when all providers, including parent providers will be required to be fingerprinted as part of the background check process

The Department will review its data match process to identify and make corrections determined to be necessary to prevent future occurrences.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

Sec. 1128. [42 U.S.C. 1320a–7] states:

(a) Mandatory Exclusion. States-The Secretary shall exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1128B(f)):

(1) Conviction of program-related crimes.—Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII or under any State health care program.

(2) Conviction relating to patient abuse.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

(3) Felony conviction relating to health care fraud.—Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996[46], under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(4) Felony conviction relating to controlled substance.—Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(b) Permissive Exclusion.—The Secretary may exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1128B(f)):

(1) Conviction relating to fraud.—Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or State law—

(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

(i) in connection with the delivery of a health care item or service, or

(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.

(2) Conviction relating to obstruction of an investigation or audit[47].—Any individual or entity that has been convicted, under Federal or State law, in connection with the interference with or obstruction of any investigation or audit related to—

(i) any offense described in paragraph (1) or in subsection (a);

(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).[48]

(3) Misdemeanor conviction relating to controlled substance.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense consisting of a misdemeanor relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(4) License revocation or suspension.—Any individual or entity—

(A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license or the right to apply for or renew such a license, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity, or

(B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional performance, or financial integrity.

(5) Exclusion or suspension under federal or state health care program.—Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under—

(A) any Federal program, including programs of the Department of Defense or the Department of Veterans Affairs, involving the provision of health care, or

(B) a State health care program, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

(6) Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services.—Any individual or entity that the Secretary determines—

(A) has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;

(B) has furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under title XVIII or under a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

(C) is—

(i) a health maintenance organization (as defined in section 1903(m)) providing items and services under a State plan approved under title XIX, or

(ii) an entity furnishing services under a waiver approved under section 1915(b)(1), and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under title XIX) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or

(D) is an entity providing items and services as an eligible organization under a risk–sharing contract under section 1876 and has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk–sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.

(7) Fraud, kickbacks, and other prohibited activities.—Any individual or entity that the Secretary determines has committed an act which is described in section 1128A, 1128B, or 1129.

(8) Entities controlled by a sanctioned individual.—Any entity with respect to which the Secretary determines that a person—

(A) (i) who has a direct or indirect ownership or control interest of 5 percent or more in the entity or with an ownership or control interest (as defined in section 1124(a)(3)) in that entity,

(ii) who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of that entity; or

(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—is a person—

(B) (i) who has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

(ii) against whom a civil monetary penalty has been assessed under section 1128A or 1129; or

(iii) who has been excluded from participation under a program under title XVIII or under a State health care program.

(9) Failure to disclose required information.—Any entity that did not fully and accurately make any disclosure required by section 1124, section 1124A, or section 1126.

(10) Failure to supply requested information on subcontractors and suppliers.—Any disclosing entity (as defined in section 1124(a)(2)) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary or by the State agency administering or supervising the administration of a State health care program—

(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom the entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000, or

(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five–year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor.

(11) Failure to supply payment information.—Any individual or entity furnishing, ordering, referring for furnishing, or certifying the need for[49] items or services for which payment may be made under title XVIII or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the

amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.

(12) Failure to grant immediate access.—Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:

(A) To the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1864(a) (relating to compliance with conditions of participation or payment).

(B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1902(a) and under section 1903(g).

(C) To the Inspector General of the Department of Health and Human Services, for the purpose of reviewing records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.

(D) To a State medicaid fraud control unit (as defined in section 1903(q)), for the purpose of conducting activities described in that section.

(13) Failure to take corrective action.—Any hospital that fails to comply substantially with a corrective action required under section 1886(f)(2)(B).

(14) Default on health education loan or scholarship obligations.—Any individual who the Secretary determines is in default on repayments of scholarship obligations or loans in connection with health professions education made or secured, in whole or in part, by the Secretary and with respect to whom the Secretary has taken all reasonable steps available to the Secretary to secure repayment of such obligations or loans, except that (A) the Secretary shall not exclude pursuant to this paragraph a physician who is the sole community physician or sole source of essential specialized services in a community if a State requests that the physician not be excluded, and (B) the Secretary shall take into account, in determining whether to exclude any other physician pursuant to this paragraph, access of beneficiaries to physician services for which payment may be made under title XVIII or XIX.

(15) Individuals Controlling a Sanctioned Entity.—

(A) Any individual—

(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

(ii) who is an officer or managing employee (as defined in section 1126(b)) of such an entity.

(B) For purposes of subparagraph (A), the term "sanctioned entity" means an entity—

(i) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

(ii) that has been excluded from participation under a program under title XVIII or under a State health care program.

(16)[50] Making false statements or misrepresentation of material facts.—Any individual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1128B(f)), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans.

(c) Notice, Effective Date, and Period of Exclusion.—

(1) An exclusion under this section or under section 1128A shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

(2) (A) Except as provided in subparagraph (B), such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

(B) Unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to payments made under title XVIII or under a State health care program for—

(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or

(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion, until the passage of 30 days after the effective date of the exclusion.

(3) (A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1128A, the minimum period (or, in the case of an exclusion of an individual under subsection (b)(12) or in the case described in subparagraph (G), the period) of the exclusion.

(B) Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries (as defined in section 1128A(i)(5) of that program[51], the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community. The Secretary's decision whether to waive the exclusion shall not be reviewable.

(C) In the case of an exclusion of an individual under subsection (b)(12), the period of the exclusion shall be equal to the sum of—

(i) the length of the period in which the individual failed to grant the immediate access described in that subsection, and

(ii) an additional period, not to exceed 90 days, set by the Secretary.

(D) Subject to subparagraph (G), in the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.

(G) In the case of an exclusion of an individual under subsection (a) based on a conviction occurring on or after the date of the enactment of this subparagraph, if the individual has (before, on, or after such date) been convicted—

(i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years, or

(ii) on 2 or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.

(d) Notice to State Agencies and Exclusion Under State Health Care Programs.—

(1) Subject to paragraph (3), the Secretary shall exercise the authority under this section and section 1128A in a manner that results in an individual's or entity's exclusion from all the programs under title XVIII and all the State health care programs in which the individual or entity may otherwise participate.

(2) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act[52] may apply, the Attorney General)—

(A) of the fact and circumstances of each exclusion effected against an individual or entity under this section or section 1128A, and

(B) of the period (described in paragraph (3)) for which the State agency is directed to exclude the individual or entity from participation in the State health care program.

(3) (A) Except as provided in subparagraph (B), the period of the exclusion under a State health care program under paragraph (2) shall be the same as any period of exclusion under title XVIII.

(B) (i) The Secretary may waive an individual's or entity's exclusion under a State health care program under paragraph (2) if the Secretary receives and approves a request for the waiver with respect to the individual or entity from the State agency administering or supervising the administration of the program.

(ii) A State health care program may provide for a period of exclusion which is longer than the period of exclusion under title XVIII.

(e) Notice to State Licensing Agencies.—The Secretary shall—

(1) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of an individual or entity excluded (or directed to be excluded) from participation under this section or section 1128A, of the fact and circumstances of the exclusion,

(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and

(3) request that the State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to the request.

(f) Notice, Hearing, and Judicial Review.—

(1) Subject to paragraph (2), any individual or entity that is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g), except that, in so applying such sections and section 205(l), any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(2) Unless the Secretary determines that the health or safety of individuals receiving services warrants the exclusion taking effect earlier, any individual or entity that is the subject of an adverse determination under subsection (b)(7) shall be entitled to a hearing by an administrative law judge (as provided under section 205(b)) on the determination under subsection (b)(7) before any exclusion based upon the determination takes effect.

(3) The provisions of section 205(h) shall apply with respect to this section and sections 1128A, 1129, and 1156 to the same extent as it is applicable with respect to title II, except that, in so applying such section and section 205(l), any reference therein to the Commissioner of Social Security shall be considered a reference to the Secretary.

(4)[53] The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.

(g) Application for Termination of Exclusion.—

(1) An individual or entity excluded (or directed to be excluded) from participation under this section or section 1128A may apply to the Secretary, in the manner specified by the Secretary in regulations and at the end of the minimum period of exclusion provided under subsection (c)(3) and at such other times as the Secretary may provide, for termination of the exclusion effected under this section or section 1128A.

(2) The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that—

(A) there is no basis under subsection (a) or (b) or section 1128A(a) for a continuation of the exclusion, and

(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

(3) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act[54] may apply, the Attorney General) of the fact and circumstances of each termination of exclusion made under this subsection.

(h) Definition of State Health Care Program.—For purposes of this section and sections 1128A and 1128B, the term "State health care program" means—

(1) a State plan approved under title XIX,

(2) any program receiving funds under title V or from an allotment to a State under such title,

(3) any program receiving funds under subtitle I of [55]title XX or from an allotment to a State under such subtitle[56], or

(4) a State child health plan approved under title XXI.

(i) Convicted Defined.—For purposes of subsections (a) and (b), an individual or entity is considered to have been "convicted" of a criminal offense—

(1) when a judgment of conviction has been entered against the individual or entity by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;

(2) when there has been a finding of guilt against the individual or entity by a Federal, State, or local court;

(3) when a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State, or local court; or

(4) when the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

(j) Definition of Immediate Family Member and Member of Household.—For purposes of subsection (b)(8)(A)(iii):

(1) The term "immediate family member" means, with respect to a person—

(A) the husband or wife of the person;

(B) the natural or adoptive parent, child, or sibling of the person;

(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

(D) the father–, mother–, daughter–, son–, brother–, or sister–in–law of the person;

(E) the grandparent or grandchild of the person; and

(F) the spouse of a grandparent or grandchild of the person.

(2) The term "member of the household" means, with respect to any person, any individual sharing a common abode as part of a single family unit with the person,

including domestic employees and others who live together as a family unit, but not including a roomer or boarder.

10-42 The Department of Social and Health Services, Aging and Disability Services Administration, Home and Community Based Services Division, does not have adequate internal controls to ensure Medicaid payments to in-home service providers are allowable and supported.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Activities Allowed or Unallowed
Questioned Cost Amount:	$460,823 Non-ARRA $115,515 ARRA

Background

The Department of Social and Health Services, Aging and Disability Services Administration, administers the Home and Community Based Services program for the state. Through the program, the state pays for home and community-based services for Medicaid beneficiaries needing long-term care. Individual or agency providers, often chosen by the Medicaid client, provide personal care and assistance allowing the client to avoid institutionalization.

The Department conducts the initial assessment of clients to determine the level of care needed. The Department authorizes the number of service hours required for that care, which forms the basis of the payment to the provider. After the initial assessment, ongoing supervision of client cases and provider services is transferred to one of 13 Area Agencies on Aging (AAA) located throughout the state.

Depending on their financial resources, clients may be required to pay a portion of the costs of services. The Department pays the remainder up to the authorized amount. The service provider is required to record hours worked on a timesheet to be signed by the client and the provider and retained by the provider for two years.

During fiscal year 2010, the Department paid approximately $688 million for in-home services. These included direct payments to AAAs and payments to in-home service providers for services that had been authorized by the AAA.

Description of Condition

In our audits for fiscal years 2008 and 2009 we reported findings regarding the Department's lack of adequate controls to ensure payments are allowable and supported. In response to the findings, the Department notified providers that they are responsible for maintaining accurate timesheets to support care hours worked and for having the timesheets available for review by the Department. The Department also issued a bulletin to case managers to review the notices with the providers and to inform clients of their responsibility to act as supervisors of individual providers.

To determine if payments for home and community-based services were supported, we randomly selected 260 providers and requested copies of their timesheets for the period. As a result of Department efforts, we noticed a significant improvement in the number of providers that responded to our request over previous

years. We also noted a significant increase in the number of providers whose timesheets were complete. See the following chart for comparison with the previous year:

Year of Audit	2009		2010	
Provider with no response or no timesheets	109	54.50%	72	27.69%
Provider with timesheet incomplete	29	14.50%	40	15.38%
Provider with complete timesheets	62	31.00%	148	56.92%
Total Providers selected	200	100.00%	260	100.00%

However, we continued to find significant weaknesses in controls intended to ensure payments are allowable and supported. During our audit, we did not receive any timesheets from 72 individual providers, representing nearly 28 percent of the providers selected. Some individual providers did not respond while others stated they were not aware of the need for timesheets. We also noted timesheets from 40 providers contained errors that affected total payments.

Cause of Condition

The Department did not ensure the AAAs adequately monitored provider services. According to the Department's contract with the AAAs, case managers are expected to inspect a sample of the timesheets when clients are reassessed for service needs. Of eight case managers we surveyed, three stated they did not review timesheets, and the other five stated they performed this review only occasionally.

The Department also stated that it considers the client to be the "employer" of the service provider, and therefore it is the client's responsibility to verify the allowability and legitimacy of payments.

Effect of Condition and Questioned Costs

Although the client may be the employer of the service provider, Medicaid clients do not regularly receive detailed information on payment claims submitted to the Department. Therefore, a client would not know if a provider submitted an incorrect or false claim.

To determine the effect of the control deficiencies, we asked the Department to obtain timesheets from 260 judgmentally selected providers for July 1, 2009 through March 31, 2010. We obtained detailed payment information from the Department and attempted to reconcile it to the timesheets to determine whether payments were legitimate and supported. Of the 260 providers reviewed, we found 148 provided adequate documentation. Of the remaining 112, we noted:

Description of issues	Number of Instances	Related Expenditures
Payments were not supported with timesheets.	72	$ 750,866.00
Providers provided incomplete timesheets and did not have all timesheets for the period requested.	*12	$ 17,920.00
Timesheets were not totaled or incorrectly totaled.	*16	$ 8,755.00
Timesheets with at least one month in which timesheet hours were less than the authorized hours on the Social Services Payment System.	*24	$ 10,650.00
Timesheets showed no variances from month to month, and/or appear to be copies.	*8	$ 108,952.00
Timesheets do not include client signature	*4	$ 18,550.00
Total	136	$ 915,693.00

*: Issues possible in more than one category, which is why the number of exceptions is higher than the number of samples selected. Related questioned costs are not duplicated.

The Department paid a total of $2,787,261.79 to these providers. We identified $915,693 in payments that are not fully supported.

Including Federal Medical Assistance funds from the American Recovery and Reinvestment Act, approximately 62 percent of the questioned amount, or $576,338 was funded by federal dollars. The remaining $339,355 was paid with state dollars.

Recommendation

We recommend the Department:

- Monitor and enforce the provisions of its contracts with the AAAs to ensure payments to providers are legitimate and supported. The Department should pursue the remedies available to it in the contract for instances of non-performance.

- Seek recovery of the funds paid to providers who were unable to adequately support payment claims.

We further recommend the Department pursue responses from the 72 providers that did not submit timesheets, and seek recovery of any unsupported payment from providers. The Department should consult with its grantor to determine if any questioned costs must be repaid to the federal government.

Department's Response

The Department concurs with this finding.

The Department plans on implementing the Provider Compensation Systems (PCS) by the end of 2012. PCS, a sub-system of Provider One, will generate intermittent notices to clients that inform them of the number of hours providers were paid during the previous month. This will allow clients to compare hours authorized against hours paid. Clients will be instructed to notify the Department if there is a discrepancy between authorized hours and paid hours.

The Department will rely on the following controls until PCS is implemented:

- *Case managers complete an assessment that results in an authorization of hours that cannot be exceeded by a provider invoice. The Social Service Payment System will not process payments in excess of hours authorized. An Individual Provider (IP) is therefore unable to claim and be reimbursed for hours that exceed those authorized by the case manager.*
- *Clients are expected to keep copies of timesheets for their individual providers. Case managers periodically review a sample of clients' time sheets and verify with sampled clients that authorized services have been provided. Case managers are instructed to document the review of time sheets and the discussion of service verification in a Service Episode Record.*

    - *In the 12 month period ending October 2010, staff reviewed a revised "Acknowledgement of My Responsibilities as the Employer of My Individual Providers" with all clients who employ an IP. This form must be distributed and reviewed with new clients who select an IP and with current clients who switch to an IP from a homecare agency or residential setting.*

- *In April 2010, all IPs delivering personal care services received a written reminder of their obligation to keep a record of the date/time that in-home services are provided to ADSA clients and complete and retain copies of their timesheets.*
- *In August of 2010 ADSA began auditing a randomly selected sample of IPs timesheets to ensure that services billed for are consistent with timesheet documentation submitted.*

In addition to controls already in place, the Department will take the following actions:

- *The Department will provide a training module to the 13 Area Agencies on Aging to be delivered to case management staff. The training emphasizes the requirement for case managers to periodically review a sample of clients' time sheets, verify with sampled clients that authorized services have been provided and document the review of time sheets and the discussion of service verification in a Service Episode Record.*
- *The Department's Case Management Program Training curriculum will be revised to include an emphasis on the requirement for case managers to periodically review a sample of clients' time sheets and verify with sampled clients that authorized services have been provided and to then document the review of time sheets and the discussion of service verification in a Service Episode Record.*
- *IPs delivering personal care services will again receive a written reminder of their obligation to keep a record of the date/time that in-home services are provided to ADSA clients and complete and retain copies of their timesheets.*
- *A randomly selected sample of IPs timesheets will be audited to determine if services billed for are consistent with timesheet documentation submitted.*

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We look forward to reviewing the improvements the Department implements during our next audit.

Applicable Laws and Regulations

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

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

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments* (2 CFR 225); Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

> 1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
> d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
> j. Be adequately documented.

Revised Code of Washington (RCW) 74.39A.095 states:

(1) In carrying out case management responsibilities established under RCW 74.39A.090 for consumers who are receiving services under the medicaid personal care, community options programs entry system or chore services program through an individual provider, each area agency on aging shall provide oversight of the care being provided to consumers receiving services under this section to the extent of available funding. Case management responsibilities incorporate this oversight, and include, but are not limited to:
   (a) Verification that any individual provider who has not been referred to a consumer by the authority established under chapter 3, Laws of 2002 has met any training requirements established by the department;
   (b) Verification of a sample of worker time sheets;
   (c) Monitoring the consumer's plan of care to verify that it adequately meets the needs of the consumer, through activities such as home visits, telephone contacts, and responses to information received by the area agency on aging indicating that a consumer may be experiencing problems relating to his or her home care;
   (d) Reassessment and reauthorization of services;
   (e) Monitoring of individual provider performance. If, in the course of its case management activities, the area agency on aging identifies concerns regarding the care being provided by an individual provider who was referred by the authority, the area agency on aging must notify the authority regarding its concerns; and
   (f) Conducting criminal background checks or verifying that criminal background checks have been conducted for any individual provider who has not been referred to a consumer by the authority.

(2) The area agency on aging case manager shall work with each consumer to develop a plan of care under this section that identifies and ensures coordination of health and long-term care services that meet the consumer's needs. In developing the plan, they shall utilize, and modify as needed, any comprehensive community service plan developed by the department as provided in RCW 74.39A.040. The plan of care shall include, at a minimum:
   (a) The name and telephone number of the consumer's area agency on aging case manager, and a statement as to how the case manager can be contacted about any concerns related to the consumer's well-being or the adequacy of care provided;
   (b) The name and telephone numbers of the consumer's primary health care provider, and other health or long-term care providers with whom the consumer has frequent contacts;
   (c) A clear description of the roles and responsibilities of the area agency on aging case manager and the consumer receiving services under this section;
   (d) The duties and tasks to be performed by the area agency on aging case manager and the consumer receiving services under this section;
   (e) The type of in-home services authorized, and the number of hours of services to be provided;
   (f) The terms of compensation of the individual provider;
   (g) A statement by the individual provider that he or she has the ability and willingness to carry out his or her responsibilities relative to the plan of care; and
   (h) (i) Except as provided in (h)(ii) of this subsection, a clear statement indicating that a consumer receiving services under this section has the right to waive any of the case management services offered by the area agency on aging under this section, and a clear indication of whether the consumer has, in fact, waived any of these services.
      (ii) The consumer's right to waive case management services does not include the right to waive reassessment or reauthorization of services, or verification that services are being provided in accordance with the plan of care.

(3) Each area agency on aging shall retain a record of each waiver of services included in a plan of care under this section.

(4) Each consumer has the right to direct and participate in the development of their plan of care to the maximum practicable extent of their abilities and desires, and to be provided with the time and support necessary to facilitate that participation.

(5) A copy of the plan of care must be distributed to the consumer's primary care provider, individual provider, and other relevant providers with whom the consumer has frequent contact, as authorized by the consumer.
(6) The consumer's plan of care shall be an attachment to the contract between the department, or their designee, and the individual provider.
(7) If the department or area agency on aging case manager finds that an individual provider's inadequate performance or inability to deliver quality care is jeopardizing the health, safety, or well-being of a consumer receiving service under this section, the department or the area agency on aging may take action to terminate the contract between the department and the individual provider. If the department or the area agency on aging has a reasonable, good faith belief that the health, safety, or well-being of a consumer is in imminent jeopardy, the department or area agency on aging may summarily suspend the contract pending a fair hearing. The consumer may request a fair hearing to contest the planned action of the case manager, as provided in chapter 34.05 RCW. When the department or area agency on aging terminates or summarily suspends a contract under this subsection, it must provide oral and written notice of the action taken to the authority. The department may by rule adopt guidelines for implementing this subsection.
(8) The department or area agency on aging may reject a request by a consumer receiving services under this section to have a family member or other person serve as his or her individual provider if the case manager has a reasonable, good faith belief that the family member or other person will be unable to appropriately meet the care needs of the consumer. The consumer may request a fair hearing to contest the decision of the case manager, as provided in chapter 34.05 RCW. The department may by rule adopt guidelines for implementing this subsection.

Washington Administrative Code (WAC) 388-71-0515 states:

An individual provider or home care agency provider must:
(1) Understand the client's plan of care that is signed by the client or legal representative and social worker/case manager, and translated or interpreted, as necessary, for the client and the provider;
(2) Provide the services as outlined on the client's plan of care, as defined in WAC 388-106-0010;
(3) Accommodate client's individual preferences and differences in providing care;
(4) Contact the client's representative and case manager when there are changes which affect the personal care and other tasks listed on the plan of care;
(5) Observe the client for change(s) in health, take appropriate action, and respond to emergencies;
(6) Notify the case manager immediately when the client enters a hospital, or moves to another setting;
(7) Notify the case manager immediately if the client dies;
(8) Notify the department or AAA immediately when unable to staff/serve the client; and
(9) Notify the department/AAA when the individual provider or home care agency will no longer provide services. Notification to the client/legal guardian must:
(a) Give at least two weeks' notice, and
(b) Be in writing.
(10) Complete and keep accurate time sheets that are accessible to the social worker/case manager; and
(11) Comply with all applicable laws and regulations.

Employment Reference Guide for Individual Providers (DSHS22-221(X) Page 8 states in part:

§ Make a check in all the personal care tasks listed on the form that you performed as defined in the Care Plan during that month.
§ After you have completed the form, have your employer review it for accuracy. If your employer agrees, he/she should sign their name under “CLIENT’S SIGNATURE”.
§ Use your timesheet to fill out your SSPS Service Invoice accurately.

§ Keep one copy for your records (for two (2) years) and give one copy to your employer for his or her files.

According to the Long Term Care manual (Chapter 3, Resources: Forms to review with Client during their Assessment)

Form/Brochure Title	Requirements
Acknowledgement of My Responsibilities as the Employer of My Individual Providers (DSHS 11-055 revised 8/2009)	Review with clients about their responsibilities when employing an Individual Provider. Between November 1, 2009 and October 31, 2010 the form must be distributed and reviewed during the Initial and Annual assessments with all clients who employ an IP. After October 31, 2010, the form must be distributed and reviewed with new clients who select an IP and with current clients who switch to an IP from a homecare agency or residential setting.
IP time sheets	Review with the client and the provider during the annual or Significant Change assessments.

10-43 The Department of Social and Health Services did not ensure that all individuals who received Medicaid benefits had valid Social Security numbers.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	$143,270.78 Non-ARRA $35,913.78 ARRA

Background

Medicaid is a state and federal partnership that provides coverage for certain low-income individuals who might otherwise go without medical care. The state Medicaid program spent more than $6.9 billion during fiscal year 2010; approximately $4.4 billion was paid with federal funds.

Federal regulations require the Department to obtain a Social Security number from each individual, including children, applying for Medicaid. 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 is sent in an overnight batch to the Social Security Administration for verification. If it cannot verify a number, the Administration sends an electronic message to the Department Community Service Office.

Description of Condition

We reviewed all Social Security numbers of Medicaid beneficiaries in the Department's two Medicaid claim processing systems: Medicaid Management Information system (MMIS) and Social Service Payment System (SSPS), and independently verified the numbers in those systems by running a computerized cross-match with the Social Security Administration's database. We performed three distinct reviews to determine if the Department was ensuring clients had valid Social Security numbers:

- A review to identify invalid Social Security numbers.
- A review to identify clients with no Social Security numbers in the claims payment systems.
- A review to identify Social Security numbers reported in the Social Security Administration's database as belonging to deceased people.

Invalid Social Security Numbers

We initially identified 487 Social Security numbers which, according to the Social Security Administration's database, have never been issued and therefore are invalid. The Department was able to resolve 460 of these, most due to data entry error. For the other 27, the Department could not provide a valid number.

No Social Security Numbers in the MMIS and SSPS

For some Medicaid client groups, such as foster or adopted children, the client's Social Security number does not appear in the claims payment systems due to confidentiality issues. As such, not finding a client's Social Security number in the payment systems does not always mean the Department does not have a valid Social Security number for the client.

During our testing we found 8,231 clients that had no Social Security number in the systems. Of those, 7,178 were foster or adopted children. For the remaining 1,053, we reviewed to determine whether the clients had valid Social Security numbers. The Department was able to resolve 677 of those by providing valid numbers. No valid number was found for the remaining 376.

Social Security Numbers belonging to deceased people

We used the Social Security Administration Death Master File and Medicaid claims data to identify payments for services provided to individuals using the Social Security number of a deceased person. We found nine clients in the system inappropriately using the Social Security number of a deceased person.

The table below summarizes the unresolved instances, and related Medicaid expenditures:

	MMIS		**SSPS**		**Total**	
		Payments		**Payments**		**Payments**
Invalid number	26	$18,862.44	1	$92.78	27	$18,955.22
No number	374	$182,555.26	2	$71,112.29	376	$253,667.55
Number belongs to deceased person	7	$11,868.29	2	$200.00	9	$12,068.29
Total	**407**	**$213,285.99**	**5**	**$71,405.07**	**412**	**$284,691.06**

The Department paid $284,691.06 for services provided to 412 clients who did not have valid Social Security numbers.

Cause of Condition

The Department has Social Security number verification procedures and has made improvements in its training and monitoring. However it is still not preventing or catching all unallowable payments.

Effect of Condition and Questioned Costs

When Medicaid benefits are paid for services to ineligible individuals, the money available for eligible clients is reduced. Payments for services for these 412 clients were $284,691.06. We are questioning $179,184.56, the federal portion of the unallowable costs.

Federal laws and regulations state unallowable payments can be recovered from the payee only if the State's Medicaid Eligibility Quality Control program finds those payments. Due to this, we are not able to officially recommend the Department refund the federal portion of payments associated with the services for those clients to the federal government.

Recommendation

We recommend the Department:

- Follow up on 412 clients for whom the Department could not provide evidence of correct Social Security numbers and re-determine their Medicaid eligibility.
- Ensure all staff involved in the verification process follow the Department's Social Security number verification procedures.

Department's Response

This finding involved Children's Administration, Economic Services Administration, and the Medicaid Purchasing Administration. Each administration provided individual responses.

Children's Administration

Children's Administration (CA) concurs with this finding.

Two of the exceptions identified during the audit are associated with CA. One was for a runaway child and the SSN was not initially available. We have since obtained the SSN for this child and it is reflected in our records. The second child was born in Canada and has dual citizenship. The Department has initiated the process to apply for a SSN for this child but one has not been issued yet.

The verification procedures used by Department staff for both of these cases has allowed CA to obtain the client's available SSN information.

Economic Services Administration

The Economic Services Administration (ESA) concurs with this finding.

The audit cited 412 exceptions, with 327 being related to ESA cases. Of these, 58 were updated with a valid SSN and 254 were closed. The remaining 15 cases will be reviewed and staff will take appropriate action.

To ensure staff follow SSN verification procedures, ESA along with the Medicaid Purchasing Administration have requested enhancements to our automated systems. The following initiatives will be developed to support the accurate processing of cases with missing or invalid SSNs:

- *Automation of the State On-line Query (SOLQ) SSN verification process at the time of application.*
- *System generated edits and assignments to ensure accurate processing and follow-up of cases with missing or invalid SSNs.*

Medicaid Purchasing Administration

The Medicaid Purchasing Administration (MPA) partially concurs with the audit findings.

The team determined the audit sample by pulling all cases that either had no Social Security Number or cases that had a number that was not verified by the Social Security Administration's system. In our opinion, this is not a valid sample of our total caseload of 1.1 million clients. This sample consisted only of cases that might be in error -- in effect, inflating the number of potential errors that might exist within the total Title XIX and Title XXI caseload. By comparing to the total 1.1 million cases, the audit team initially found 8,727 potential errors, a 7.9% potential error rate. But of that number of potential errors, the audit team found only 410 actual errors, or a 0.047% error rate. In addition, only 84 of the cited errors were under Medicaid's control, resulting in a Medicaid error rate of only 0.009%.

Twelve of these 84 cases were already closed or corrected. The remaining 72 (86%) were Take Charge family-planning-only cases. In the past, these clients have received one medical ID card covering a 12-month certification period. Beginning in May 2010, however, the Medicaid payment system changed to ProviderOne. This system only shows one month of a client's eligibility, which enables the department to close Take Charge certifications when needed. This new functionality in ProviderOne will eliminate the Take Charge problem since the department regularly terminates these cases when eligibility ends, rather than waiting until the end of the certification period as before.

Medicaid now shares monthly reports on cases that lack SSNs or have invalid SSNs with the Economic Services Administration so that workers in either administration may correct them quickly. Staff has now been trained on the need for SSNs and how to verify them through the State OnLine Query. In addition, the Eligibility A-Z manual has been updated with the most current procedures.

MPA will work with ESA to implement the enhancements ESA described in the last paragraph of their response to this finding.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

The Code of Federal Regulations is explicit regarding obtaining and verifying Social Security numbers as a condition of Medicaid eligibility.

Title 42, Code of Federal Regulations, Section 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 . . . .

Title 42, Code of Federal Regulations, Section 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.

Title 42, Code of Federal Regulations, Section 435.910 (e) states:

> If a Medicaid applicant cannot remember or has not been issued a Social Security number 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.

Title 42, Code of Federal Regulations, Section 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 . . .

Title 42, Code of Federal Regulations, Section 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.

(c) 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.

10-44 The Department of Social and Health Services Medicaid Purchasing Administration's[3] internal controls are insufficient to ensure payment rates for its Healthy Options managed care program are based on accurate data.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Special Tests and Provisions
Questioned Cost Amount:	None

Background

From July 2009 through June 2010, the state paid more than $1.3 billion to managed healthcare providers, an increase of $12 million over the previous year. These payments include funds made available through the American Recovery and Reinvestment Act of 2009.

The Department pays managed healthcare providers a uniform, pre-determined, per-patient monthly rate regardless of the number of times a patient is seen each month or the services provided. This is known as a capitation rate. Different managed health care plans may have different rates. Providers are required to submit information regarding the patient visit to the Medicaid Purchasing Administration, including the cost of the services and demographic, diagnostic and geographic data.

The Administration contracts with an actuary to analyze this data to use in developing capitation rates. In general, the rate is higher for plans including more seriously ill people.

In a report in August 2010, the U.S. Government Accountability Office stated the accuracy and completeness of data used to set managed care rates is a critical component to ensure the rates are appropriate. In fiscal years 2003 through 2009, we reported concerns regarding the Administration's lack of review of the accuracy of data received from providers that is used to determine the rates in the state.

Description of Condition

We found the Administration does not verify the accuracy of data from providers that is used to determine the rates, even though it has the knowledge and expertise to do so. The Administration has an actuarially sound process for calculating rates, however actuarial certification does not ensure the reported data is reliable. If underlying data used is inaccurate or incomplete, it could result in inaccurate rates.

Cause of Condition

The Department does not agree with the finding and believes its controls are sufficient to ensure data used in the rate-setting process is accurate and complete. Specifically, the Department cites:

- The actuary's comparisons of data to managed healthcare providers' financial statements and prior year data, and a limited review of individual services provided by managed healthcare facilities.

[3] Formerly Health and Recovery Services Administration (HRSA)

- Fraud and abuse controls at the managed healthcare providers to prevent provider fraud.
- That it has had no findings regarding rate-setting in two Centers for Medicare and Medicaid Services (CMS) reviews.
- CMS approved its rates.

The controls the Department cites are not specifically designed to verify the accuracy and completeness of the data, and therefore cannot be relied on to achieve that objective. A lack of identified fraud or findings by CMS does not reasonably ensure data integrity.

Effect of Condition

The Department is increasing the risk that rates paid to providers are inaccurate.

Recommendation

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

Department's Response

The Department (Medicaid Purchasing Administration (MPA)) continues to not concur with this audit finding.

There are sufficient controls in-place to assure that managed care rates are set based on the verified managed care organizations (MCO) actual costs of care. Actuarially certified, proprietary cost information is submitted directly to the Department's (MPA) actuary. The actuary verifies the information submitted by comparing it to audited financial statements submitted to the Office of the Insurance Commissioner, and encounter data submitted to the Department (MPA). The actuary also does analysis of prior years, compares MCOs to each other and resolves outliers that arise from its analyses with the MCOs.

In addition, the MCOs each have compliant fraud and abuse controls to prevent provider fraud. These controls provide reasonable assurance that the data used in rate-setting is accurate and complete. This assertion is supported by the fact that the Department (MPA) has had no findings regarding rate setting in two Centers for Medicare and Medicaid Services (CMS) reviews and has had its rates consistently approved by CMS with their full understanding of our rate setting methodology.

Auditor's Concluding Remarks

Without reviewing the accuracy and completeness of data used to set managed care rates the Department cannot ensure the rates are appropriate. We thank the Department for its response, and will follow up during our next audit.

Applicable Laws and Regulations

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

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

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.

10-45 The Department of Social and Health Services, Aging and Disability Services Administration, does not have adequate controls in place to ensure all applicant-owned assets are counted when Medicaid eligibility is determined.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	None

Background

The Medicaid program covers long-term care services for individuals who are unable to afford it. In order to ensure the availability of long-term care services for people who truly need them, the Federal Deficit Reduction Act of 2005 tightened Medicaid rules to make it more difficult for individuals with resources to pay for their own long-term care to inappropriately transfer assets for less than fair market value in order to qualify for coverage.

When an individual applies for Medicaid coverage for long-term care, the state conducts a review, or "look-back", to determine whether the individual (or his or her spouse) transferred assets to another person or party for less than fair market value to become eligible. The Act lengthened the "look-back period" to 60 months (five years) prior to the date of the application.

When individuals transfer assets at less than fair market value in order to qualify for Medicaid long-term care services, he or she is subject to a penalty that delays the date Medicaid long-term care services begin. Under the Act, the penalty period for transfers made on or after February 8, 2006, begins on either the date of the asset transfer, or the date the individual is determined to be eligible for Medicaid coverage, whichever is later.

The Department of Social and Health Services, Aging and Disability Services Administration, administers long-term care services under Medicaid. In fiscal year 2010, the Department spent more than $1.4 billion on these services.

Description of Condition

In our audit for fiscal years 2008 and 2009 we reported findings relating to the Department's inadequate controls over the look-back. The Department responded that it did not concur with the finding and believed relying on self-declaration by the client regarding asset transfers or sales within is sufficient.

During our current audit, we found no changes in the conditions reported in our previous two audits. Bank statements the Department reviews do not provide a reasonable picture of the applicant's financial situation over the five year look-back period or to ensure the Department is able to identify all assets owned or transferred by applicants.

Cause of Condition

The Department does not agree that federal rules require review of financial activities for the previous five years, unless a client declares he or she made an asset transfer or sale, or if it finds inconsistent information in financial records or other problems with the application.

Effect of Condition

Lack of adequate procedures to identify the financial resources of applicants when Medicaid eligibility is determined increases the risk of ineligible individuals receiving long-term care through the Medicaid program.

Recommendation

We recommend the Department establish and follow internal controls that will reasonably ensure all assets applicants own during the look-back period are counted when Medicaid eligibility is determined.

Department's Response

The Department does not concur with this finding.

The Department disagrees with the SAO for the following reasons:

- *Most clients do not have proof of all financial activities that occurred during the last five years, which would be all of their financial statements from banks and other financial institutions. The process that the client or Department would have to go through to provide that much history would be lengthy and expensive, and would not meet the federal requirement in 42CFR 435.902 that an agency's policies and procedures for determining eligibility must be conducted in a manner consistent with simplicity of administration and is in the best interests of applicants and recipients.*

- *The Department would have to pay banks to provide archived statements that the clients no longer have per WAC 388-490-0005(7). The length of time it would take to request and then review a minimum of 60 bank statements, with the possibility of hundreds more if there are multiple accounts at different banks, would make it impossible to meet our standard of promptness for Medicaid applications with existing staff. Many additional FTEs would be required. Requiring all clients to provide 60 months of bank statements would not be cost-effective.*

- *Unless transfers were made with the intent of qualifying for long-term care benefits the Department cannot impose a transfer penalty. RCW 74.08.080(2)(g) states that the burden is on the department to prove by a preponderance of the evidence that the person knowingly and willingly assigned or transferred the resource at less than fair market value for the purpose of qualifying…for medical assistance". Applicants who have or had enough resources to consider transferring assets are usually applying for public assistance for the first time. If transfers occurred between 2 – 5 years prior to applying, what we find is that those persons were usually unaware of Medicaid policies at that time because they were in reasonably good health, were not contemplating future long-term care needs, and were simply helping family members. If they were transferring assets to qualify that long ago it is often difficult to prove. Specific planning for future Medicaid eligibility usually occurs within a few months of the application.*

- *Requiring clients to provide five years of bank statements would only pertain to bank accounts that are declared. No system is in place to identify undeclared bank accounts and other types of undeclared transfers which is the primary reason for reliance on self-declaration.*

- *The Department is committed to ensuring that Medicaid clients are financially eligible for the program benefits that they receive and will continue to pursue and verify any asset transfers that it becomes aware of through the written application, the subsequent interview, or discovered through other means. Applicants complete the DSHS Application for Benefits. This form specifically asks if the applicant or applicant's spouse has sold, traded, given away, or transferred a resource in the last five years, and if so, what and when. The application states that the person signing it is declaring an understanding that they can be criminally prosecuted for making a false statement or failing to report something. The signature certifies and declares under penalty of perjury under the laws of the State of Washington that the information given is true and correct.*

  In addition, the Department is taking the following actions:

  - *Staff will routinely check online county assessor systems to see if clients have transferred property within the county they reside in.*
  - *If the bank statements from the last three or six months contain payments or credits that present red flags we will look as far into this as necessary to resolve the issue.*
  - *If the client declares a transfer, staff will request and obtain verification and thoroughly evaluate that transfer to ensure that it is consistent with Medicaid rules.*
  - *If the interview is inconsistent with the application, staff will evaluate and probe inconsistencies as necessary.*
  - *If staff learn of possible transfers through other means they always follow-up and verify.*

The Department submitted policies and procedures to, our regional representative at Region 10 CMS, in June 2009. We asked them to review them and comment on whether they meet federal guidelines. We received CMS' email response December 22, 2009. The following is a direct quote from the CMS email:

> *"While we understand your dilemma with the State Auditor's Office on the matter of documenting 5-years of bank statement to ensure all assets of applicants during the look-back period are countable when Medicaid eligibility is determined. The CMS cannot specifically comment on the state process for conducting the 5-year look back for transfer of assets which could impact a state's flexibility in documenting and verifying these transfers. This continues to be an operational matter, states have flexibility to implement this provision according to the general "rules of reason" and to give workers procedural guidance as to how to explore or document past financial transactions that might have been asset transfers. CMS affirms the initial guidance on flexibility given to states to implement policies that provide for looking back 5 years.*
>
> *The 5-year look back period only changes for transfer made after February 8, 2006, the effective date of the law. States are actively engaged in the pursuit of the asset verification systems which will provide for external verification of the reported financial information made by applicants, until then states must have sufficient procedures to capture and verify the reported client information.*
>
> *If you require any additional information please let me know."*

The Department believes this response validates our position that asking for bank statements for the entire look-back period is not required. The Department believes the methods described above meet the "rules of reason" test referred to by CMS in their email.

Auditor's Remarks

We thank the Department for its response and commitment to continuing discussions on this issue. We expect the Department to have internal controls that will reasonably ensure all assets applicants own during the look-back period are countable when Medicaid eligibility is determined. The current internal controls the Department has cannot provide a reasonable picture of the applicant's financial situation over the five year look-back period.

Applicable Laws and Regulations

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

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

Title 42, United States Code, section 1396p, as amended by the Deficit Reduction Act of 2005, states in part:

> (c)(1)(B)(i) The look-back date specified in this subparagraph is a date that is … (…in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005, 60 months) before the date specific in clause (ii).
>
> (c)(1)(D)(ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

Revised Code of Washington 74.08.335, Transfers of property to qualify for assistance, states:

> Temporary assistance for needy families and disability lifeline benefits shall not be granted to any person who has made an assignment or transfer of property for the purpose of rendering himself or herself eligible for the assistance. There is a rebuttable presumption that a person who has transferred or transfers any real or personal property or any interest in property within two years of the date of application for the assistance without receiving adequate monetary consideration therefore, did so for the purpose of rendering himself or herself eligible for the assistance. Any person who transfers property for the purpose of rendering himself or herself eligible for assistance, or any person who after becoming a recipient transfers any property or any interest in property without the consent of the secretary, shall be ineligible for assistance for a period of time during which the reasonable value of the property so transferred would have been adequate to meet the person's needs under normal conditions of living: PROVIDED, That the secretary is hereby authorized to allow exceptions in cases where undue hardship would result from a denial of assistance.

Revised Code of Washington 74.39A.160, Transfer of assets — Penalties, states:

> (1) A person who receives an asset from an applicant for or recipient of long-term care services for less than fair market value shall be subject to a civil fine payable to the department if:
>
> (a) The applicant for or recipient of long-term care services transferred the asset for the purpose of qualifying for state or federal coverage for long-term care services and the person who received the asset was aware, or should have been aware, of this purpose;
>
> (b) Such transfer establishes a period of ineligibility for such service under state or federal laws or regulations; and
>
> (c) The department provides coverage for such services during the period of ineligibility because the failure to provide such coverage would result in an undue hardship for the applicant or recipient.
>
> (2) The civil fine imposed under this section shall be imposed in a judicial proceeding initiated by the department and shall equal (a) up to one hundred fifty percent of the amount the department expends for the care of the applicant or recipient during the period of ineligibility

attributable to the amount transferred to the person subject to the civil fine plus (b) the department's court costs and legal fees.

(3) Transfers subject to a civil fine under this section shall be considered null and void and a fraudulent conveyance as to the department. The department shall have the right to petition a court to set aside such transfers and require all assets transferred returned to the applicant or recipient.

10-46 The Department of Social and Health Services, Economic Services Administration, does not have adequate controls to ensure sufficient action is taken to correct errors identified by the Medical Eligibility Quality 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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	None

Background

Federal regulations require the state to operate a Medicaid Eligibility Quality Control System (MEQC) to identify and reduce errors in Medicaid eligibility determinations and claims processing. Once the MEQC has identified errors in eligibility or claims, the Department is required to correct them, and recover Medicaid funds paid on ineligible claims. The Department also is required to take administrative action to prevent and reduce errors, and to submit to its federal grantor, the Centers for Medicare and Medicaid Services, a report of its error analysis and a corrective action plan.

The state had Medicaid expenditures of approximately $6.9 billion in fiscal year 2010, $4.4 billion of which was federal dollars.

Description of Condition

The Department completed 12 MEQC projects during the 2010 fiscal year. We reviewed two of them: Retroactive Medicaid Eligibility and Self-Employment Income Eligibility to determine if the Department followed up on any issues identified by the projects.

For these two projects, we found the MEQC process identified 443 eligibility determination errors. We selected a random sample of 20 identified errors from the first project, and 25 errors from the second project to determine if the Department reviewed the errors and took adequate corrective action. We found the Department did not take adequate corrective action for seven clients from our sample of 20 in the first project:

- For two cases we found no documentation to show staff responsible for follow up of eligibility errors was alerted to errors identified by MEQC.
- For five cases the Department did not receive income documentation that would allow a determination on client eligibility.

We found staff appropriately followed up on all eligibility errors found by the second project

Cause of Condition

The Department does not provide adequate training to eligibility staff to ensure they can correctly follow up on errors identified by MEQC.

Management does not sufficiently monitor to ensure adequate corrective action takes place in a timely manner.

Effect of Condition

Inadequate follow up on errors identified by MEQC increases the risk of individuals who are not eligible for Medicaid continuing to receive Medicaid benefits.

Recommendation

We recommend the Department:

- Provide adequate training to eligibility staff to ensure follow up on errors identified by MEQC.
- Strengthen monitoring to ensure adequate corrective action takes place in a timely manner.

Department's Response

The Department concurs with this finding.

Since the time this audit was conducted, the Department has formalized monitoring procedures for assigning, tracking and follow-up on the correction of errors identified through the MEQC reviews.

At the conclusion of a review, the MEQC Unit creates a spreadsheet (problem report), identifying potential errors. This spreadsheet is uploaded to Barcode and sent to the MEQC Program Manager at the Medicaid Purchasing Administration (MPA) for distribution to the field. The MEQC Program Manager organizes the problem report by Community Services Division Customer Service Center district (region), based on where the client resides. Each district specific report is sent to the appropriate district contact (a supervisor in the district office) for correction. The district contact (supervisor) assigns the case errors to staff in the district call center for correction.

The MPA MEQC Program Manager monitors the progress of corrections, and sends out follow-up reminders as necessary, to ensure all errors are corrected and reported back to the MEQC Unit within 45 days.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We look forward to reviewing the improvements the Department has implemented during our next audit.

Applicable Laws and Regulations

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

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

Title 42, code of Federal Regulation, Section 431 states in part:

> § 431.810 Basic elements of the Medicaid eligibility quality control (MEQC) program.
>
> (a) General requirements. The agency must operate the MEQC program in accordance with this section and §§431.812 through 431.822 and other instructions established by CMS.

(b) Review requirements. The agency must conduct MEQC reviews in accordance with the requirements specified in §431.812 and other instructions established by CMS.
(c) Sampling requirements. The agency must conduct MEQC sampling in accordance with the requirements specified in §431.814 and other instructions established by CMS.

§ 431.818 Access to records: MEQC program.

(a) The agency, upon written request, must mail to the HHS staff all records, including complete local agency eligibility case files or legible copies and all other documents pertaining to its MEQC reviews to which the State has access, including information available under part 435, subpart I, of this chapter.
(b) The agency must mail requested records within 10 working days of receipt of a request, unless the State has an alternate method of submitting these records that is approved by CMS or has received, on an as-needed basis, approval from CMS to extend this timeframe by 3 additional working days to allow for exceptional circumstan**ces.**

§ 431.820 Corrective action under the MEQC program.

The agency must—

(a) Take action to correct any active or negative case action errors found in the sample cases;
(b) Take administrative action to prevent or reduce the incidence of those errors; and
(c) By September 15 each year, submit to CMS a report on its error rate analysis and a corrective action plan based on that analysis. The agency must submit revisions to the plan within 60 days of identification of additional error-prone areas, other significant changes in the error rate (that is, changes that the State experiences that increase or decrease its error rate and necessitate immediate corrective action or discontinuance of corrective actions that effectively control the cause of the error rate change), or changes in planned corrective action.

10-47 The Department of Social and Health Services, Medicaid Purchasing Administration[4], does not have adequate controls in place to ensure all individuals who receive Medicaid benefits are financially eligible.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number	5-1005WA5MAP, 5-1005WA5ADM, 5-1005WAARRA
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	None

Background

The Medicaid program pays for medical assistance for certain individuals and families with low incomes and limited financial resources. Federal and state laws and regulations establish Medicaid eligibility requirements. To be eligible, an individual must, among other things, meet citizenship requirements; submit an application for Medicaid benefits; furnish his or her Social Security number; be eligible for the specific services received; and not exceed income and financial resource levels established in state regulation. Information to support the eligibility determination must be included in each applicant's case file.

The Department must include all household members when calculating income and resource eligibility. People who live together, such as families, whose income or resources are counted to decide eligibility, are termed an Assistance Unit.

Once the Department initially determines an applicant is eligible, it must annual re-verify information such as income to determine whether the individual still is eligible for benefits. Staff is required to document the results of the eligibility determinations.

More than 725,000 Assistance Units in Washington receive Medicaid benefits. Income and resource thresholds, which are subject to yearly adjustments, vary based on eligibility category and the number of family members in the Unit.

Description of Condition

We selected the Medical Coverage Group for Categorically Needy Children for review because it is the largest coverage group. More than 384,000 Units in this category received Medicaid benefits during the period July 1, 2009 through March 31, 2010.

We obtained income and eligibility data from the Department for that time period. We then sorted the Units with the Categorically Needy Children coverage designation into four groups: Units with one to two members, Units with three to four members, Units with five or more members, and Units with no reported net income. We randomly selected 200 Units for review to determine if the Department ensured that only members of financially eligible Units received benefits. No reported income was identified as a risk indicator since we would expect most units to have at least some reportable income. Additionally, the

[4] Formerly Health and Recovery Services Administration (HRSA)

results of prior quality assurance reviews at the Department have shown that Units with three or four members have a higher risk for error, so we weighted our sampling to include more Units in those categories.

We reviewed for the following criteria:

1. Evidence the Department did a review to account for all income generated by the Unit.
2. Evidence the Department adequately reviewed information and documents available in determining eligibility.
3. Sufficient documents to support the Department's eligibility determination.
4. Adequate documentation on how the Department calculated gross income used to determine eligibility.

We found exceptions in 15 out of 200 instances:

AU Description	Population	Sample size	Exceptions
AU net reported income less than $.05	83,239	70	5
AU with 1 & 2 members	221,107	30	1
AU with 3 & 4 members	68,742	70	4
AU with 5 or more members	10,945	30	5
Total	**384,033**	**200**	**15**

In 11 instances, net income used to determine income eligibility was not accurate or adequate. For example, the Department did not verify clients' income declarations and staff incorrectly deducted unallowable expenditures such as meals and home mortgage interest from gross income. We found 10 of the 11 instances were related to Units reporting income from self-employed individuals. Four other cases had errors in income calculation and allocation that could affect eligibility.

Cause of Condition

Department policies do not provide clear guidelines regarding what income documentation is required and how to review it.

Also, the Department does not provide adequate training to social workers to ensure they can correctly determine financial eligibility for the Medicaid program, especially for self-employed applicants.

Effect of Condition

Due to the lack of adequate controls, ineligible individuals could receive Medicaid benefits. The Department cannot support the eligibility of 15 out of 200 Assistance Units we reviewed. Projecting our results to the entire Categorically Needy Children population, this equates to anywhere from a low of 5,700 to a high of 32,000 Assistance Units whose eligibility determination is not supported.

Our audit work was designed to determine if the Department adequately determines and documents income eligibility. It was not designed to determine if those individuals or Units are eligible for Medicaid.

Recommendations

We recommend the Department provide the guidance, resources, and training needed to ensure staff can successfully determine which documents are required to determine Unit income and calculate income eligibility, especially when income cannot be independently verified, as with the self-employed.

Department's Response

The Department (Medicaid Purchasing Administration (MPA)) partially concurs with this finding.

The total children's medical caseload for July 1, 2009, through March 31, 2010, was at 384,033. Two hundred cases were sampled, and 15 cases were cited with exceptions. The department (MPA) agrees that two of the 15 cases lacked income documentation to determine if the clients were eligible for medical coverage. To address this, the department (MPA) will continue to provide ongoing training and guidance to staffs on income calculation and on the need for documentation. This will help eliminate these procedural errors without creating barriers for applicants or delaying access to medical care.
The department (MPA) disagrees with the other thirteen cases, which contained procedural errors even though the clients remained eligible for medical benefits. The procedural errors amounted to weak verification of determining accountable household income for self-employed individuals. Additionally, per RCW 74.09.402 (WAC 388-416-0015), children's medical cases remain open for a 12-month continuous certification period, regardless of changes other than death, moving out of Washington State, or aging out of the program. This means that any increase in income during the audit certification period would not affect the children's eligibility during those 12 months.

Auditor's Concluding Remarks

We thank the Department for its response, and will follow up during our next audit.

Sampling Method

We used the U.S. Department of Health and Human Services, Office of Inspector General- Office of Audit Services appraisal programs to estimate the total number of Assistance Units for which Medicaid income eligibility determinations made by the Department were not reliable.

Projection of Sample Results	
Precision at the 90-Percent Confidence Level	
	Attributes Appraisal
Midpoint	19,068
Lower limit	5,784
Upper limit	32,352

Extrapolating the results of our statistical sample to the entire Categorically Needy Children program, we estimate the number of possible Units that Medicaid income eligibility determinations made by the Department might not be reliable could range between the lower limit of our projected results (5,784) and the upper limit (32,352).

These Units have a higher chance of not meeting the income eligibility of the Medicaid program. Individuals who are members of financially ineligible AUs are not eligible for Medicaid benefits.

Applicable Laws and Regulations

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

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

Title 42, code of Federal Regulations, Section 435 states in part:

§ 435.948 Requesting information.

(a) Except as provided in paragraphs (d), (e), and (f) of this section, the agency must request information from the sources specified in this paragraph for verifying Medicaid eligibility and the correct amount of medical assistance payments for each applicant (unless obviously ineligible on the face of his or her application) and recipient. The agency must request—

(1) State wage information maintained by the SWICA during the application period and at least on a quarterly basis;

(2) Information about net earnings from self-employment, wage and payment of retirement income, maintained by SSA and available under Section 6103(l)(7)(A) of the Internal Revenue Code of 1954, for applicants during the application period and for recipients for whom the information has not previously been requested;

(3) Information about benefit and other eligibility related information available from SSA under titles II and XVI of the Social Security Act for applicants during the application period and for recipients for whom the information has not previously been requested;

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

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

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

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

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

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

(i) AFDC;

(ii) Medicaid;

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

(iv) SWICA;

(v) Unemployment compensation;

(vi) Food stamps; and

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

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

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

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

basis, and from unemployment compensation agencies only during the application period. An individual is institutionalized for purposes of this section when he or she is required to apply his or her income to the cost of medical care as required by §§435.725, 435.733, and 435.832.

(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 the agency administering the AFDC program, or SSA under section 1634 of the Act, determines the eligibility of an applicant or recipient, the requirements of this section do not apply to that applicant or recipient.

§ 435.1002 FFP for services.

(a) Except for the limitations and conditions specified in §§435.1007, 35.1008, 435.1009, and 438.814 of this chapter, FFP is available in expenditures for Medicaid services for all recipients whose coverage is required or allowed under this part.

(b) FFP is available in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided except that, for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the recipient's liability. (See §§435.914 and 436.901 of this subchapter for regulations on retroactive eligibility for Medicaid.)

(c) FFP is available in expenditures for services covered under the plan that are furnished—

(1) To children who are determined by a qualified entity to be presumptively eligible;

(2) During a period of presumptive eligibility;

(3) By a provider that is eligible for payment under the plan; and

(4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

§ 435.916 Periodic redeterminations of Medicaid eligibility.

(a) The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months, however—

(1) The agency may consider blindness as continuing until the review physician under §435.531 determines that a recipient's vision has improved beyond the definition of blindness contained in the plan; and

(2) The agency may consider disability as continuing until the review team under §435.541 determines that a recipient's disability no longer meets the definition of disability contained in the plan.

(b) *Procedures for reporting changes.* 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.

(c) *Agency action on information about changes.* (1) The agency must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility.

(2) If the agency has information about anticipated changes in a recipient's circumstances, it must redetermine eligibility at the appropriate time based on those changes.

Washington Administration Code (WAC) 388-450-0215 states: *How does the department estimate my assistance unit's income to determine my eligibility and benefits?*

(1) We decide if your assistance unit (AU) is eligible for benefits and calculate your monthly benefits based on an estimate of your AU's gross monthly income and expenses. This is known as prospective budgeting.

(2) We use your current, past, and future circumstances for a representative estimate of your monthly income.

(3) We may need proof of your circumstances to ensure our estimate is reasonable. This may include documents, statements from other people, or other proof as explained in WAC 388-490-0005.

(4) We use one of two methods to estimate income:

(a) Anticipating monthly income (AM): With this method, we base the estimate on the actual income we expect your AU to receive in the month (see subsection (5)); and

(b) Averaging income (CA): With this method, we add the total income we expect your AU to receive for a period of time and divide by the number of months in the period (see subsection (6)).

(5) Anticipating monthly income: We must use the anticipating monthly method:

(a) For the month you apply for benefits unless:

(i) We are determining eligibility for children's medical programs as listed in WAC 388-505-0210 (3) through (6) or pregnancy medical as listed in WAC 388-462-0015. For children's and pregnancy medical we can use either method; or

(ii) You are paid less often than monthly (for example: you are paid quarterly or annually). If you are paid less often than monthly, we average your income for the month you apply. Section (6) explains how we average your income.

(b) When we estimate income for anyone in your AU, if you or anyone in your AU receive SSI-related medical benefits under chapter 388-475 WAC.

(c) When we must allocate income to someone who is receiving SSI-related medical benefits under chapter 388-475 WAC.

(d) When you are a destitute migrant or destitute seasonal farmworker under WAC 388-406-0021. In this situation, we must use anticipating monthly (AM) for all your AU's income.

(e) To budget SSI or Social Security benefits even if we average other sources of income your AU receives.

(6) Averaging income: When we average your income, we consider changes we expect for your AU's income. We determine a monthly amount of your income based on how often you are paid:

(a) If you are paid weekly, we multiply your expected income by 4.3;

(b) If you are paid every other week, we multiply your expected income by 2.15;

(c) In most cases if you receive your income other than weekly or every other week, we estimate your income over your certification period by:

(i) Adding the total income for representative period of time;

(ii) Dividing by the number of months in the time frame; and

(iii) Using the result as a monthly average.

(d) If you receive your yearly income over less than a year because you are self employed or work under a contract, we average this income over the year unless you are:

(i) Paid on an hourly or piecework basis; or

(ii) A migrant or seasonal farmworker under WAC 388-406-0021.

(7) If we used the anticipating monthly income method for the month you applied for benefits, we may average your income for the rest of your certification period if we do not have to use this method for any other reason in section (5).

(8) If you report a change in your AU's income, and we expect the change to last through the end of the next month after you reported it, we update the estimate of your AU's income based on this change.

(9) If your actual income is different than the income we estimated, we don't make you repay an overpayment under chapter 388-410 WAC or increase your benefits unless you meet one of the following conditions:

(a) You provided incomplete or false information; or
(b) We made an error in calculating your benefits.

Washington Administrative Code (WAC) 388-503-0505 General eligibility requirements for medical programs states:

1. Persons applying for benefits under the medical coverage programs established under chapter 74.09 RCW must meet the eligibility criteria established by the department in chapters 388-400 through 388-555 WAC.
2. Persons applying for medical coverage are considered first for federally funded or federally matched programs. State-funded programs are considered after federally funded programs and are not available to the client except for brief periods when the state-funded programs offer a broad scope of care which meet a specific client need.
3. Unless otherwise specified in program specific WAC, the eligibility criteria for each medical program is as follows:
   a. Verification of age and identity (chapters 388-404, 388-406, and 388-490 WAC); and
   b. Residence in Washington state (chapter 388-468 WAC); and
   c. Citizenship or immigration status in the United States (chapter388-424 WAC); and
   d. Possession of a valid Social Security Account Number (chapter 388-476 WAC); and
   e. Assignment of medical support rights to the state of Washington (388-505-0540); and
   f. Cooperation in securing medical support (chapter 388-422 WAC); and
   g. Application for Medicare and enrollment into Medicare's prescription drug program if:
      i. It is likely that the individual is entitled to Medicare; and
      ii. The state has authority to pay Medicare cost sharing as described in chapter 388-517 WAC.
   h. Countable resources within program limits (chapters 388-470 and 388-475 and 388-478 WAC); and
   i. Countable income within program limits (chapters 388-450 and 388-475 and 388-478 WAC).
4. In addition to the general eligibility requirements in subsection (3) of this section, each program has specific eligibility requirements as described in applicable WAC.
5. Persons living in a public institution, including a correctional facility, are not eligible for the department's medical coverage programs. For a person under age twenty or over age sixty-five who is a patient in an institution for mental disease, see WAC 388-513-1315 (13) for exception.
6. Persons terminated from SSI or TANF cash grants and those who lose eligibility for categorically needy (CN) medical coverage have their CN coverage continued while their eligibility for other medical programs is redetermined. This continuation of medical coverage is described in chapter 388-434 WAC.

Washington Administrative Code (WAC) 388-478-0065 Income and resource standards for family medical programs states:

1. The categorically needy income level (CNIL) standard for family medical is the same as the grant payment standards for the TANF cash program as stated in WAC 388-478-0020.
2. The countable resource standards for family medical are the same as those of the TANF/SFA cash program as stated in WAC 388-470-0005.
3. Each unborn child is counted as a household member when determining household size for:
   1. Family medical
   2. Pregnancy medical; and
   3. Children's medical.

Washington Administrative Code (WAC) 388-505-0210 Apple Health for Kids Programs (Emergency Effective 4-1-2010) states:

Funding for coverage under Apple Health for Kids may come through Title XIX (medicaid), Title XXI (CHIP), or through state-funded programs. There are no resource limits for the Apple Health for Kids programs. Apple Health for Kids coverage is free to children in households with incomes of no more than two-hundred percent of the federal poverty level (FPL), and available on a premium basis to children in households with incomes of no more than three-hundred percent FPL.

1. Newborns are eligible for federally matched categorically needy (CN) coverage through their first birthday when:
   a. The newborn's mother is eligible for medical assistance:
      i. On the date of the newborn's birth, including a retroactive eligibility determination; or
      ii. Based on meeting a medically needy (MN) spenddown liability with expenses incurred on, or prior to, the date of the newborn's birth.
   b. The newborn is a resident of the state of Washington.
2. Children under the age of nineteen who are U.S. citizens, U.S. nationals, or qualified aliens as described in WAC 388-424-0001 and WAC 388-424-0006 (1), (4) and (5) are eligible for free federally matched CN coverage when they meet the following criteria:
   a. State residence as described in chapter 388-468 WAC;
   b. A social security number or application as described in chapter 388-476 WAC;
   c. Proof of citizenship or immigrant status and identity as required by WAC 388-490-0005 (11);
   d. Family income is at or below two-hundred percent Federal Poverty Level (FPL) as described in WAC 388-478-0075 at each application or review; or
   e. They received supplemental security income (SSI) cash payments in August 1996 and would continue to be eligible for those payments except for the August 1996 passage of amendments to federal disability definitions.
   f. They are eligible for SSI-related CN coverage.
3. Non-citizen children under the age of nineteen, who do not meet qualified alien or permanently residing under color of law (PRUCOL) status as described in WAC 388-424-0006, are eligible for free state funded coverage with the same scope of services as children covered by CN medicaid when they meet the following criteria:
   a. State residence as described in chapter 388-468 WAC; and
   b. Family income is at or below two hundred percent FPL at each application or review.
4. Children under the age of nineteen who are U.S. citizens, U.S. nationals, or qualified aliens as described in WAC 388-424-0001 and 388-424-0006 (1), (4), and (5) are eligible for premium-based federally-matched CN coverage as described in chapter 388-542 WAC when they meet the following criteria:
   a. State residence as described in chapter 388-468 WAC;
   b. A social security number or application as described in chapter 388-476 WAC;
   c. Proof of citizenship or immigrant status and identity as required by WAC 388-490-0005 (11);
   d. Family income is over two-hundred percent FPL, as described in WAC 388-478-0075, but not over three-hundred percent FPL at each application or review;
   e. They do not have other creditable health insurance as described in WAC 388-542-0050; and
   f. They pay the required monthly premiums as described in WAC 388-505-0211.
5. Noncitizen children under the age of nineteen, who do not meet qualified alien or PRUCOL status as described in WAC 388-424-006, are eligible for premium-based state-funded coverage with the same scope of services as children covered by CN medicaid when they meet the following criteria:
   a. State residence as described in chapter 388-468 WAC;
   b. Family income is over two-hundred percent FPL, as described in WAC 388-478-0075, but not over three-hundred percent FPL at each application or review;
   c. They do not have other creditable health insurance as described in WAC 388-542-0050; and
   d. They pay the required monthly premium as described in WAC 388-505-0211.

7. Children under the age of nineteen who reside or are expected to reside in a medical institution, intermediate care facility for the mentally retarded (ICF/MR), hospice care center, nursing home, institution for mental diseases (IMD) or inpatient psychiatric facility may be eligible for Apple Health for Kids healthcare coverage based upon institutional rules described in WAC 388-505-0260. Individuals between the age of nineteen and twenty-one may still be eligible for healthcare coverage but not under Apple Health for Kids. See WAC 388-505-0230 "Family related institutional medical" and WAC 388-513-1320 "Determining institutional status for long-term care" for more information.
8. Children who are in foster care under the legal responsibility of the state, or a federally recognized tribe located within the state, and who meet eligibility requirements for residency, social security number, and citizenship are eligible for federally-matched CN medicaid coverage through the month of their:
   a. Eighteenth birthday;
   b. Twenty-first birthday if the Children's Administration determines they remain eligible for continued foster care services; or
   c. Twenty-first birthday if they were in foster care on their eighteenth birthday and that birthday was on or after July 22, 2007.
9. Children are eligible for state-funded CN coverage through the month of their eighteenth birthday if they:
   a. Are in foster care under the legal responsibility of the state or a federally-recognized tribe located within the state; and
   b. Do not meet social security number and citizenship requirements in subsection (2) (a) and (b) of this section.
10. Children who receive subsidized adoption services are eligible for federally matched CN coverage.
11. Children under the age of nineteen not eligible for apple health for kids programs listed above may be eligible for one of the following medical assistance programs not included in apple health for kids:
   a. Family medical as described in WAC 388-505-0220;
   b. Medical extensions as described in WAC 388-523-0100; or
   c. SSI-related MN if they:
      i. Meet the blind and/or disability criteria of the federal SSI program, or the condition of subsection (2) (e); and
      ii. Have countable income above the level described in WAC 388-478-0070 (1).
   d. Home and community based waiver programs as described in chapter 388-515 WAC; or
   e. Alien medical as described in WAC 388-438-0110, if they:
      i. Have a documented emergency medical condition as defined in WAC 388-500-0005;
      ii. Have income more than three hundred percent FPL; or
      iii. Have income less than three hundred percent FPL, but do not qualify for premium-based coverage described in subsection (5) of this section because of creditable coverage.
12. Except for a child described in subsection (7), an inmate of a public institution, as defined in WAC 388-500-0005, is not eligible for any Apple Health for Kids program.

10-48 The Department of Social and Health Services' internal controls are inadequate to ensure non-emergency medical transportation expenditures are allowable and adequately supported.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Activities Allowed/Unallowed, Allowable Costs/Cost Principles
Questioned Cost Amount:	None

Background

The Department of Social and Health Services provides eligible Medicaid recipients transportation to and from non-emergency, medically-necessary appointments. Medicaid clients who qualify are either provided transportation or are reimbursed for their travel costs. The appointments must be for services eligible to be paid by the Medicaid program.

Transportation services include public transit, client and volunteer mileage reimbursement, wheel chair-equipped vans, taxis, ferries and fuel vouchers. In less frequent cases, if a client must travel to a distant provider, lodging and food may be included.

Since 1989, Washington State has used a brokerage system to provide non-emergency medical transportation for eligible Medicaid clients. Brokers contract with the Department to deal directly with the clients to arrange, authorize or deny transportation services. Brokers decide the form of transportation a client receives.

Brokers are expected to verify the client's eligibility in the Department database and to authorize or deny the transportation request based on whether it is medically necessary. Brokers are responsible for contracting with transportation providers. The brokers keep all documentation to support eligibility determinations; the providers keep documentation supporting the trip.

It is the responsibility of the Department to monitor the brokers to ensure they and the providers comply with federal and state Medicaid regulations and that transportation services are legitimate, allowable, reasonable and adequately supported.

The state has eight brokers in 13 regions and spent approximately $75 million on the program in fiscal year 2010.

Description of Condition

During the previous two audits, we reported that the Department did not adequately monitor brokers to ensure non-emergency transportation expenditures are allowable and supported. To address our concerns, the Department developed monitoring protocols and planned on performing on-site monitoring of the brokers. However, on-site monitoring did not occur during state fiscal year 2010.

Cause of Condition

The Department stated that travel restrictions imposed by the Governor due to budget cuts prevented it from performing on-site monitoring. Although the Department has offices across the state, due to program complexity only staff in the nonemergency medical transportation program located in Olympia have been trained to perform this monitoring.

Effect of Condition

Without adequate monitoring, the Department cannot ensure non-emergency medical transportation expenditures are legitimate, reasonable and adequately supported.

Recommendation

We recommend the Department monitor transportation broker contracts and operations to ensure all Medicaid rules are followed and services the brokers provided are legitimate, reasonable and adequately supported.

Department's Response

The Department (Medicaid Purchasing Administration (MPA)) partially concurs with this finding.

We acknowledge that on-site monitoring of activities for the transportation brokers was not completed according to the monitoring plan for 2010 which was primarily due to the state's freeze on all non-essential travel during the current fiscal crisis, temporary layoffs, work required for the re-procurement of these contracts.

However, the Department (MPA) was able to make improvements in the following areas:

- *Staff accomplished a less formal review of several components of the desk monitoring tool to include: communications with contractors regarding the Financial & Operating Reports and the fleet inventories/inspection schedules;*
- *Staff completed monthly reviews of the Broker A-19's and report packets;*
- *Broker reports of accidents and incidents (another component of the desk monitoring tool), were recorded in a separate risk management database;*
- *Copies of the annual independent audits of the brokers were requested and reviewed;*
- *Coordinated with federal partners regarding the monitoring and audit activities of another large broker;*
- *Developed an "individual trips" database to allow for improved monitoring capabilities which was necessitated by the fact that we received CMS's approval to change the transportation program from administrative to medical match. This database, for example, will allow us to match a client and their trip to a covered medical service; and*
- *During the development of the procurement products and the resulting new contracts, we have improved several quality standards in the contract requirements, and we will be adding these new elements to a revised monitoring tool.*

All these refinements will result in a dramatically improved desk monitoring capability, the effectiveness of which will be increased by the performance clauses contained in the new brokerage contracts. Finally, we are planning at least one on-site monitoring visit per broker in 2011.

Auditor's Concluding Remarks

We thank the Department for its response and commitment to monitoring brokers to ensure all Medicaid rules are followed and services the brokers provided are legitimate, reasonable and supported. We look forward to reviewing the improvements the Department has implemented during our next audit.

Applicable Laws and Regulations

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

Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments* (2 CFR 225), states:

Appendix A, Section C - Basic Guidelines:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
   a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
   d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
   j. Be adequately documented.
2. Reasonable costs. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. The question of reasonableness is particularly important when governmental units or components are predominately federally-funded. In determining reasonableness of a given cost, consideration shall be given to:
   a. Whether the cost is of a type generally recognized as ordinary and necessary for the operation of the governmental unit or the performance of the Federal award.
   b. The restraints or requirements imposed by such factors as: Sound business practices; arm's-length bargaining; Federal, State and other laws and regulations; and, terms and conditions of the Federal award.
   c. Market prices for comparable goods or services.
   d. Whether the individuals concerned acted with prudence in the circumstances considering their responsibilities to the governmental unit, its employees, the public at large, and the Federal Government.
   e. Significant deviations from the established practices of the governmental unit which may unjustifiably increase the Federal award's cost.

Washington Administrative Code (WAC) 388-546-5100 Nonemergency transportation program scope of coverage

(1) The department's health and recovery services administration (HRSA) covers transportation that is necessary for its clients to receive medically necessary HRSA covered services. See WAC 388-546-0100 through 388-546-1000 for Ambulance transportation that covers emergency ambulance transportation and limited nonemergency ground ambulance transportation as medical services.

(2) Licensed ambulance providers, who contract with HRSA's transportation brokers, may be reimbursed for nonemergency transportation services under WAC 388-546-5200 as administrative services.

(3) HRSA covers nonemergency transportation under WAC 388-546-5000 through 388-546-5500 as an administrative service as provided by the Code of Federal Regulations (42 CFR 431.53 and 42 CFR 440.170 (a)(2)). As a result, clients may not select the transportation provider(s) or the mode of transportation (service mode).

(4) Prior authorization by HRSA is required for all out-of-state nonemergency transportation. Border areas as defined by WAC 388-501-0175 are considered in-state under this section and subsequent sections.
   (a) HRSA reviews requests for out-of-state nonemergency transportation in accordance with regulations for covered healthcare services, including WAC 388-501-0180, 388-501-0182 and 388-501-0184.
   (b) Nonemergency transportation is not provided to or from locations outside of the United States and U.S. territories, except for the limitations for British Columbia, Canada, identified in WAC 388-501-0184.
(5) HRSA requires all nonemergency transportation to and from covered services to meet the following:
   (a) The covered service must be medically necessary as defined in WAC 388-500-0005;
   (b) It must be the lowest cost available service mode that is both appropriate and accessible to the client's medical condition and personal capabilities; and
   (c) Be limited to the local provider of type as follows:
      (i) Clients receiving services provided under HRSA's fee-for-service program may be transported only to the local provider of type. HRSA's transportation broker is responsible for considering and authorizing exceptions.
      (ii) Clients enrolled in HRSA's managed care (healthy options) program may be transported to any provider supported by the client's managed care plan. Clients may be enrolled in a managed care plan but are obtaining a specific service not covered under the plan. The requirements in subsection (5)(c)(i) apply to these fee-for-service services.
(6) HRSA does not cover nonemergency transportation services if the covered medical services are within three-quarters of a mile walking distance from the client's residence. Exceptions to this rule may be granted by HRSA's transportation broker based on the client's documented medical condition or personal capabilities, or based on safety or physical accessibility concerns, as described in WAC 388-546-5400(1).
(7) A client must use personal or informal transportation alternatives if they are available and appropriate to the client's needs.
(8) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed-route public transportation system unless the need for more specialized transportation is present and documented. Examples of such a need are the client's use of a portable ventilator, a walker or a quad cane.
(9) HRSA does not cover any nonemergency transportation service that is not addressed in WAC 388-546-1000 or in 388-546-5000 through 388-546-5500. See WAC 388-501-0160 for information about obtaining approval for noncovered transportation services, known as exception to rule (ETR).
(10) If a medical service is approved by ETR, both the broker and MAA must separately prior approve transportation to that service.
(11) HRSA may exempt members of federally recognized Indian tribes from the brokered transportation program. Where HRSA approves the request of a tribe or a tribal agency to administer or provide transportation services under WAC 388-546-5000 through 388-546-5400, tribal members obtain their transportation services as provided by the tribe or tribal agency.
(12) A client who is denied service under this chapter may request a fair hearing per chapter 388-02 WAC.

Washington Administrative Code (WAC) 388-546-5200 Nonemergency transportation program broker and provider requirements.

(1) MAA requires that all nonambulance transportation providers serving MAA clients be under subcontract with the department's contracted transportation broker. MAA's transportation brokers may subcontract with ambulance providers for nonemergency trips in licensed ground ambulance vehicles as administrative services. See WAC 388-546-5100(2).

(2) MAA requires all contracted and subcontracted transportation providers under this chapter to be licensed, equipped, and operated in accordance with applicable federal, state, and local laws.
(3) MAA's transportation brokers determine the level of transportation service needed by the client and the mode of transportation to be used for each authorized trip.
(4) MAA's transportation brokers must comply with the terms specified in their contracts.
(5) MAA's transportation brokers may require up to forty-eight hours advance notice of a requested trip (see WAC 388-546-5300(2)) with the exception of hospital requests or urgent care trips. MAA allows its transportation brokers to accommodate requests that provide less than forty-eight hours advance notice, within the limits of the resources available to a broker at the time of the request.
(6) If MAA's transportation broker is not open for business and unavailable to give advance approval for a hospital discharge or urgent care request as described in subsection (5), the subcontracted transportation provider must either:
(a) Provide the transportation in accordance with the broker's instructions and request an after-the-fact authorization from the transportation broker within seventy-two hours of the transport; or
(b) Deny the transportation, if the requirements of this section cannot be met.
(7) If the subcontracted transportation provider provides transportation as described in subsection (6), the broker may agree to grant retroactive authorization as provided in WAC 388-546-5300(3). Such retroactive authorization must be:
(a) Documented as to the reasons retroactive authorization is needed; and
(b) Agreed to by the broker within seventy-two hours after the transportation to a medical appointment.
(8) MAA, through its transportation brokers, does not pay for transportation under the following conditions:
(a) Clients are not eligible for transportation services when medical services are within reasonable walking distance (normally three-quarters of a mile actual traveling distance), taking into account the client's documented medical condition and personal capabilities (see WAC 388-546-5100(6));
(b) Clients must use personal or informal transportation alternatives if they are available and appropriate to the clients' needs (see WAC 388-546-5100(7));
(c) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed route public transportation under the terms of WAC 388-546-5100(8);
(d) MAA or MAA's transportation broker may deny transportation services requested if the request is not necessary, suitable, or appropriate to the client's medical condition (see WAC 388-546-5100 (1) and (5)(a));
(e) The medical services requiring transportation must be services that are covered by the client's medical program (see WAC 488-546-5100(1)); or
(f) The transportation selected by the broker for the client must be the lowest cost available alternative that is both appropriate and accessible to the client's medical condition and personal capabilities.
(9) The transportation broker mails a written notice of denial to each client who is denied coverage of transportation within three business days of the denial.

Washington Administrative Code (WAC) 388-546-5300 Nonemergency transportation program client requirements.

(1) Clients must be compliant with MAA's transportation brokers, the brokers' subcontracted transportation providers, and MAA's medical services providers. A client who is in noncompliance may have limited transportation service mode options available. The broker mails the client a written notice of limited transportation service mode options within three business days of the broker's decision that transportation service mode options are limited.

(2) Clients must request, arrange and obtain authorization for transportation forty-eight hours in advance of a medical appointment. Exceptions to the forty-eight-hour advance arrangements are described in subsection (3) of this section and in WAC 388-546-5200 (5) and (6).
(3) If MAA's contracted broker is not open for business at the time nonemergency transportation is needed, the client must follow the transportation broker's instructions to obtain transportation service.
(4) MAA will cover a clients transportation to medically necessary covered services with local providers of type. Transportation services will be covered to nonlocal providers of type in the following circumstances:
  (a) The client is enrolled in a healthy options managed health care plan and the client's primary care provider (PCP) or a PCP referred provider is not the closest available provider;
  (b) The client's service is covered by a third party payer and the payer requires or refers the client to a specific provider;
  (c) A charitable or other voluntary program (e.g., Shriners) is paying for the client's medical service;
  (d) The medical service required by the client is not available within the local healthcare service area;
  (e) The total cost to MAA is lower when the services are obtained outside of the local healthcare service area; or
  (f) The out-of-area service is required to provide continuity of care for the client's ongoing care as:
    (i) Documented by the client's primary care provider; and
    (ii) Agreed to by MAA's contracted transportation broker.
(5) MAA may require transportation brokers to refer any of the exception categories listed in subsection (4) to MAA's medical director or the medical director's designee for review and/or prior authorization of the medical service.
(6) If local medical services are not available to a client because of noncompliance with MAA's transportation brokers, the brokers' subcontracted transportation providers, or MAA's medical services providers, MAA does not cover nonemergency transportation to out-of-area medical services for the client. MAA's contracted broker mails a written notice to the client within three business days of the broker's determination that the client's documented noncompliance results in a denial to out-of-area transportation services.

Washington Administrative Code (WAC) 388-546-5400 Nonemergency transportation program general reimbursement limitations.

(1) To be reimbursed, MAA requires that a trip be a minimum of three-quarters of a mile from pick-up point to drop off point (see WAC 388-546-5100(6)). MAA's transportation broker may grant exceptions to the minimum distance requirement for any of the following conditions:
  (a) When there is medical justification for a shorter trip;
  (b) When the trip involves an area that MAA's contracted broker considers to be unsafe for the client, other riders, or the driver; or
  (c) When the trip involves an area that the broker determines is not physically accessible to the client.
(2) MAA reimburses for return trips from covered medical services if the return trips are directly related to the original trips. MAA, through its transportation broker, may deny coverage of a return trip if any delays in the return trip are for reasons not directly related to the original trip.
(3) MAA does not reimburse any costs related to intermediate stops that are not directly related to the original approved trip.
(4) MAA's transportation broker may authorize intermediate stops that are directly related to the original approved trip if the broker determines that the intermediate stop is likely to limit or

eliminate the need for supplemental covered trips. MAA considers the following reasons to be related to the original trip:

(a) Transportation to and from an immediate subsequent medical referral; or

(b) Transportation to a pharmacy to obtain one or more prescriptions when the pharmacy is within a reasonable distance of the original medical appointment route.

(5) MAA may pay the costs of meals and lodging for clients who must be transported to out-of-area medical services. MAA's transportation brokers make the determination that meals and lodging are necessary based on client need and the reasonableness of costs (as measured against state per diem rates).

(6) MAA may pay transportation costs, including meals and lodging, for authorized escorts. MAA's transportation brokers make the determination that the costs of escorts are necessary based on client need and reasonableness of costs (as measured against state per diem rates).

(7) MAA does not provide escorts or pay the wages of escorts. MAA does not pay for the transportation of an escort when the client is not present unless the broker documents exceptional circumstances causing the broker to determine that the service is necessary to ensure that the client has access to medically necessary care.

(8) MAA may reimburse for the transportation of a guardian with or without the presence of the client if the broker documents its determination that such a service is necessary to ensure that the client has access to medically necessary care.

10-49 The Department of Social and Health Services did not have adequate controls to ensure the federal share of overpayments made to Medicaid providers are refunded to the federal government in an accurate and 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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Allowable Costs/Cost Principles
Questioned Cost Amount:	None

Background

Most Medicaid expenditures are payments to providers of medical treatment, prescriptions, medical equipment, home health care, and other services. Providers submit payment claims to the Department of Social and Health Services. Since October 1, 2008, more federal dollars have been available for these payments, known as the Federal Medical Assistance Percentage (FMAP) due to the American Recovery and Reinvestment Act of 2009. This means the state has been receiving federal money to pay for more than 60 percent of Medicaid costs, up from the previous 50 percent.

The Department has a number of post-payment audits designed to identify and recover overpayments. When it finds overpayments, the Department has one year from the date of discovery to pay back to the federal government its share of overpayments, even if the state has not recovered the overpayment from the provider. The state does not have to refund the overpayment if the provider has filed for bankruptcy or has gone out of business.

When they find overpayments, Department Administrations are responsible for forwarding that information to the Office of Financial Recovery (OFR), the official collection agency for the Department . OFR tracks the overpayment recoupment process and works with the Office of Accounting Services (OAS) to ensure the federal share of overpayments is refunded. If overpayment information is not forwarded to OFR, the federal portion of the overpayment will not be refunded to the federal government.

The federal Medicaid program operates on a reimbursement basis, meaning the state pays program costs and then submits a claim to the federal government to recover the costs. Because of this, payments owed to the federal government are made by reducing the amount of the reimbursement requested.

The state had Medicaid expenditures of approximately $6.9 billion in fiscal year 2010, approximately $4.4 billion of which was federal dollars.

Description of Condition

In our audits for fiscal years 2005 through 2009, we reported findings relating to the Department's inadequate controls over overpayment refunding. To address our recommendation, the Department requiring OFR to send monthly notices to Department Administrations reminding them to provide timely referral of all overpayments to OFR for collection and reimbursement to the federal government. OFR was to request confirmation from each Administration that all overpayments had been forwarded.

However, the Department did not follow this policy.

Cause of Condition

OFR stated that due to staffing reductions, it discontinued the monthly notices.

Effect of Condition

Without adequate monitoring of overpayment reporting, the Department cannot ensure the federal share of overpayments is refunded to the federal government in an accurate and timely manner. By not reporting overpayments in a timely manner, the Department effectively denied the grantor the use of funds that otherwise would have been available for the Medicaid program.

Recommendation

We recommend the Department follow its own policy and monitor to ensure all overpayments discovered are forwarded to OFR and subsequently refunded to the federal government in a timely manner.

Department's Response

The Department concurs with the finding with qualifications. The Department's Office of Financial Recovery (OFR) has found that reminders have been ineffective in ensuring timely overpayment referrals. In addition, the reminders have not provided a good return on investment. OFR will comply with current requirements while working to revise the policy.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

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

Patient Protection and Affordable Care; as amended by the Health Care and Education Reconciliation Act of 2010, together called the Affordable Care Act (ACA): SEC. 6506. "OVERPAYMENTS."

> (a) Extension of Period for Collection of Overpayments Due to Fraud-
>
> (1) IN GENERAL- Section 1903(d)(2) of the Social Security Act (42 U.S.C. 1396b(d)(2)) is amended-
>
> (A) in subparagraph (C)--
>
> (i) in the first sentence, by striking `60 days' and inserting `1 year'; and
>
> (ii) in the second sentence, by striking `60 days' and inserting `1-year period'; and
>
> (B) in subparagraph (D)--
>
> (i) in inserting `(i)' after `(D)'; and
>
> (ii) by adding at the end the following:
>
> `(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as

applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.'.

(2) EFFECTIVE DATE- The amendments made by this subsection take effect on the date of enactment of this Act and apply to overpayments discovered on or after that date.

(b) Corrective Action- The Secretary shall promulgate regulations that require States to correct Federally identified claims overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate corrective action.

Title 42, Code of Federal Regulations, Section 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.

Title 42, Code of Federal Regulations, Section 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.

Title 42, Code of Federal Regulations, Section 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...

Office of Financial Recovery: Financial Policy No. 002 states in part:

PURPOSE:
This policy describes administrative and legal authorities which require the Department to identify and collect all overpayments from clients or vendors and the administrative requirement that the Department provide timely overpayment notices to the Office of Financial Recovery (OFR).

SCOPE:
The scope of this policy applies to all overpayments identified and assessed by the Department.

POLICY:
1. Department Administrations shall be responsible for providing timely overpayment referrals as they occur to OFR for collection.
2. OFR will be responsible for providing monthly notices to Department Administrations reminding them to submit all overpayments to OFR for collection and reimbursement to the federal government as required by administrative policy and law.
3. Each month, the OFR Chief will request confirmation from each Department Administration that they are in compliance with this policy.

10-50 The Department of Social and Health Services paid Medicaid providers for services that were not provided to Medicaid beneficiaries.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Activities Allowed or Unallowed
Questioned Cost Amount:	$ 30,408.79 Non-ARRA $ 7,622.59 ARRA

Background

Medicaid is a state and federal partnership that provides coverage for certain low–income individuals who might otherwise go without medical care. The state Medicaid program spent more than $6.9 billion in state and federal dollars during fiscal year 2010.

Federal regulations state an overpayment is the amount a Medicaid agency paid to a provider in excess of the amount allowable for furnished services. Therefore, most payments to providers after the date of a Medicaid client's death are classified as overpayments.

The Department of Social and Health Services receives data from the state Department of Health quarterly that it uses to identify deceased Medicaid clients. These clients are to be removed from the program. The Department also runs a data query that identifies Medicaid services paid after a client's date of death. Once identified, the Department starts a process to recoup the payments made after the client's date of death.

Description of Condition

We analyzed Medicaid claims paid through the Department's Medicaid claim processing systems: Medicaid Management Information system (MMIS) and Social Service Payment System (SSPS) from July 1, 2009, to April 30, 2010 and identified 2,637 Medicaid beneficiaries who appeared to receive Medicaid services after their deaths. The Department paid $2,577,367.32 for those services.

We selected 351 of those Medicaid beneficiaries based on the number of payments and the total amount paid. The Department paid a total of $809,517.91 to providers for services to these Medicaid beneficiaries. We reviewed all detailed transactions and noted services had been provided to 269 of these clients prior to their death. We also noted the Department paid a total of $4,099.18 for allowable services such as monthly insurance premiums and monthly medical emergency response services in the month of beneficiaries' deaths. These expenditures are allowable because services are charged for a month.

The table below summarizes the results of our work:

Description	MMIS			SSPS		
	Clients	Payments	Questioned Costs	Clients	Payments	Questioned Costs
Services provided before date of death. Payments allowable	17*	$187,167.80	0	252*	$474,396.93	0
Services provided after date of death. Recoupment started.	8	$28,265.87	0	21	$55,163.31	0
Payments covered for the month of beneficiaries' deaths. Allowable	6	$998.77	$0.00	68	$3,100.41	$0.00
Services provided after date of death. Payments unallowable		$3,266.47	$3,266.47		$57,158.35	$57,158.35
Total	30*	$219,698.91	$3,266.47	321	$589,819.00	$57,158.35

*Clients possible in more than one category, which is why the number of exceptions is higher than the number of clients reviewed. Related expenditures are not duplicated.

The Department paid a total of $60,424.82 for services that providers claimed for 74 deceased Medicaid beneficiaries.

Cause of Condition

Although the Department conducts quarterly review to identify deceased clients and payments made after client's date of death, the review is not preventing or detecting all unallowable payments.

Effect of Condition and Questioned Costs

The Department paid $60,424.82 to providers for services for deceased Medicaid beneficiaries. We are questioning $38,031.38, which is the federal portion of the expenditures.

Recommendation

We recommend the Department:

- Continue to strengthen procedures for identifying deceased beneficiaries to prevent overpayments in the future.
- Recover $60,424.82 in unallowable payments from providers.
- Refund $38,031.38 to the federal government.

Department's Response

This finding involved the Aging and Disability Services Administration and the Medicaid Purchasing Administration. Both provided individual responses.

Aging and Disability Services Administration

The Aging and Disability Services Administration (ADSA) concurs with this finding.

The Department will continue its work to strengthen processes that may provide a timelier and more consistent way to inform field staff about deceased clients. Currently field staff receive this information from a variety of sources, including relatives, death notices in the papers, ACES-Social Security Data

Exchange matches, and other sources. There is no departmental or legal requirement to notify field offices. The availability and consistency of this information will improve when phase two of Provider One is completed. At that time staff should have uniform access to the same data sources for information about client deaths.

Medicaid Purchasing Administration

The Medicaid Purchasing Administration (MPA) concurs with this finding.

The audit identified transactions totaling $3,266 in payments made through the Medicaid Management Information System (MMIS) that were paid after the date of death. The Date of Death in the MMIS has since been verified and the payments have been recouped in SFY 2011.

The audit recommended that MPA "continue to strengthen procedures for identifying deceased beneficiaries to prevent overpayments in the future." MPA continues to be a stakeholder in a Department of Health (DOH) initiative that will provide on-line access to DOH death data. The initiative will provide death data in a timelier manner, but has yet to be implemented. DOH remains dependent upon counties for receipt of death data, resulting in a lag in receipt of the information. Due to this lag, DSHS will continue its successful post-pay review activities by using the quarterly DOH death data file to identify and recoup claims paid for deceased clients.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

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

U.S. Office of Management and Budget Circular A-87: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
   - u. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
   - v. Be allocable to Federal awards under the provisions of 2 CFR part 225.
   - w. Be authorized or not prohibited under State or local laws or regulations.
   - x. 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.
   - y. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
   - z. Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.

aa. Except as otherwise provided for in 2 CFR part 225, be determined in accordance with generally accepted accounting principles.
bb. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period, except as specifically provided by Federal law or regulation.
cc. Be the net of all applicable credits.
dd. Be adequately documented.

Title 42, Code of Federal Regulations, Part 433.304 defines an overpayment as following;

> *Overpayment* means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.

10-51 The Department of Social and Health Services, Health and Recovery Services Administration, does not have adequate procedures to ensure Medicaid is the payer of last resort for pharmacies.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Activities Allowed/Unallowed, Allowable Costs/Cost Principles
Questioned Cost Amount:	None

Background

Medicaid is the "payer of last resort", meaning those who administer it are to identify and bill other payment sources 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 Medicaid coverage. Pharmacies submit claims for Medicaid client prescriptions through an electronic point-of-sale system, which processes requests for payment through a series of criteria within the system, or edits. Claims are paid if they successfully pass all edits.

Pharmacies that submit claims to Medicaid must document third-party payers that may be liable. 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 pharmacy may use manual override codes to override the system edits intended to identify and deny these claims. Override codes are recognized nationally as part of electronic claims processing standards. However, they were established for uses such as processing payment for a drug the client's insurance does not cover, but which is covered by Medicaid.

The pharmacy can enter either accurate third-party information or override codes to bypass the system. Due to this significant, inherent control weakness, claims for pharmaceutical payments are susceptible to errors or abuse. The Medicaid program could pay claims that should have been paid in whole or in part by third parties.

The Department paid more than $420 million to pharmacies for services to Medicaid clients in fiscal year 2010. Of that, more than $14.7 million was paid for claims using various override codes.

Description of Condition

In our audits for fiscal years 2006 through 2009, we reported a lack of adequate controls over use of override codes. To compensate, the Department established a post-payment audit program to identify and recover payments made to providers who inappropriately billed Medicaid.

The Department paid more than $14 million for claims processed using override codes in fiscal year 2010. It audited only 4.65 percent of the claims. The table below provides details.

	2008	2009	2010
Total Pharmacy Medicaid Claims Paid Using Override Codes	$19,560,496.82	$20,627,840.66	$14,772,065.00
Total Pharmacy Medicaid Claims Audited	$1,333,714.07	$507,781.44	$687,632.50
% of Claims Audited	6.82%	2.46%	4.65%

We also analyzed post-payment audit data. As shown in the table below, a significant portion of the payments audited by the Department are found to be inappropriate and are recovered. These recoveries include state and federal money.

	2008	2009	2010	Total
Total audits completed	12	15	*61 (11)	38
Total Pharmacy Medicaid Claims Audited	$1,333,714.07	$507,781.44	$687,632.50	$2,529,128.01
Overpayments Identified	$624,164.18	$333,287.57	$340,074.77	$1,297,526.52
Overpayments Recovered as of 6/21/2010	$550,848.58	$241,302.24	$220,193.93	$1,012,344.75
Overpayment Percentage	46.80%	65.64%	49.46%	51.30%
Recovery Percentage	41.30%	47.52%	32.02%	40.03%
Collection Percentage	88.25%	72.40%	64.75%	78.02%

Auditor Notes: *51 of the 61 were individual pharmacies in a single company.

We found that while a significant portion of overpayments audited are inappropriate, only a small portion of payments are audited. The Department could not demonstrate the amount of audit coverage is adequate to address the risk of overpayments.

Cause of Condition

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.

The Department has not performed a cost-benefit analysis to determine what would be an appropriate amount of post-payment audit coverage to maximize recovery of overpayment.

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 should have been paid by third parties. Due to the lack of an analysis to determine the appropriate level of post-payment audits, the Department cannot reasonably ensure it is maximizing the identification and recovery of improper payments.

The Department's own audit work shows approximately $1.3 million, or more than 51 percent, of the amount audited over the past three years was improperly billed to Medicaid. The Department had recovered more than $1 million of those overpayments from pharmacies as of June 21, 2010. 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, as required by federal regulations.

- Perform on-going cost benefit 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 (Medicaid Purchasing Administration (MPA)) does not concur with this finding.

The Department (MPA) currently allows providers to make eligibility checks with ProviderOne that includes known third party payer information as stated in the first part of last year's Corrective Action Plan. The Department (MPA) did not implement the 270/271 transaction between health plans as targeted in the Corrective Action Plan since the Deficit Reduction Act of 2005 requires that the Secretary of Health and Human Services specify a manner in which the state Medicaid agencies and health plans may exchange eligibility and coverage data. The Secretary of Health and Human Services issued her recommendations in June of 2010 so states could use the new format as a tool to enable all states and all payers to comply with the Act's data exchange requirements. This includes the Payer Initiated Eligibility/Benefit (PIE) Transaction and the Accredited Standards Committee (ASC) X12 270/271 Health Care Eligibility/Benefit Inquiry and Response Standard Transactions (270/271 Transaction). The Department (MPA) will be pursuing implementation of these transactions.

The Department (MPA) will continue to explore other ways to enhance third party liability information in ProviderOne, including a new vendor who will perform automated data matches of MPA enrollment data against extended carrier files. This will enhance the Department's (MPA) third party liability cost avoidance and recovery and will enhance relevant data available in the pharmacy Point of Sale system at the time that a claim is adjudicated.

The Department (MPA) disagrees with a statement in the Effect of Condition: "…due to the lack of an analysis to determine the appropriate level of post-payment audits, the Department cannot reasonably ensure it is maximizing the identification and recovery of improper payments…" and the resulting audit recommendation. The 2009 State Government Performance Review Opportunities for Washington report of the State Auditor acknowledges that "the Department uses a risk assessment to prioritize and target pharmacy claims with a high potential for a return on investment." The report further states that the risk assessment process is effective in identifying high-risk payments, but current Department resources are limited. They identified an opportunity for additional funding for auditors to perform this work. The Department (MPA) agrees that more post-payment third party liability reviews could be performed if more resources were allocated to this task.

Auditor's Concluding Remarks

We thank the Department for its response, and will review this area during our next audit.

Applicable Laws and Regulations

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

> The auditee shall:
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the

provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

Title 42 Code of Federal Regulations, Section 433.139 (b) (1) states:

> 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.

Title 42 Code of Federal Regulations, Section 433.140 FFP and repayment of Federal share, states in part.

(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.

Washington Administrative Code (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:
  (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.

10-52 The Department of Social and Health Services, Medicaid Purchasing Administration[5], does not have adequate controls to ensure providers meet initial and ongoing eligibility requirements to participate in the Medicaid 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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Provider Eligibility
Questioned Cost Amount:	None

Background

Medicaid is a jointly funded state and federal partnership providing coverage for low-income individuals who otherwise might go without medical care. The state Medicaid program spent more than $6.9 billion during fiscal year 2010. It paid more than $6.1 billion of that directly to providers.

The Department of Social and Health Services' Medicaid Purchasing Administration Provider Enrollment Unit reviews the qualifications of health care providers who want to participate in the state's Medicaid program.

Eighty-one different types of providers, such as durable medical equipment suppliers, physicians, pharmacists, and others, provide services to Medicaid beneficiaries. Federal regulations require any Medicaid provider to have current, valid licenses for their field of service. Each provider must complete and sign a Core Provider Agreement and submit information about their business and what services they provide. Typically, the provide copies of:

- Business license(s).
- Current professional license.
- Internal Revenue Service W-9 (tax identification) form.
- Liability insurance (if applicable).
- Medicare certification (if applicable).
- Drug Enforcement Administration certification (if applicable).

Providers submit these documents to the Provider Enrollment Unit, which reviews them for accuracy and completeness. When the enrollment process is completed, the Unit assigns the provider an identification number.

Certain requirements also apply to specific types of providers, such as those who distribute durable medical equipment. This refers to any piece of equipment, such as wheel chairs, hearing aids and breathing devices, designed to assist those suffering from an illness or injury which restricts their normal functions. Federal law requires these providers to maintain a physical facility from which to do business to ensure clients receive support associated with medical equipment needs. Post office boxes are not considered a physical facility.

[5] Formerly Health and Recovery Services Administration

Additionally, federal law requires these providers to be accredited by an organization approved by the Centers for Medicare and Medicaid Services (CMS). The accreditation must identify specific products and services the provider may supply in order for payment to occur. The accreditation process helps ensure these providers are able to provide appropriate, quality equipment and assistance to clients.

During fiscal year 2010, more than 21,000 providers participated in Medicaid programs.

Description of Condition

We reviewed what systems are in place at the Provider Enrollment Unit to ensure providers meet Medicaid eligibility requirements.

We found the Unit ensures providers have appropriate licenses when first determining their eligibility. However, it does no verification subsequent to that determination. This can allow for providers with expired licenses to continue providing services to Medicaid clients.

We also reviewed how the Unit ensures durable medical equipment providers meet eligibility requirements for their field of service and accreditation. We found the Unit did not have adequate procedures to verify accreditation.

The Unit relies on the Office of Program Integrity's Medical and Hospital Audit Unit to ensure equipment providers have a physical location. That Office has a procedure requiring drive-bys to verify locations. It reports any negative results to the Unit. During our audit, we found that staff did not do these drive-by verifications during fiscal year 2010.

Cause of Condition

The Provider Enrollment Unit uses a computer system that has the capability to deny payment claims from providers who have expired licenses. The Department stated it intends to use this function in the future, but does not now have procedures in place to review for expired licenses. It does not know when it will begin using these procedures.

The Unit was unaware of the federal requirement to ensure medical equipment providers are accredited by an approved organization, and did not do so. The requirement came into effect in 2008.

With regards to drive-by verifications, the Office of Program Integrity changed its focus during fiscal year 2010 and assigned fewer staff to field audits. Those field audits were not focused on durable medical equipment provider verifications or drive-bys.

Effect of Condition

Provider eligibility requirements help ensure Medicaid clients receive qualified care and services. Inadequate controls to ensure providers meet eligibility requirements throughout their enrollment increases the risk of ineligible providers being paid for providing services to Medicaid clients and not being identified in a timely manner, if at all.

Recommendation

We recommend the Department:

- Strengthen controls to ensure all providers participating in the Medicaid program meet eligibility requirements initially and throughout their enrollment. This includes general requirements and requirements specific to medical equipment providers.
- Implement controls to ensure providers with expired licenses are not paid for services.
- Ensure equipment providers maintain an appropriate physical location for providing services.

Department's Response

The Department (Medicaid Purchasing Administration (MPA)) does not concur with the finding.

The Department (MPA) does ensure that all requirements for Durable Medical Equipment providers are met. Regarding accreditation, the federal citation noted by the audit team applies to "Conditions for Medicare Payment" and is not relevant to Medicaid payments. The specific notation referenced is 42 CFR 424.57 (c)(22). This citation is under Subchapter B, Medicare Program, Part 424, Conditions for Medicare Payment. The accreditation process is a Medicare requirement.

Medicaid also has a Change Request in process with the ProviderOne vendor, CNSI. It will allow a data exchange of professional and facility license information between Medicaid and the Department of Health. With the implementation of this Change Request, updated license information will be automatically uploaded into the ProviderOne system from the Department of Health database. This will ensure that claims for expired professional and facility licenses will not pay. We expect this Change Request to be in effect within the next six months. Business licenses were not captured in the legacy payment system, so the business license field is new to the ProviderOne system. It is a requirement for enrollment to document the business license dates in ProviderOne. ProviderOne automatically sends the provider a letter 30 days prior to the expiration date of a business license. The provider is required to then send the Provider Enrollment Unit proof of an updated license. There is currently no edit to deny claims on business license end dates, though a Change Request will be submitted to request this type of edit.

We also require these providers to have a physical location in order to be enrolled as a provider; we do not accept a Post Office Box as a valid physical address.

The Department's (MPA) Office of Program Integrity does not have an official policy or procedure requiring auditors to do drive-by verification of Durable Medical Equipment providers, since there is no federal or state rules or regulations requiring drive-by verification. Historically, if the Office of Program Integrity auditors were going to be out in the field doing on-site audits, then they would try to do some drive-by verification of provider facilities in the same geographical region as their assigned audits. This was not possible during 2010 due to system conversion to ProviderOne, and the changeover from the old Fraud and Abuse Detection System (FADS) to a second generation FADS system. Instead, we focused on desk reviews of older audits in order clear backlogs. In addition, our staffing resources are much more limited due to hiring freezes, temporary layoffs and attrition.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

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

Title 42, Code of Federal Regulations, Section 424.57 - Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing privileges.

(c) Application certification standards. The supplier must meet and must certify in its application for billing privileges that it meets and will continue to meet the following standards. The supplier:
  (7) Maintains a physical facility on an appropriate site. The physical facility must contain space for storing business records including the supplier's delivery, maintenance, and beneficiary communication records. For purposes of this standard, a post office box or commercial mailbox is not considered a physical facility. In the case of a multi-site supplier, records may be maintained at a centralized location;
  (22) All suppliers of DMEPOS and other items and services must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services.

Title 42, Code of Federal Regulations, Section 424.510, Requirements for enrolling in the Medicare program.

(d) Providers and suppliers must meet the following enrollment requirements:
  (2) *Content of the enrollment application*. Each submitted enrollment application must include the following:
    (iii) Submission of all documentation, including all applicable Federal and State licensure and regulatory requirements that apply to the specific provider or supplier type that relate to providing health care services, required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program.

Washington Administrative Code (WAC) 388-502-0010 - Payment – Eligible providers defined.

The department pays enrolled providers for covered healthcare services, equipment and supplies they provide to eligible clients.
  (1) To be eligible for enrollment, a provider must:
    (a) Be licensed, certified, accredited, or registered according to Washington state laws and rules; and
    (b) Meet the conditions in this chapter and chapters regulating the specific type of provider, program, and/or service.

Washington Administrative Code (WAC) 388-543-1200 - Providers who are eligible to provide services.

(1) The department requires a provider who supplies DME and related supplies, prosthetics, orthotics, medical supplies and related services to a client to meet all of the following. The provider must:
  (a) Have the proper business license; and
  (b) Be certified, licensed and/or bonded if required, to perform the services billed to the department. Out-of-state prosthetic and orthotics providers must meet their state regulatory requirements.
(2) The department may reimburse qualified providers for DME and related supplies, prosthetics, orthotics, medical supplies, repairs, and related services on a fee-for-service (FFS) basis as follows:
  (a) DME providers for DME and related repair services;
  (b) Medical equipment dealers, pharmacies, and home health agencies under their medical vendor provider number for medical supplies, subject to the limitations in this section;

(c) Licensed prosthetics and orthotics providers who are licensed by the Washington state department of health in prosthetics and orthotics. This does not apply to medical equipment dealers and pharmacies that do not require licensure to provide selected prosthetics and orthotics;

(d) Physicians who provide medical equipment and supplies in the physician's office. The department may pay separately for medical supplies, subject to the provisions in the department's resource based relative value scale (RBRVS) fee schedule; and

(e) Out-of-state orthotics and prosthetics providers who meet their state regulations.

(3) The department terminates from medicaid participation any provider who violates program regulations and policies, as described in WAC 388-502-0020.

10-53 The Department of Social and Health Services Medicaid Purchasing Administration[6] does not perform a retrospective drug use review of pharmaceutical claims data to identify patterns of fraud or abuse as required by federal law.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Utilization Control and Program Integrity
Questioned Cost Amount:	None

Background

Medicaid is a state and federal partnership that provides coverage for certain low–income individuals who might otherwise go without medical care. One significant cost to Medicaid is prescription drugs. The Department paid more than $420 million to pharmacies for services to Medicaid clients in fiscal year 2010. The Department's Point-of-Sale System (POS) processes pharmaceutical claims for Medicaid client prescriptions. It runs each request for payment through a series of criteria, known as edits, within the system. The Department pays the claims if they successfully pass all edits.

Federal laws require state Medicaid programs to have a retrospective drug use review program to identify patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary use. Medicaid administrators such as the Department must do these reviews at least quarterly to examine the activities of physicians, pharmacists and Medicaid recipients. Federal law requires this examination to include an analysis of physicians' prescribing practices, drug use by patients and, where appropriate, dispensing practices of pharmacies.

In a report issued in September 2009, the U.S. Government Accountability Office found tens of thousands of Medicaid beneficiaries and providers involved in potential fraudulent purchases of controlled substances, abusive purchases of controlled substances, or both, in five states: California, Illinois, New York, North Carolina, and Texas[7]. In our audits for fiscal years 2008 and 2009, we reported concerns regarding the Department's noncompliance with federal law that requires a retrospective drug use review of pharmaceutical claims date at least quarterly.

Description of Condition

During our audit, we found no changes in the conditions that we reported in our previous audits. The Department does not perform a retrospective drug use review of pharmaceutical claims data at least quarterly as required by federal regulation.

Cause of Condition

The Department believes its review of prescription drug activity in order to analyze the medical appropriateness of prescribing and dispensing is sufficient to fulfill the requirements of federal law.

[6] Formerly Health and Recovery Services Administration (HRSA)
[7] GAO-09-957

Effect of Condition

The Department is not using available resources to identify patterns of fraud, abuse, and misuse of pharmaceutical claims paid with Medicaid funds, increasing the risk these situations could occur and not be detected in a timely manner.

Recommendation

We recommend the Department comply with federal law regarding quarterly analysis of pharmaceutical claims data to identify patterns of fraud, abuse, and misuse of pharmaceuticals paid for with Medicaid funds.

Department's Response

The Department (Medicaid Purchasing Administration (MPA)) does not concur with this finding.

This audit area continues to be one in which the auditors and the Department (MPA) disagree on the intent and focus of the CFR requirements. The Department's (MPA) focus is on the appropriateness of prescribing physicians drug selection, and its clinical appropriateness while the auditors' focus continues to be on the usefulness of the utilization review in detecting fraud.

Title 42 CFR stipulates the Department (MPA) must perform quarterly retrospective Drug Utilization Review (DUR) via:

> *"(b) Use of predetermined standards. Retrospective DUR includes, but is not limited to, using predetermined standards to monitor for the following:*
>
> > *(1) Therapeutic appropriateness, that is, drug prescribing and dispensing that is in conformity with the predetermined standards.*
> > *(2) Overutilization and underutilization, as defined in Sec. 456.702.*
> > *(3) Appropriate use of generic products, that is, use of such products in conformity with State product selection laws.*
> > *(4) Therapeutic duplication as described in Sec. 456.705(b)(1).*
> > *(5) Drug-disease contraindication as described in Sec. 456.705(b)(2).*
> > *(6) Drug-drug interaction as described in Sec. 456.705(b)(3).*
> > *(7) Incorrect drug dosage as described in Sec. 456.705(b)(4).*
> > *(8) Incorrect duration of drug treatment as described in Sec. 456.705(b)(5).*
> > *(9) Clinical abuse or misuse as described in Sec. 456.705(b)(7)"*

The Pharmacy Policy Section uses data to determine which drug or classes (if any) require additional clinical oversight or provider education. Predetermined standards are used along with a professional drug advisory committee to monitor all the measures cited above, including overutilization and abuse and misuse of any medication for that quarter. If "Abuse" and "Misuse" is identified in the process, the "suspected" abuser is referred to our internal resources of the Department (MPA): Office of Patient Review and Coordination (PRC), the Quality Management Team Unit (QMT), the Payment Review Program Unit (PRP) and the Office of Payment Review and Audit (OPRA). The Department (MPA) has designated the Office of Payment Review and Audit (OPRA), part of our payment integrity division, as the Department's (MPA) contact point for referrals to the Medicaid Fraud and Control Unit (MFCU). This was an internal protocol put into place in 2004 so there would be coordination and one source for this external body to interface with.

The Department (MPA) conducts retrospective reviews for this purpose on an ongoing basis with multiple reviews occurring each quarter. Each of the measures cited above is analyzed on the basis of utilization trends, new drugs available in the marketplace, and new medically accepted indications for covered outpatient drugs. Analysis is completed and any significant results of that analysis are reported to the Centers for Medicare and Medicaid Services (CMS) Region 10. These results are reported on forms CMS

specifically created for reporting the results of the analysis on each of these measures, including overutilization and abuse and misuse.

The Department (MPA) believes it has presented reports to the SAO which document our compliance with the CFR and will continue to work with the SAO to understand what additional documentation would meet their needs.

The CFR does not stipulate which drug class or specific drug(s) should be reviewed each quarter. It does not stipulate these reviews must be done looking at every physician's prescribing practices every quarter. Nor does it say the DUR must be conducted on every drug every quarter. The Department (MPA) meets this requirement by looking at drug utilization by types of drugs or groups of drugs in a systematic way designed to identify the flags outlined above.

The Department (MPA) has previously contacted the pharmacist with CMS, in September 2009 to confirm that Washington Medicaid was in compliance with the federal requirements regarding retrospective and prospective DUR. The pharmacist sent an email that verifies Washington's compliance.

Finally, the Department maintains that it is in compliance with these regulations based on 42 CFR Ch. IV sec. 456.714, which states:

> *§ 456.714 DUR/surveillance and utilization review relationship.*
> *(a) The retrospective DUR requirements in this subpart parallel a portion of the surveillance and utilization review (SUR) requirements in subpart A of this part and in part 455 of this chapter.*
> *(b) A State agency may direct DUR staffs to limit review activities to those that focus on what constitutes appropriate and medically necessary care to avoid duplication of activities relating to fraud and abuse under the SUR program."*

Auditor's Concluding Remarks

We thank the Department for its response and commitment to continuing discussions on this issue.

Retrospective Drug Utilization Review (DUR) is a two-part system. The first component is the ongoing periodic examination of claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and Medicaid recipients associated with specific drugs or groups of drugs. The purpose of this component of retrospective DUR is to reduce the frequency of misuse and overuse of Medicaid drug benefits.

The second component of retrospective DUR is an ongoing periodic examination of claims data and other records to assess the clinical quality of prescribing and dispensing of Medicaid-covered drugs. The purpose of this component of retrospective DUR is to reduce the frequency of therapeutic problems associated with the use of those drugs.

The Department did not perform a retrospective drug use review of pharmaceutical claims data in order to identify patterns of fraud, abuse, or gross overuse among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs.

The Department established procedures to perform the second component of retrospective DUR, believing this was sufficient. We re-affirm our finding, and look forward to continuing discussions with the Department and its grantor in order to achieve resolution.

Applicable Laws and Regulations

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

The auditee shall:

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

Title 42, Code of Federal Regulations, Section 456.703 states in part:

(a) *General.* Except as provided in paragraphs (b) and (c) of this section, in order for FFP to be paid or made available under section 1903 of the Act for covered outpatient drugs, the State must have in operation, by not later than January 1, 1993, a DUR program consisting of prospective drug review, retrospective drug use review, and an educational program that meets the requirements of this subpart. The goal of the State's DUR program must be to ensure appropriate drug therapy, while permitting sufficient professional prerogatives to allow for individualized drug therapy.

Title 42, Code of Federal Regulations, Section 456.709 states:

(a) General. The State plan must provide for a retrospective DUR program for ongoing periodic examination (no less frequently than quarterly) of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs. This examination must involve pattern analysis, using predetermined standards, of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies. This program must be provided through the State's mechanized drug claims processing and information retrieval systems approved by CMS (that is, the Medicaid Management Information System (MMIS)) or an electronic drug claims processing system that is integrated with MMIS. States that do not have MMIS systems may use existing systems provided that the results of the examination of drug claims as described in this section are integrated within their existing system.

(b) Use of predetermined standards. Retrospective DUR includes, but is not limited to, using predetermined standards to monitor for the following:
   (1) Therapeutic appropriateness, that is, drug prescribing and dispensing that is in conformity with the predetermined standards.
   (2) Overutilization and underutilization, as defined in Sec. 456.702.
   (3) Appropriate use of generic products, that is, use of such products in conformity with State product selection laws.
   (4) Therapeutic duplication as described in Sec. 456.705(b)(1).
   (5) Drug-disease contraindication as described in Sec. 456.705(b)(2).
   (6) Drug-drug interaction as described in Sec. 456.705(b)(3).
   (7) Incorrect drug dosage as described in Sec. 456.705(b)(4).
   (8) Incorrect duration of drug treatment as described in Sec. 456.705(b)(5).
   (9) Clinical abuse or misuse as described in Sec. 456.705(b)(7).

Title 42 Code of Federal Regulations 455.2 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.

Title 42 Code of Federal Regulations 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.

Title 42 Code of Federal Regulations 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 Sec.1002.309 of this title; or
  (2) In States with no certified Medicaid fraud control unit, or in cases where no referral to the State Medicaid fraud control unit is required under paragraph (a)(1) of this section, conduct a full investigation or refer the case to the appropriate law enforcement agency.
(b) If there is reason to believe that a recipient has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.
(c) If there is reason to believe that a recipient has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

Title 42 Code of Federal Regulations 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.

Washington Administrative Code (WAC) 388-530-4050 Drug use and claims review states:

(1) The department's drug use review (DUR) consists of:
  (a) A prospective drug use review (Pro-DUR) that requires all pharmacy providers to:
    (i) Obtain patient histories of allergies, idiosyncrasies, or chronic condition(s) which may relate to drug utilization;
    (ii) Screen for potential drug therapy problems; and
    (iii) Counsel the patient in accordance with existing state pharmacy laws and federal regulations
  (b) A retrospective drug use review (Retro-DUR), in which the department provides for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and individuals receiving benefits.
(2) The department reviews a periodic sampling of claims to determine if drugs are appropriately dispensed and billed. If a review of the sample finds that a provider is inappropriately dispensing or billing for drugs, the department may implement corrective action that includes, but is not limited to:
  (a) Educating the provider regarding the problem practice(s);
  (b) Requiring the provider to maintain specific documentation in addition to the normal documentation requirements regarding the provider's dispensing or billing actions;
  (c) Recouping the payment for the drug(s); and/or
  (d) Terminating the provider's core provider agreement (CPA).

10-54 The Department of Social and Health Services, Aging and Disability Services Administration, billed approximately $600,000 to the Medicaid program for services provided to ineligible individuals.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Allowable Costs/Cost Principles
Questioned Cost Amount:	$ 322,204.66 Non-ARRA $ 80,767.25 ARRA

Background

The Medicaid program pays for medical assistance for certain individuals and families with low income and resources. Federal and state laws, regulations and other requirements establish Medicaid eligibility. Generally, an individual must, among other things, not exceed state-established income and resource thresholds, meet citizenship requirements, submit a written application for Medicaid benefits, furnish his or her Social Security number and be eligible for the services received.

In Washington, the Medicaid program covers children up to age 19 in families whose income is up to 200 percent of the Federal Poverty Level.

Description of Condition

During our audit, we found expenditures for personal care services provided to 102 Children's Health Insurance Program (CHIP) beneficiaries were charged to the Medicaid program. CHIP covers children up to age 19 in families whose income falls between 201 and 300 percent of the Federal Poverty Level. CHIP beneficiaries are not eligible for the Medicaid program. More than 16,000 children are enrolled in CHIP. The table below summarizes the results of our work;

Service Description	Questioned Costs	Federal Share
Personal Care Services	$640,247.71*	$402,971.91

* Incurred during the period from October 1, 2008 through June 30, 2010.

Cause of Condition

Staff at the Aging and Disability Services Administration, which administers personal care services for children with developmental disabilities, was not aware expenditures for services provided to CHIP beneficiaries should be fully charged to the CHIP, instead of Medicaid.

Effect of Condition and Questioned Costs

The Department charged $640,247.71 to the Medicaid program for services provided to ineligible individuals. We are questioning $402,971.91, which is the federal portion of the expenditures.

Recommendation

We recommend the Department:

- Establish and follow adequate procedures to ensure CHIP expenditures are not charged to Medicaid.

- Refund to the federal government $402,971.91 in unallowable costs charged to Medicaid.

Department's Response

The Department concurs with this finding that Medicaid funds were used to serve CHIP beneficiaries in error.

Department staff within Aging and Disability Services Administration (ADSA) was not aware of the correct process and client eligibility criteria for charging funds to the SCHIP grant. ADSA is now working with Medicaid Purchasing Administration and Economic Services Administration staff to establish methodologies to ensure that expenditures are properly charged to the SCHIP grant and not Medicaid.

ADSA will work with CMS regarding these questioned costs.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Compliance Supplement, Part 4 (March 2009)- Department of Health and Human Services (HHS), Medicaid Cluster, III. Compliance Requirements, states in part:

> To be allowable, Medicaid costs for medical services must be:
>
> (1) covered by the State plan and waivers;
> (2) for an allowable service rendered (including supported by medical records or other evidence indicating that the service was actually provided and consistent with the medical diagnosis);
> (3) properly coded; and
> (4) paid at the rate allowed by the State plan. Additionally, Medicaid costs must be net of applicable credits (e.g., insurance, recoveries from other third parties who are responsible for covering the Medicaid costs, and drug rebates), paid to eligible providers, and only provided on behalf of eligible individuals.

Title 42, Code of Federal Regulations, Section 435.1002 FFP for services, states:

(a) Except for the limitations and conditions specified in §§435.1007, 35.1008, 435.1009, and 438.814 of this chapter, FFP is available in expenditures for Medicaid services for all recipients whose coverage is required or allowed under this part.
(b) FFP is available in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided except that, for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the recipient's liability. (See §§435.914 and 436.901 of this subchapter for regulations on retroactive eligibility for Medicaid.)
(c) FFP is available in expenditures for services covered under the plan that are furnished—
    (1) To children who are determined by a qualified entity to be presumptively eligible;
    (2) During a period of presumptive eligibility;
    (3) By a provider that is eligible for payment under the plan; and
    (4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

10-55 The Department of Social and Health Services, Medicaid Purchasing Administration[8], did not ensure managed care premium payments were paid only for Medicaid eligible clients, resulting in the loss of approximately $1 million of public funds.

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) 93.778 Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1005WA5MAP, 5-1005W5ADM, 5-1005WAARRA
Applicable Compliance Component:	Activities Allowed/Cost Principles
Questioned Cost Amount:	$ 474,387.67 Non-ARRA $ 118,915.06 ARRA

Background

Medicaid services are provided to clients through fee-for-service and managed care. Those using traditional fee-for-service health care access medical service providers directly. Providers submit bills for payment directly to the state. In managed care, a managed care organization (MCO) receives a fixed monthly payment for each Medicaid recipient enrolled in the plan and is responsible for ensuring patients have access to a wide range of medical services.

The managed care system in Washington state is known as Healthy Options. Through the program, the Medicaid Purchasing Administration contracts with MCOs to provide a defined benefits to Medicaid beneficiaries. Approximately 60 percent of Medicaid clients are enrolled in managed care plans. The Department paid more than $1.2 billion for MCO premiums during state fiscal year 2010.

The contract between the Department and MCOs states the Department is allowed to recoup, retroactively, premium payments should a client die or if the Department identifies other coverage, such as private insurance or Supplemental Security Income for newborns up to two months old. In all other cases, the Department cannot recoup premium payments for clients no longer eligible for Medicaid unless the Department notifies the MCOs before the first day of the benefit month.

Description of Condition

We reviewed Medicaid MCO premium payments in state fiscal year 2010 to determine whether premium payments were made only for eligible clients.

We found the Department paid premium payments for 53 individuals who were disenrolled from the Medicaid program. Thirty-eight of those individuals had been disenrolled for more than a year, some as far back as 2005.

We also noted the Department paid managed care premium payments in state fiscal year 2010 for 3,344 individuals who were disenrolled or terminated from Medicaid prior to the benefit month. The Department did not reconcile the list of clients it used to make payments to MCOs to the Automated Client Eligibility System prior to the benefit period to ensure all clients were still eligible for Medicaid. Due to the lack of

[8] Formerly Health and Recovery Services Administration (HRSA)

proper reconciliation, the Department failed to notify MCOs of individuals who were no longer eligible for Medicaid before the first day of the benefit month.

Cause of Condition

Premium payments were made through the Medicaid Management Information System, which was designed to interface with the Departments client eligibility database. This interface is supposed to help ensure such payments are not made for individuals who are not eligible for Medicaid. However, we found the eligibility information in the two systems did not match. The Department does not know why there were discrepancies.

The Department did not reconcile the list of eligible Medicaid clients it used to pay MCOs to ensure all clients are still eligible for the Medicaid program.

Effect of Condition and Questioned Costs

The Department made premium payments of $323,795.65 for 53 individuals who were disenrolled from the Medicaid program. Of those 53 individuals, 38 individuals were disenrolled before July 1, 2009 but the Department continued paying the premiums.

The table below summarizes payments the Department made since 2005 for those individuals:

Fiscal Year	Number of Disenrolled Clients	Number of Payments	Total Payments
2005	20	310	$58,788.46
2006	19	153	$29,530.71
2007	18	302	$62,347.67
2008	18	293	$66,152.71
2009	20	132	$29,871.96
2010	53	235	$77,104.14
Total	53*	1,425	$323,795.65

*: Individuals possible in more than one fiscal year

We also identified 3,344 clients who were eligible for the Medicaid program at the time premiums were paid, but that were subsequently disenrolled, so they were not eligible for Medicaid for the month in which the premium was paid.

The table below summarizes the results of our review:

Fiscal Year	Number of Clients	Total Payments
2010	3,344	$618,852.47

In summary, the Department paid a total of $942,648.12 to MCOs for individuals no longer eligible for Medicaid. The Department cannot recoup those amounts from the MCOs since it did not notify them of the eligibility changes in a timely manner.

We are questioning $593,302.73, which is the federal portion of the expenditures.

Recommendation

We recommend the Department:

- Perform a reconciliation between the Medicaid payment system and the client eligibility system prior to the beginning of the benefit month to ensure that MCO premium payments are made only for eligible clients.

- Refund $593,302.73 to the federal government.

Department's Response

The Department (Medicaid Purchasing Administration (MPA) concurs with this finding.

- *The Department (MPA) conducted a thorough analyses of the data submitted to us by SAO and concluded that the small group of cases cited was accurately described. The findings were a result of limitations within the legacy MMIS system.*
- *This limitation has been resolved with the implementation of Provider One. Currently, we have established business rules that will disenroll ineligible clients when their eligibility changes between cutoff and premium payment.*

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

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

Title 42, Code of Federal Regulations, Section 435.1002 FFP for services, states:

> (a) Except for the limitations and conditions specified in §§435.1007, 35.1008, 435.1009, and 438.814 of this chapter, FFP is available in expenditures for Medicaid services for all recipients whose coverage is required or allowed under this part.
> (b) FFP is available in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided except that, for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the recipient's liability. (See §§435.914 and 436.901 of this subchapter for regulations on retroactive eligibility for Medicaid.)
> (c) FFP is available in expenditures for services covered under the plan that are furnished—
> (1) To children who are determined by a qualified entity to be presumptively eligible;
> (2) During a period of presumptive eligibility;
> (3) By a provider that is eligible for payment under the plan; and
> (4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

10-56 The Department of Health charged federal grants for expenditures after the grant period had closed.

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 U3RHS007562-01-04; 4 U3REP070019-01-03
Applicable Compliance Component:	Period of Availability
Questioned Cost Amount:	$154,991.62

Background

The Washington State Department of Health administers the federal National Bioterrorism Hospital Preparedness Program grant that enhances the ability of hospitals and health care systems to prepare for and respond to biological and other public health emergencies. The Department distributes this money to public and private entities that provide these services and retains a portion to pay administrative costs. The Department spent approximately $11,450,000 in grant funds in fiscal year 2010.

Grant money is awarded for predefined project periods during which funds may be expended or obligated for allowable program activities. Once a project period has ended, the Department has 90 days to pay any expenses that were incurred during the project period. Within 90 days of the project period ending the Department must file a financial status report with the U.S. Department of Health and Human Services. From that point forward no further charges may be made to the grant unless the grantor approves an extension.

Description of Condition

The Department had two federal grants whose project periods ended during the period under audit. One ended on August 8, 2009 and one ended on August 31, 2009. Federal regulations allow expenses incurred prior to these dates to be paid through November 6, 2009 and November 29, 2009 respectively. We determined that $154,991.62 in expenditures were paid after theses dates. We examined the supporting documentation for these expenditures and determined they were otherwise allowable.

Cause of Condition

Department management focused on ensuring grant funds were obligated during the project period, but did not monitor to ensure those obligations were paid prior to the 90 day period expiring.

Effect of Condition and Questioned Costs

By not ensuring all obligations were paid in accordance with federal requirements, the Department improperly charged expenditures to the federal grants. This could jeopardize future federal funding to the Department.

Additionally, because the Department continued to charge the grant after the closing date, it was unable to file all required financial reports in a timely manner. The report due November 29, 2009 was filed on April 16, 2010.

We identified $154,991.62 in expenditures that were improperly charged to the National Bioterrorism Hospital Preparedness Program. We are questioning those costs as unallowable charges. The federal grantor could disallow these charges and require the Department to pay back the money.

Recommendations

We recommend the Department ensure grants are not charged more than 90 days after a grant project period has ended unless an extension has been approved by the grantee.

The Department should consult with its grantor to determine what, if any, of the questioned costs should be repaid.

Department's Response

We concur with the State Auditor's office finding to the extent that a number of grant obligations were paid past the 90 days following the end of grant availability period. We will review our controls governing grant billing and work to ensure that proper cut-off procedures are implemented.

In addition we will work with the federal grantor to resolve the questions costs associated with these transactions which were otherwise allowable.

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 this area during our next audit.

Applicable Laws and Regulations

U.S. Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300 states in part:

> The auditee shall:
>
> (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

Title 45 Code of Federal Regulations, Part 92 – Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments --Table of Contents

> Sec. 92.23 Period of availability of funds.
>
> (a) General. Where a funding period is specified, a grantee may charge to the award only costs resulting from obligations of the funding period unless carryover of unobligated balances is permitted, in which case the carryover balances may be charged for costs resulting from obligations of the subsequent funding period.
>
> (b) Liquidation of obligations. A grantee must liquidate all obligations incurred under the award not later than 90 days after the end of the funding period (or as specified in a program regulation) to coincide with the submission of the annual Financial Status Report (SF-269). The Federal agency may extend this deadline at the request of the grantee.

10-57 The Department of Social and Health Services, Aging and Disability Services Administration, Division of Behavioral Health and Recovery, did not comply with the federal requirement for independent peer reviews for the Substance Abuse Prevention and Treatment Block Grant.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.959 Substance Abuse Prevention and Treatment Block Grant
Federal Award Number:	B08T1010056
Applicable Compliance Component:	Special Test and Provisions
Questioned Cost Amount:	None

Background

The Substance Abuse Prevention and Treatment Block Grant is the primary tool the federal government uses to fund state substance abuse prevention and treatment programs designed by the states. For federal fiscal year 2009 and 2010, the state Department of Social and Health Services received $34.9 million through this grant.

The Department provides residential and outpatient treatment services to clients through various contractors. Federal requirements state the Department must have an annual independent peer review of at least 5 percent of these contractors to assess the quality, appropriateness, and efficacy of treatment services. That process is designed to ensure continuous improvements to the services.

Prior to June 30, 2010, the Department relied on the Citizen's Advisory Council on Alcoholism and Drug Addiction to do the independent peer reviews. The Legislature eliminated the Council effective June 30, 2010.

Description of Condition

The Department did not comply with the peer review requirement in 2010. The most recent review was completed in June 2009 by the Citizen's Council.

Cause of Condition

The Citizen's Council was scheduled to perform the independent peer review during 2010. However, it was focused on the impending elimination and could not do the review. The Department was unable to find another party to conduct the peer review prior to the end of the fiscal year. The Department is working with the Mental Health Policy Advisory Committee to complete the peer review in the future.

Effect

Without an annual peer review the Department misses the opportunity to identify and make improvements to the program. Independent peer reviews help ensure clients receive quality, effective treatment programs. Additionally, the lack of an appropriate required peer review could jeopardize future federal funding.

Recommendations

We recommend the Department ensure the annual peer review is performed as required. We also recommend the Department identify more than one option to ensure the required annual independent peer review is completed.

Department's Response

The Department concurs with this finding.

A newly created Behavioral Health Advisory Council will be responsible for facilitating and overseeing the peer review process. A contract with Accumentra will be extended to perform oversight of all peer review functions.

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

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

> The auditee shall:
>
> (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

Title 45, Code of Federal Regulations, Section 96.136 Independent Peer Review

(a) The State shall for the fiscal year for which the grant is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved, and ensure that at least 5 percent of the entities providing services in the State under such program are reviewed. The programs reviewed shall be representative of the total population of such entities.

(b) The purpose of independent peer review is to review the quality and appropriateness of treatment services. The review will focus on treatment programs and the substance abuse service system rather than on the individual practitioners. The intent of the independent peer review process is to continuously improve the treatment services to alcohol and drug abusers within the State system. ``Quality," for purposes of this section, is the provision of treatment services which, within the constraints of technology, resources, and patient/client circumstances, will meet accepted standards and practices which will improve patient/client health and safety status in the context of recovery. ``Appropriateness," for purposes of this section, means the provision of treatment services consistent with the individual's identified clinical needs and level of functioning.

(c) The independent peer reviewers shall be individuals with expertise in the field of alcohol and drug abuse treatment. Because treatment services may be provided by multiple disciplines, States will make every effort to ensure that individual peer reviewers are representative of the various disciplines utilized by the program under review. Individual peer reviewers must also be knowledgeable about the modality being reviewed and its underlying theoretical approach to addictions treatment, and must be sensitive to the cultural and environmental issues that may influence the quality of the services provided.

(d) As part of the independent peer review, the reviewers shall review a representative sample of patient/client records to determine quality and appropriateness of treatment services, while adhering to all Federal and State confidentiality requirements, including 42 CFR Part 2. The reviewers shall examine the following:

    (1) Admission criteria/intake process;
    (2) Assessments;
    (3) Treatment planning, including appropriate referral, e.g., prenatal care and tuberculosis and HIV services;
    (4) Documentation of implementation of treatment services;
    (5) Discharge and continuing care planning; and

(6) Indications of treatment outcomes.

(e) The State shall ensure that the independent peer review will not involve practitioners/providers reviewing their own programs, or programs in which they have administrative oversight, and that there be a separation of peer review personnel from funding decision makers. In addition, the State shall ensure that independent peer review is not conducted as part of the licensing/certification process.

(f) The States shall develop procedures for the implementation of this section and such procedures shall be developed in consultation with the State Medical Director for Substance Abuse Services.