Financial Findings Reported Under Government Auditing Standards

2013-001 State's internal controls over payroll payments processed by Human Resources Management System and Medicaid payments processed by ProviderOne are inadequate to ensure those payments are properly processed and recorded.

Background

It is the responsibility of state management to design and follow internal controls that provide reasonable assurance regarding the reliability and accuracy of information used for financial reporting. The Legislature, federal agencies and bondholders rely on the information included in financial statements and reports to make decisions.

Description of Condition

Our audit identified the following weaknesses in internal controls we consider to be significant deficiencies that could lead to inaccurate or unreliable financial reporting:

Human Resources Management System (HRMS)

The HRMS processed 1.7 million payroll transactions for approximately 70,000 Washington state employees totaling $3.6 billion in payroll costs for the fiscal year ended June 30, 2013.

In previous audits, we reported internal control deficiencies related to the HRMS. Improvements have been made; however, the following control weaknesses continue to exist with the HRMS:

- Controls are inadequate over the input of Employee Master Data – Individuals can make changes to data in HRMS without system enforced review and approval. The system lacks adequate controls that prevent payments from being paid to individuals that exceed a reasonable amount.
- Some employees at the Department of Enterprise Services (DES) have excessive access to HRMS and can make changes to programs and place them into production without a second review or approval. HRMS is not supported by a Disaster Recovery Back Up Site or a Disaster Recovery and Business Resumption Plan.

During the current audit, we also observed an internal control weakness at the Department of Social and Health Services (DSHS). DSHS had approximately 426,000 payroll transactions totaling $1.1 billion for the fiscal year. We found the DSHS did not consistently run or review an available payroll report (S4259 payroll journal report) designed to detect errors and prevent payroll overpayments.

ProviderOne System

The Health Care Authority (HCA) has contracted with a vendor, which uses a system known as ProviderOne to process state Medicaid payments. For the fiscal year ended June 30, 2013, ProviderOne processed approximately 42 million Medicaid transactions totaling $4.5 billion. During the previous audit, we identified and communicated deficiencies in controls over the ProviderOne system. The HCA has made improvements; however, we determined a significant deficiency continued to exist.

The HCA did not adequately monitor the ProviderOne system. Specifically, the contract with the vendor did not require the vendor to obtain a review of the ProviderOne system's internal controls to determine whether they are properly designed and operate as intended in the processing and recording of Medicaid payments.

Cause of Condition

HRMS

Those responsible for the initial implementation of HRMS focused on configuring the system to perform accurate calculations and interfacing information with state agency systems, rather than on edits to provide assurance over reasonableness of data entry and system-enforced independent review. While improvements have been made to correct previously reported conditions, remaining conditions were not reviewed by Office of Financial Management (OFM) and DES for prioritization. Additionally, DES has not developed a plan for a backup and recovery strategy, as it intended when these conditions were previously reported.

DSHS did not follow its agency policy requiring the generation and review of an S4259 payroll journal report to ensure payroll is complete and accurate. The agency did not consistently run and review its payroll journal reports during the audit period.

ProviderOne

HCA and the vendor did not adequately address responsibilities, controls and requirements for monitoring in the contract for the ProviderOne system. HCA did not have complete knowledge of the extent of their monitoring responsibilities for ProviderOne.

Effect of Condition

HRMS

Inadequate controls within HRMS have or could lead to the following conditions:

- Untimely detection of payroll overpayments at agencies, if agency internal controls fail
- Undetected changes in the HRMS programs and data

In addition, these internal control weaknesses could lead to the inability to resume the payroll system in a timely fashion after a disaster.

As a result of the internal control deficiencies discussed above, we were required to perform additional audit procedures at DSHS to verify the accuracy of payroll expenditures. We found DSHS made at least 500 payroll overpayments during the fiscal year ended June 30, 2013. Because circumstances of each overpayment is different, the agency's accounting treatment varied. Therefore, we were not able to determine the total dollar amount of these overpayments. Overpayments included:

- A cook at Western State Hospital received a payment for 638 hours of overtime in one pay period. The amount of the error in the payment was $11,028. There was no control that limits the input of overtime hours. A normal pay period is 80 hours.
- A pharmacist at Eastern State Hospital was overpaid $14,068 in one pay period when his pay rate was incorrectly altered and changed to an hourly rate of $1,017.
- An office assistant received an overpayment of $1,042 when an input error was made. The employee worked eight hours in a single day; however, 88 hours was input into the system.
- A security guard at Western State Hospital was overpaid $2,008 when an input error was made for hours worked in a single day. An entry of 107 hours was input for one day and accepted by the system. The actual hours worked was 10.7 hours.

ProviderOne

The failure to assure that the vendor received an internal control audit for the ProviderOne system could lead to inaccurate financial reporting in the state's general fund. Additionally, the lack of monitoring creates an environment in which the state cannot be sure the vendor maintains proper internal controls to prevent:

- Misuse, loss or misappropriation of public funds
- Inaccurate payments
- Unauthorized software changes to the ProviderOne system

As a result of the internal control deficiencies, we were required to perform additional audit procedures to verify the accuracy of human services expenditures reported in the state's general fund.

We will be issuing an additional finding related to ProviderOne in our Single Audit of the State of Washington. This audit examines compliance with federal grant requirements and internal controls over the expenditure of grant money.

Recommendations

To strengthen internal controls over the HRMS system, we recommend:

- OFM and DES modify current preventative controls in HRMS to assure state employees do not receive unreasonable payroll payments due to incorrect input.
- Access to HRMS programs be restricted so that there are not individuals with the access to make changes to programs and move changes into production without review or approval of a second individual.
- DES comply with OCIO policy and establish a disaster recovery plan for HRMS.
- DSHS consistently comply with its policy to run and review payroll reports prior to approving the payroll.

To strengthen internal controls over the ProviderOne system, we recommend:

HCA continue to improve the monitoring and oversight of the ProviderOne system to verify internal controls are in place and effective in ensuring the accuracy and integrity of the information.

State's Response

Human Resources Management System (HRMS)

The Department of Enterprise Services (DES), in partnership with the Office of Financial Management (OFM), will identify and analyze options to incorporate system-enforced review and approval edits. Some of this analysis will be dependent on implementation decisions related to the new enterprise Time, Leave and Attendance system now being implemented. DES and OFM anticipate that this analysis will be complete by June 30, 2015.

There is currently a preventative control in HRMS that halts processing of an individual's pay if gross pay is over a certain amount. By June 30, 2014, DES, in partnership with OFM, will analyze this control to determine how it can be used more effectively.

By December 1, 2013, DES will ensure that no individuals have access to make changes to programs or move changes into production without review or approval of a second individual.

DES is currently working on Disaster Recovery and Business Resumption Planning to comply with the OCIO policy. DES anticipates that this issue will be resolved within the next year.

The Department of Social and Health Services takes the accuracy of payroll very seriously. The overpayments noted in the audit represent about one-tenth of one percent of all payroll transactions in the Department each year. The Department always followed the accounting treatment as prescribed for recording overpayments. That accounting treatment varies depending on the type of overpayment involved.

The Department has established agency metrics related to payroll overpayments and underpayments and included these metrics within the Financial Services Administration's Strategic Plan. The Department has identified and undertaken Lean projects within its statistically most challenging areas for payment accuracy and will continue these efforts in the future. Additionally, the Department will continue to work with management at the institutions to further timely and efficient reporting of time and leave in order to reduce input pressures during the payroll exit process.

The Department has also implemented a time and leave tool called "Leave Tracker" for headquarters and certain field staff. The Department is working to resolve access and logistical issues so that its usage can be expanded to the institutions. Use of Leave Tracker expedites time and leave recording by the employee and electronically routes it to the supervisor for approval and ultimately to the timekeeper. Leave Tracker also has two features for timekeeping staff that support the internal control and accuracy of time and leave input. One function is a semi-automated transaction by transaction comparison between Leave Tracker and HRMS Cross Application Timesheet (CATs). The second gives a summary total of hours for the pay period for each employee which allows for easy comparison to the summary totals on the payroll journal.

As noted in the audit, time collection and processing policies and procedures are documented. The Department regularly provides time and attendance training to timekeepers, supervisors, and employees. These classes stress the internal control elements of the Department's time collection and processing procedures including the importance of running and reconciling the pre-emptive payroll journals prior to payroll exit each period.

Each of the overpayments noted by the auditors has either been fully recovered by the Department or are is the process of being recovered from the employee.

ProviderOne

The state recognizes the significance and the priority of internal controls over recording and reporting financial transactions. Initially, the state relied on the certification process conducted by the federal Centers for Medicare and Medicaid Services (CMS) to document the sufficiency of ProviderOne internal controls. The CMS certification process was very comprehensive in nature and resulted in the state's ProviderOne being the first in the country to achieve federal certification without a single finding. That said, the state recognizes the value of and, in January 2013, added a requirement to the ProviderOne contract for an independent audit of the system of internal controls at the vendor location. An audit of a service organization's internal controls involves a phased approach. The phases were specified in the contract with the first report due in the spring of 2014.

Auditor's Concluding Remarks

We thank the State for their diligence in addressing the internal control issues discussed. These actions will enhance the fiscal accountability and financial reporting of the State's financial activity. We will evaluate the State's corrective action during our next audit.

Applicable Laws and Regulations

Government Auditing Standards, July 2007 Revision – Section 5.11 provides that auditors should report material weaknesses and significant deficiencies in internal control.

The American Institute of Certified Public Accountants, Statement on Auditing Standards No. 115 defines significant deficiencies and material weaknesses as follows:

a. 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.

b. 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.

Washington State Office of Financial Management
State Administrative & Accounting Manual

Chapter 20 - Internal Control and Auditing

Section: 20.10.20 July 1,2008 The Budget and Accounting Act is found in Chapter 43.88 RCW. RCW 43.88.160(4), states in part . . .the director of the Office of Financial Management (OFM), as an agent of the governor, shall:

"Develop and maintain a system of internal controls and internal audits comprising methods and procedures to be adopted by each agency that will safeguard its assets, check the accuracy and reliability of its accounting data, promote operational efficiency, and encourage adherence to prescribed managerial policies for accounting and financial controls. The system developed by the director shall include criteria for determining the scope and comprehensiveness of internal controls required by the classes of agencies, depending on the level of resources at risk.

Each agency head or authorized designee shall be assigned the responsibility and authority for establishing and maintaining internal audits following the standards of internal auditing of the institute of internal auditors..."

Section: 20.15.50.a - Annual assurance

A risk assessment and internal control review process provides management with reasonable assurance that controls are operating as expected. In addition, the process should be used to determine if internal control modifications are needed by considering events that have occurred, processes or procedures that have changed, new projects or programs that are being planned or implemented, and other changes within the agency that may have additional risks. If the review uncovers internal control weaknesses or if prior weaknesses still exist, they should be documented and addressed.

Periodically, an agency should conduct a comprehensive review of the internal control structure to determine if it is adequately addressing agency risks. This can be done agency-wide at one time or by sections of the agency over a period of time.

Agencies must maintain adequate written documentation of activities conducted in connection with risk assessments, review of internal control activities and follow-up actions. This documentation includes any checklists and methods used to complete these activities. Refer to Subsection 20.25.50 for required documentation. For sample checklists and procedures, refer to the OFM Administrative and Accounting Resources website at:
http://www.ofm.wa.gov/resources/default.asp.

Agencies have the flexibility to assign appropriate staff to complete the risk assessments and review of internal control activities required by this policy. The internal control officer is the person appointed by the agency head who is assigned responsibility for coordinating and scheduling the agency-wide effort of evaluating and reporting on reviews and improving control activities. The internal control officer also provides assurance to the agency head that the agency has performed the required risk assessments and the necessary evaluative processes. This communication may be ongoing and informal, but at least once per year, this assurance must be made in writing to the agency head.

The internal control officer is responsible for ensuring that the required documentation is maintained and available for review by agency management, the State Auditor's Office (SAO), and OFM.

Office of the Chief Information Officer (OCIO) Policy No. 151, states in part

Planning for IT Disaster Recovery and Business Resumption
POLICY STATEMENT

1. Each agency will develop disaster recovery/business resumption plans.
   1.1. Agencies dependent on voice telecommunications, data telecommunications, video telecommunications, or computer services for carrying out their missions must develop disaster recovery/business resumption plans.
   1.2. Agencies that purchase computer services or telecommunications services from other state agencies or commercial concerns will integrate their disaster recovery/business resumption plans, including off-site storage of data, with the service providers' plans.

2. Each agency will maintain and update disaster recovery/business resumption plans annually.
   2.1. Agencies will also update disaster recovery/business resumption plans following any significant change to their computing or telecommunications environment.
3. Each agency will test disaster recovery/business resumption plans annually.
   3.1. Agencies will correct any deficiencies revealed by the test. The type and extent of testing adopted by an agency will depend on:
   - Criticality of agency business functions.
   - Cost of executing the test plan.
   - Budget availability.
   - Complexity of information system and components.
4. Each agency will train their employees to execute the recovery plans. Training will consist of:
   - Making employees aware of the need for a disaster recovery/business resumption plan.
   - Informing all employees of the existence of the plan and providing procedures to follow in the event of an emergency.
   - Training all personnel with responsibilities identified in the plan to perform the disaster recovery/business resumption procedures providing the opportunity for recovery teams to practice disaster recovery/business resumption skills.
5. Each agency will annually certify the updating and testing of the disaster recovery/business resumption plan.
   5.1. An annual disaster recovery/business resumption plan confirmation letter must be included in the agency IT portfolio and submitted to the OCIO by August 31 of each year. By way of this letter, the head of each agency confirms to the Board that a disaster recovery/business resumption plan has been reviewed, updated, and tested.
6. The State Auditor may audit disaster recovery/business resumption plans and tests for compliance with policy and standards.

2013-002 The University of Washington did not have sufficient internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act (FFATA) are filed for the Research and Development cluster.

Federal Awarding Agencies:	U.S. Department of Defense Department	
	U.S. National Science Foundation	
	U.S. Department of Health and Human Services National Institutes of Health	
Pass-Through Entity:	None	
CFDA Number and Title:	12.000	Department of Defense Contract Only
	12.300	Basic and Applied Scientific Research
	47.050	Geosciences
	93.351	Research Infrastructure Programs
	93.847	Diabetes, Digestive, and Kidney Diseases Extramural Research
	93.853	Extramural Research Programs in the Neurosciences and Neurological Disorders
	93.859	Biomedical Research and Research Training
	93.865	Child Health and Human Development Extramural Research
Federal Award Number:	Numerous	
Applicable Compliance Component:	Reporting	
Questioned Cost Amount:	None	

Background

The Federal Government sponsors a variety of research and development (R&D) activities using a variety of types of funding, most commonly grants, in order to achieve objectives agreed upon between the sponsoring agency and the grantee. The types of R&D conducted under these agreements also vary widely. The objective of individual projects is explained in the Federal award document. The University of Washington received $838.3 Million in Federal awards during fiscal year 2013, of that amount, $97.5 Million was passed through to subrecipients.

Under the Federal Funding Accountability and Transparency Act, the University is required to collect and report information on each sub-award of $25,000 or more in federal funds in the Federal Funding Accountability and Transparency Sub-award Reporting System. Reporting is required for federal funds having Accountability Act reporting terms and conditions included in the grant award. This generally applies to all new federal awards after October 2010. The reporting must be done by the end of the month following the month in which the sub-award was fully executed or obligated. The intent of the Accountability Act is to hold the government accountable for each spending decision and to reduce wasteful spending.

Description of Condition

The University does not have monitoring controls in place to ensure that subawards over $25,000 on applicable awards are reported in the Accountability Act reporting system.

Out of 28 subawards randomly selected, seven subawards were either reported between four and eleven months late, or were not reported at all. Additionally, all of the subawards that were reported late listed the incorrect award amount.

The University modified their reporting, both during and after the audit period, to show cumulative amounts rather than reporting each award separately, and did not keep copies of the reports prior to modification. We were unable to verify if

the individual obligations were reported, the accuracy of the reporting information at the time of reporting, and/or which version of the reporting the awards were included in.

Cause of Condition

The University does not have a process in place for tracking subawards after they have determined them to be subject to Accountability Act reporting, nor do they have a process for identifying which subaward reports are outstanding. We also determined there was no secondary review process in place before the reports were submitted.

Effect of Condition

By not correctly submitting the required Accountability Act reports, the federal government's ability to ensure transparency and accountability of federal spending is diminished. Grant conditions allow the grantor to penalize the University for noncompliance, suspending or terminating the award, and withholding future awards.

Recommendation

We recommend the University of Washington put a process in place to track, monitor, and report subawards over $25,000 when required. We also recommend that a secondary review be performed prior to report submittal.

University's Response

The University has processes in place to review each prime award for each subaward executed to determine whether the prime award is FFATA applicable and therefore report the subaward in FSRS. Starting in December 2012 the University updated its FSRS reporting process to include maintaining a pdf copy of each report filed. The University will add a monthly review of all new prime awards that had subawards executed under them in that month to provide an additional review for FFATA applicability. In addition the University will add a secondary review of draft FSRS reports each month before submitting the reports to ensure all information has been entered accurately

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, states in part:

Section 300

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, Section 170 states in part:

APPENDIX A TO PART 170—AWARD TERM

I. Reporting Subawards and Executive Compensation.

a. Reporting of first-tier subawards.

1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111–5) for a subaward to an entity (see definitions in paragraph e. of this award term).

2. Where and when to report.
    i. You must report each obligating action described in paragraph a.1. of this award term to http://www.fsrs.gov.
    ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)
3. What to report. You must report the information about each obligating action that the submission instructions posted at http://www.fsrs.gov specify.

2013-003 The Department of Commerce does not have sufficient internal controls to ensure all of its subrecipients receive audits as required.

Federal Awarding Agency:	U.S. Department of Housing and Urban Development U.S. Environmental Protection Agency U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	14.239 HOME Investment Partnerships 66.468 Capitalization Grants for Drinking Water 66.468A Capitalization Grants for Drinking Water – American Recovery and Reinvestment Act (ARRA) 93.568 Low Income Home Energy Assistance Program 93.569 Community Services Block Grant
Federal Award Number:	2013G992201; 2012G992201; 2012G99BX11; 2011G992204; 2011G992201; 2010G992212; M13-SG530100; MM11-SG-53-0100; M10-SG-53-0100; FS-99083911; FS-99083910; FS-99083909; FS-99083908; 2F-96087801 (ARRA) 13B1WACOSR; 10B1WACOSR; 901WACOS2; 09B1WACOSR;
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

Federal regulations require the Department of Commerce to monitor the grant-funded activities of subrecipients. This includes ensuring that organizations that spend $500,000 or more in federal grant money during a fiscal year receive an audit of expenditures and internal controls over that money, in accordance with the federal Office of Management and Budget Circular A-133. This requirement is designed to ensure grant money is used for authorized purposes in compliance with laws, regulations and the provisions of contracts or grant agreements. Grant recipients must submit the results of these audits to a federal clearinghouse within nine months of their fiscal year end.

The Department also has a written policy and procedures aimed at ensuring all subrecipient audits are received, reviewed, and entered into the central database. The audit policy and procedures specify that it is the responsibility of the program managers to ensure the Department's contractors comply with applicable audit requirements in a timely manner.

In October 2012, the Department enhanced its Contract Management system with a new audit tracking module. Once the audit reports are received, they are reviewed and input in the Department's central audit tracking database. The internal auditor reviews the audit reports and notifies the program managers of the programs with federal dollars at risk. If findings are reported, the program manager is responsible for requesting a corrective action plan from the subrecipient and for ensuring the corrective actions are performed.

Description of Condition

The Department has not established an effective process to ensure its subrecipients submit audit reports timely. Currently, the program managers wait for subrecipients to submit their audit reports to the Department. Program managers also rely on internal audit to handle the audit tracking function. This approach alone is not sufficient to ensure timely compliance with the audit requirement.

The Department does not have a sufficient tracking mechanism at the program level or the central level to ensure each subrecipient meeting the dollar threshold is receiving an audit. This includes ensuring that subrecipients who receive less than $500,000 from the Department obtain an audit when required. Currently, the Department does not have a way of determining if subrecipients receive federal funding from other sources. Without further contact with these subrecipients, the Department does not know whether they have met the audit requirement.

Audits received centrally are recorded and tracked in the new audit tracking module. However, system reports are not generated at a sufficient frequency to ensure the Department follows up timely on past due audit reports.

We reported similar issues during the fiscal year 2011 and 2012 audits.

Cause of Condition

The Department has a policy that would ensure compliance with federal requirements, but failed to follow it. Responsibilities for ensuring required audits are obtained and submitted timely, as outlined in the policy, are not clearly communicated with or sufficiently understood by program managers. While the Department invested in new audit tracking capabilities, it does not utilize them effectively to ensure that all subrecipients who need an audit have one performed and submit it to the Department within the nine month period specified in the contract provisions.

Effect of Condition

We judgmentally selected 22 subrecipients across programs that received at least $500,000 directly from the Department. The Department did not have audit reports for three of the 22 subrecipients as required by OMB Circular A-133. We also found seven of the reports were received by the Department after the nine month deadline including one report that was 311 days late.

We selected three additional subrecipients that were missing audit reports during our fiscal year 2012 audit. One of them was still missing an audit report, and two reports were received more than nine months after the deadline.

The Department cannot be certain whether all of its subrecipients who met the threshold for an A-133 audit complied with federal grant requirements and therefore, cannot ensure that it has met the monitoring requirement of its federal grantor.

Recommendation

We recommend the Department ensure that its existing audit policy and procedures are clearly communicated, understood, and followed by program staff. Additionally, we recommend the Department develop specific controls to determine the federal audit status of all subrecipients. These controls should be aimed at preventing rather than simply addressing noncompliance.

Department's Response

The Department concurs with the finding. To address the fiscal year 2012 subrecipient finding, the Department enhanced its capabilities in the Contract Management System (CMS) to provide a report of those entities expending $500,000 or more in federal funds, the entity's fiscal year end date, and the due date of the A-133 audit.

The fiscal year 2013 finding states the Department lacked clear communication on policies and procedures. The Department will review existing policies and procedures to more clearly articulate the responsibilities of the Internal Auditor and Program Managers for these processes. The Department will communicate the results of the review through all levels of the agency. Corrective action will include reviewing current policies and procedures, establishing roles and responsibilities, and stating time frames.

Updates to policies and procedures will include production of a quarterly report for divisions to use to identify A-133 audit reports that are due. The reports will enable the Department to proactively remind entities of their audit report due dates. The policy will provide guidance when audit reports are delinquent. Training related to policy changes will be tracked. Testing of the implementation will be conducted. The Department will obtain the missing audit reports identified in the finding.

During fiscal year 2013, the Department began a process of identifying and contacting grantees that did not meet the threshold for A-133 audit requirements. The Department will continue to enhance the process of identifying those recipients who received less than $500,000 from the Department and may have received federal funding from other sources. This will ensure the Department identifies and obtains the required audit reports.

The Internal Auditor will report to executive management quarterly on the progress to obtain missing A-133 reports, provide data on audit reports currently received or due, training attendance, and improvements made to existing processes.

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*, states in part:

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.
(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.

(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.

2013-004 The Department of Commerce does not have sufficient internal controls to ensure HOME Investment Partnership program income is used before requesting federal cash draws.

Federal Awarding Agency:	U.S. Department of Housing and Urban Development
Pass-Through Entity:	None
CFDA Number and Title:	14.239 HOME Investment Partnership
Federal Award Number:	M09-SG-53-0100, M10-SG-53-0100, M11-SG-53-0100, M13-SG530100
Applicable Compliance Component:	Program Income and Cash Management
Questioned Cost Amount:	None

Background

The HOME Investment Partnership program is designed to provide decent and affordable housing for low-income households. The Department of Commerce administers the HOME program. The Department uses HOME funds for two major programs: HOME General Purpose program and HOME Tenants Based Rental Assistance program. The General Program supports the construction, acquisition or rehabilitation of affordable housing units and creates rental and homeownership opportunities statewide for low-income households. The Tenants Based program provides homeless and low-income households with rental assistance.

For the General Purpose program, the Department provides the HOME loans to local governments, housing authorities or nonprofits to finance the construction of multi-family rental housing units. The Department receives program income through payments of principal and interest on the loans. Federal regulations require the Department pay out the program income before requesting additional federal cash draws.

In fiscal year 2013, the Department requested close to $7 million of HOME funds. The program generated approximately $1,053,500 in program income.

During our fiscal year 2012 audit we determined the Department's HOME program did not have sufficient internal controls to ensure that program income was used prior to drawing federal funds.

As part of our fiscal year 2013 audit, we reviewed the Department's Finding and Corrective Action Plan to determine the status of the prior audit finding. The Department's corrective action plan provides for establishing procedures and internal controls to ensure program income is used prior to drawing federal funds. It also states that the US Bank HOME Program Income account will be reconciled monthly by fiscal staff and the balance provided to HOME program managers to record the income into the Integrated Disbursement & Information System. It further states that program managers will review the program income balance in the federal system and use those funds prior to drawing grant funds and that the account will be brought as close to zero as possible before the federal cash draw is requested.

The completion date of the corrective action was listed as November 2012.

Description of Condition

We found the Department does not have controls in place to ensure all HOME program income is used before requesting additional federal HOME funds. Further, the Department had not established a process for entering information on program income receipts into the federal Integrated Disbursement & Information System on a regular basis. We noted that, while the Department took steps to reduce the program income account balance, it did not fully complete its corrective action plan causing federal funds to continue to be drawn prior to using program income.

Specifically we found:

1) Program income was not drawn prior to requesting federal funds. Federal draws were made throughout the year totaling $6,963,699. The Department made an effort to reduce the balance of the program income account by making monthly draws from September 2012 to March 2013 for a total of $1,053,534, yet they did not draw program income to zero at any time prior to drawing additional federal funds. Further, federal draws made during the months of April, May and June 2013 where not offset by available program income.

2) Program income balance on June 30, 2013 was $352,229. In addition, we further note that although outside of our audit period, we found the Department continued to draw federal funds without using program income after our audit period and the program income balance grew to $573,545 as of January 31, 2014.

3) Program income was not recorded in the federal Integrated Disbursement & Information System on a monthly basis. The Department had not established a process for entering information on program income receipts into the federal Integrated Disbursement & Information System on a regular basis. Our analysis of the program income detail report revealed that no program income was recorded during fiscal year 2013 in the federal system. Additionally, only one cumulative entry was made on August 12, 2013 to record all of the fiscal year 2013 program income.

Cause of Condition

The program income account is reconciled monthly by fiscal staff and reports are forwarded to HOME program managers to enter the receipts into the Integrated Disbursement & Information System. While this process provides useful information on the available program income balance, it does not show the most current account balance. As a result, the Department cannot ensure that all program income available at the time of the draw is offset against the federal draw.

Further, the Department did not have an established process for entering program income information into the Integrated Disbursement & Information System as required by the federal grantor. Because receipts were not entered timely into the system, federal draws were not reduced by the amount of program income available causing excess federal funds to be drawn. The Department cites difficulties with working in the federal system and reconciling the federal system to the account balance as a cause for the condition.

Effect of Condition

As a result of this condition the Department received excess federal funds of approximately $350,000 during fiscal year 2013. Without a process to ensure that program income receipts are entered timely into the system, the Department cannot ensure that it complies with the requirement of its federal grantor to use program income first.

Additionally, the Department may be required to submit interest earned on this money to the federal government, if the interest earnings exceeded $100.

Recommendation

We recommend the Department:

- Enter all program income receipts into the Integrated Disbursement and Information System in a timely manner prior to making a draw.
- Develop policies and procedures necessary to disburse HOME program income before requesting additional federal cash draws.
- Consult with its grantor and the state Office of Financial Management to determine if any interest earnings are owed to the federal government.

Department's Response

The Department concurs with the finding. The Department did not record program income in the Integrated Disbursement and Information System (IDIS) in 2013 because staff new to the program was unable to navigate IDIS and was unaware of the requirement to input program income information. The reconciliation did not identify the missing IDIS information; it only included the bank and account balances.

The current reconciliation process will be reviewed to strengthen internal controls. The Department will refine its methodology for ensuring program income is spent before federal funds are drawn. The methodology will address the use of program income for both project and administrative costs.

In addition, the HOME program will update the procedures manual to:

- *Reference the regulations related to HOME program income*

- *Provide detailed navigation steps for IDIS*
- *Assign specific staff responsibilities*
- *Include instructions for establishing discrete accounting codes for federal and program income funds, to include separate codes for Department administration, grantee administration, and project expenses*

The Accounting Department will update the procedures manual to:

- *Reference the regulations for use of HOME program income*
- *Outline the steps required before federal dollars are drawn, including the requirement for entering the program income into IDIS prior to drawing funds*
- *Assign specific staff responsibilities, including supervisory review*
- *Identify the timing of notification to program management of program income balances*

Oversight of our corrective actions will include:

- *Monthly report of program income balance, interest earned, and uses of the balances to the Program Manager of the HOME Program*
- *Monthly review by the Accounting Supervisor of the reconciliation*
- *Testing of the corrective action process by the Internal Auditor to ensure the corrective actions implemented effectively address federal draw requirements*

The Department determined the interest on the program income account was $96. The Department will ensure the interest earned on the program income remains below the $100 in the future by maintaining a minimal balance in the program income bank account.

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.

Circular A-102 Common Rule for the administration of grants and cooperative agreements to state and local governments, 24 C.F.R. §85.21 Payment, states in part:

> (f) Effect of program income, refunds, and audit recoveries on payment.
> (1) Grantees and subgrantees shall disburse repayments to and interest earned on a revolving fund before requesting additional cash payments for the same activity.
> (2) Except as provided in paragraph (f)(1) of this section, grantees and subgrantees shall disburse program income, rebates, refunds, contract settlements, audit recoveries and interest earned on such funds before requesting additional cash payments.

U.S. Office of Management and Budget Circular A-102, *Grants And Cooperative Agreements With State and Local Governments*, states in part:

e. Program Income

(2) Federal agencies shall instruct grantees to deduct program income from total program costs as specified in the grants management common rule at paragraph __.25 (g)(1), unless agency regulations or the terms of the grant award state otherwise. Authorization for recipients to follow the other alternatives in paragraph __.25 (g) (2) and (3) shall be granted sparingly.

U.S. Office of Management and Budget Circular A-133 Compliance Supplement 2012, Part 3-Compliance Requirements, C. Cash Management, states in part:

. . .interest earned by local government and Indian tribal government grantees and subgrantees on advances is required to be submitted promptly, but at least quarterly, to the Federal agency. Up to $100 per year may be kept for administrative expenses.

Title 24, Code of Federal Regulations, part 92, section 502 - Program disbursement and information system, states in part:

(c) Disbursement of HOME funds.

(1) After complete project set-up information is entered into the disbursement and information system, HOME funds for the project may be drawn down from the United States Treasury account by the participating jurisdiction by electronic funds transfer. The funds will be deposited in the local account of the HOME Investment Trust Fund of the participating jurisdiction within 48 to 72 hours of the disbursement request. Any drawdown of HOME funds from the United States Treasury account is conditioned upon the provision of satisfactory information by the participating jurisdiction about the project or tenant-based rental assistance and compliance with other procedures, as specified by HUD.

(2) HOME funds drawn from the United States Treasury account must be expended for eligible costs within 15 days. Any interest earned within the 15 day period may be retained by the participating jurisdiction as HOME funds. Any funds that are drawn down and not expended for eligible costs within 15days of the disbursement must be returned to HUD for deposit in the participating jurisdiction's United States Treasury account of the HOME Investment Trust Fund. Interest earned after 15 days belongs to the United States and must be remitted promptly, but at least quarterly, to HUD, except that a local participating jurisdiction may retain interest amounts up to $100 per year for administrative expenses and States are subject to the Intergovernmental Cooperation Act (31 U.S.C. 6501 et seq.).

(3) HOME funds in the local account of the HOME Investment Trust Fund must be disbursed before requests are made for HOME funds in the United States Treasury account.

Title 2, Code of Federal Regulations, Grants and Agreements, Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, Subpart f – Audit Requirements, Section 200.516, Audit findings, states in part:

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

(7) Instances where the results of audit follow-up procedures disclosed that the summary schedule of prior audit findings prepared by the auditee in accordance with §200.511 Audit findings follow-up, paragraph (b) materially misrepresents the status of any prior audit finding.

2013-005 The Employment Security Department did not attempt to collect $881,375 overpaid to claimants for Federal Additional Compensation unemployment insurance.

Federal Awarding Agency:	U.S. Department of Labor
Pass-Through Entity:	None
CFDA Number and Title:	17.225 Unemployment Insurance
	17.225A Unemployment Insurance – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	UI-23925-13-55-A-53; UI-22347-12-55-A-53; UI-21133-11-55-A-53;
Applicable Compliance Component:	Special Tests and Provisions
Questioned Cost Amount:	$881,375 ARRA

Background

The Employment Security Department administers the Unemployment Insurance program that provides benefits to workers during periods of involuntary unemployment. The federal government and employers in Washington State primarily fund the program. In fiscal year 2013, Employment Security paid approximately $2 billion in benefits, $849 million of which was paid with money from the federal government.

As part of the American Recovery and Reinvestment Act legislation, states were allowed to issue an extra $25 per benefit week in Temporary Federal Additional Compensation to eligible claimants. This $25 was added to the regular weekly benefit for each claimant. In Washington State, these payments were made for benefit weeks between February 28, 2009 and December 11, 2010. The Department issued approximately $479 million in these payments during that time.

When the Department determines a benefit payment was improper, an overpayment is assessed and an overpayment notice letter is sent to claimants informing them of the amount they owe. The notice letters for overpayments that included the Federal Additional Compensation money contained the following statement: "*Since you are at fault for causing the overpayment, you are also at fault for the Federal Additional Compensation (FAC) payments in the amount of $__. We will bill you for this at a later date.*"

Once an overpayment notice letter is sent to a claimant, the Department has three years in which to initiate collection action. State law does not allow proceedings to collect such overpayments to begin after the three years have elapsed. The total outstanding Federal Additional Compensation overpayments as of June 30, 2013 was $6,490,682

Description of Condition

The Department has established collection methods for benefit overpayments that begin shortly after the overpayment notice letter is sent. The Department did not use these methods to collect on Federal Additional Compensation overpayments during the first part of fiscal year 2013. Between July 1, 2012 and September 7, 2012, the Department was unable to commence collection activity for $881,375 in Federal Additional Compensation overpayments. The Department had three years to begin collection of these overpayments before they became uncollectible under state law. All of these overpayments are now uncollectible.

Cause of Condition

The Department relies on software systems to record and track overpayments. Beginning in fiscal year 2009, and continuing through fiscal year 2012, the federal and state governments have passed legislation that made significant changes to the Unemployment Insurance program. Each change required the Department to reprogram its software systems. Due to the complexity of programming changes and limitations on staff able to perform them, the Department

was not able to make all changes immediately, but instead had to prioritize each change as it occurred. The Federal Additional Compensation overpayments were not incorporated into the software system and were not included in the Department's collections.

On September 7, 2012, the Department completed the necessary computer programming to bill, collect, and account for Federal Additional Compensation overpayments. Billing statements were subsequently mailed to claimants who had outstanding Federal Additional Compensation overpayment balances. As of June 30, 2013, the Department successfully collected $4,167,784 in these overpayments. Department efforts will continue as permitted by state and federal law to collect outstanding Federal Additional Compensation overpayment balances.

Effect of Condition and Questioned Costs

Between July 1, 2012 and September 7, 2012, $881,375 in Federal Additional Compensation overpayments became uncollectible because the Department had not initiated collection by the deadline for doing so. We are questioning these costs since the Department identified them as overpayments and did not attempt to collect them.

We question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support an expenditure.

Recommendation

We recommend the Department continue to bill, collect, and account for collection of Federal Additional Compensation overpayments before they become uncollectible.

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

Department's Response

As noted by the auditor, effective September 7, 2012 the Employment Security Department took the required steps to calculate, bill and collect FAC overpayments. The audit confirms the department has been successfully collecting FAC overpayments. As of August 30, 2013 ESD has billed 72,027 claimants for a total of $11,718,950 in FAC overpayments and collected $4,376,838 in principal and interest. Active collection efforts continue.

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.

Assistance for Unemployed Workers and Struggling Families Act- Section 2002, Agreement Between the State of Washington and the Secretary of Labor, U.S. Department of Labor, states in part:

> VIII. The Agency will take such action as reasonably may be necessary to recover for the account of the United States all benefit amounts erroneously paid and restore any lost or misapplied funds paid to the state for benefits or the administration of this agreement.

Revised Code of Washington 50.24.190, Limitation of actions, states in part:

> The commissioner shall commence action for the collection of contributions, interest, penalties, and benefit overpayments imposed by this title by assessment or suit within three years after a return is filed or notice of benefit overpayment is served. No proceedings for the collection of such amounts shall be begun after the expiration of such period.

2013-006 The Employment Security Department did not comply with the Federal Funding Accountability and Transparency Act reporting requirements for the Workforce Investment Act program.

Federal Awarding Agency:	U.S. Department of Labor
Pass-Through Entity:	None
CFDA Number and Title:	17.258 WIA Adult Program 17.258A WIA Adult Program – American Recovery and Reinvestment Act (ARRA) 17.259 WIA Youth Activities 17.260A WIA Dislocated Workers – American Recovery and Reinvestment Act (ARRA) 17.278 WIA Dislocated Worker Formula Grants
Federal Award Number:	AA-20227-10-55-A-53, AA-21429-11-55-A-53, AA-22969-12-55-A-53, AA-24126-13-55-A-53
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The federal Workforce Investment Act (WIA) provides a range of workforce development activities administered through the Employment Security Department and local area Workforce Development Councils (WDCs). These activities provide employment and training services designed to benefit employers, dislocated workers, and low-income youth.

The Department spent $58 million in WIA funds in fiscal year 2013, of which nearly $55 million was distributed to subrecipients.

Under the Federal Funding Accountability and Transparency Act, the Department is required to collect and report information on each sub-award of $25,000 or more in federal funds in the Federal Funding Accountability and Transparency Sub-award Reporting System. The reporting must be done by the end of the month following the month in which the sub-award was made. The intent of the Accountability Act is to empower citizens with the ability to hold the government accountable for spending decisions and, as a result, reduce wasteful spending in the government.

Description of Condition

We obtained a listing from the Department's Contracts Office showing that there were 119 WIA sub-awards entered into during fiscal year 2013.

During our review, we found the Department did not have internal controls in place to ensure the fiscal year 2013 Accountability Act reports were filed correctly.

We learned that the employee responsible for Accountability Act reporting does not track and enter each sub-award separately into the Federal Funding Accountability and Transparency Act Subaward Reporting System. In January 2013, the Department reported a lump sum total for each WDC. We inquired about a secondary review for entering the information, and were informed that this employee is the only person involved in the process of tracking and entering into the federal electronic reporting system.

The employee's understanding is that it was appropriate to report a lump sum for each WDC, because each WDC has their own Data Universal Numbering System (DUNS) number. The employee was not aware that sub-awards are required to be reported separately by the end of the following month after the contract was signed.

Cause of Condition

The Department did not have policies and procedures to ensure it was compliant with the Accountability Act reporting requirements.

The Department had one employee assigned to file the required reports. This employee was not aware of proper Accountability Act reporting requirements. There was no independent review of the employee's work to verify Accountability Act reports were being filed as required. The Department did not have a process to monitor grant activities to ensure the information was accurately submitted.

Effect of Condition

By not correctly submitting the required Accountability Act reports, the federal government's ability to ensure transparency and accountability of federal spending is diminished. 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 establish policies and procedures to ensure all Accountability Act reports are submitted accurately and timely.

Department's Response

The Employment Security Department is aware of its responsibility for reporting federal sub-grant awards on the Federal Funding Accountability Transparency Act Sub-award Reporting System (FSRS). The department has developed policies and procedures for ensuring sub-awards are properly reported on the FSRS and that entries are reviewed and reconciled to the federal grant documents for accuracy.

Also, the department has attempted for several months to update the information in the FSRS and has been unable to do so. ESD has been unable to update a critical field required for reporting purposes (zip code plus 4 in the address field). Department staff have contacted the federal website help desk several times and have been unable to get assistance to resolve the issue. The department is documenting these attempts as directed by the State Auditor's Office to reflect our good faith effort to comply with this requirement.

ESD will continue to pursue resolution of this issue until it is corrected at the federal level and we are able to report our sub-grant information.

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 2, Code of Federal Regulations, APPENDIX A TO PART 170—AWARD TERM, states, in part:

> I. Reporting Subawards and Executive Compensation.
>
> a. Reporting of first-tier subawards.
>
> 1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery

funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111–5) for a subaward to an entity (see definitions in paragraph e. of this award term).

2. Where and when to report.
   i. You must report each obligating action described in paragraph a.1. of this award term to http://www.fsrs.gov.
   ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)
3. What to report. You must report the information about each obligating action that the submission instructions posted at http://www.fsrs.gov specify.

2013-007 The Department of Ecology did not comply with the Federal Funding Accountability and Transparency Act reporting requirements for the Performance Partnership Grant program.

Federal Awarding Agency:	U.S. Environmental Protection Agency
Pass-Through Entity:	None
CFDA Number and Title:	66.605 Performance Partnership Grant
Federal Award Number:	BG-99086007
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The Washington State Department of Ecology administers the Performance Partnership Grant. This federal grant enhances the water and air quality work the Department performs.

The Department distributes money to seven local air quality agencies. When the Department gives an award to one of these entities it generally includes federal grant funds and state funds and covers two fiscal years. These entities use the funds to:

- Prevent and reduce air pollution, which includes ensuring compliance with all air quality laws and regulations
- Reduce emissions of high priority air pollutants, especially fine particles (PM2.5), ozone precursors, and air toxics
- Prevent violations of federal air quality standards; and
- Increase efficiencies and reduce transaction costs in air quality program administration and implementation

The Department spent approximately $10.5 million in Performance Partnership Grant funds in fiscal year 2013.

Under the Federal Funding Accountability and Transparency Act, the Department is required to collect and report information on each sub-award or amendment of $25,000 or more in federal funds in the Federal Funding Accountability and Transparency Sub-award Reporting System. The reporting must be done by the end of the month following the month in which the sub-award was made. The intent of the Accountability Act is to empower citizens with the ability to hold the government accountable for spending decisions and, as a result, reduce wasteful spending in the government.

Description of Condition

We determined there were two sub-awards or amendments totaling $135,335 entered into during fiscal year 2013 that should have been reported in the Federal Funding Accountability and Transparency Act Subaward Reporting System for the Performance Partnership Grant program. The Department actually reported 12 subawards totaling $4,890,490 during fiscal year 2013.

During our review, we found the Department did not have sufficient internal controls in place to ensure the fiscal year 2013 Accountability Act reports were filed correctly. The Department was reporting awards that had already been previously reported; some of which were reported correctly and some with the wrong dollar amount. We also found some reports that were reported more than one time.

	Amount that Should Have Been Reported	Date the Report was Due	Amount and Date Actually Reported				
			12/6/2011	12/6/2011	1/27/2013	1/27/2013	Cumulative Reporting Errors
	$ 267,122.00	9/30/2011	$ 267,122.00		$ 267,122.00	$ 267,122.00	$ 534,244.00
	$1,811,838.00	10/31/2011	$1,269,498.00		$1,269,498.00	$1,269,498.00	$1,996,656.00
	$ 105,335.00	7/31/2012					$ (105,335.00)
	$ 30,000.00	10/31/2012			$ 30,000.00		$ -
	$ 389,264.00	10/31/2011	$ 389,264.00				$ -
	$ 163,243.00	9/30/2011	$ 135,846.00		$ 135,846.00	$ 135,846.00	$ 244,295.00
	$ 352,453.00	9/30/2011	$ 352,453.00		$ 352,453.00	$ 352,453.00	$ 704,906.00
	$ 308,604.00	9/30/2011	$ 267,612.00	$267,612.00	$ 267,612.00		$ 494,232.00
	$ 393,264.00	10/31/2011	$ 271,520.00		$ 271,520.00	$ 271,520.00	$ 421,296.00
Totals	**$3,821,123.00**		**$3,220,927.00**		**$4,890,490.00**		**$ 4,290,294.00**

Cause of Condition

While the Department had policies and procedures in place, they were not sufficient to ensure it was compliant with the Accountability Act reporting requirements. The written guidance provided to the program and fiscal staff was unclear as to what amounts should be reported and when an amount was reportable.

The process in place for identifying whether a report had already been filed was not sufficient to prevent double and triple reporting. The written guidance provided to staff for this process was also insufficient to ensure accurate reporting.

The Department had assigned the responsibility to submit the required reports to program and fiscal staff but did not have supervisory or managerial reviews in place.

Effect of Condition

By not reporting proper amounts and reporting awards multiple times, the information available to the public was incorrect. When viewing the federal awards in the public system users should have seen nine awards totaling $3,821,123, however what was actually reported was 20 awards totaling $8,111,417.

By not correctly submitting the required Accountability Act reports, the federal government's ability to ensure transparency and accountability of federal spending is diminished. 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 establish policies and procedures to ensure Accountability Act reports are submitted accurately. We also recommend the Department correct the subawards that have been improperly reported in the Federal Funding Accountability and Transparency Sub-award Reporting System.

Department's Response

The Department concurs with the finding. To address the weaknesses noted in the finding, Ecology has:

- *Conducted training on Federal Funding Accountability and Transparency Act reporting requirements.*
- *Clarified written procedures to ensure Accountability Act reports are submitted accurately and timely.*

- *Corrected improper reporting in the Federal Funding Accountability and Transparency Sub-award Reporting System.*
- *Communicated updated procedure and conducted training to the team assigned the responsibility of reporting Accountability Act data.*

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.

Title 2, Code of Federal Regulations, Appendix A To Part 170—Award Term, states, in part:

> I. Reporting Subawards and Executive Compensation.
>
> a. Reporting of first-tier subawards.
>
> 1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111–5) for a subaward to an entity (see definitions in paragraph e. of this award term).
> 2. Where and when to report.
>
> i. You must report each obligating action described in paragraph a.1. of this award term to http://www.fsrs.gov.
>
> ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)
>
> 3. What to report. You must report the information about each obligating action that the submission instructions posted at http://www.fsrs.gov specify.

2013-008 The Department of Ecology improperly claimed $53,971.49 in federal reimbursement for the Performance Partnership Grant program.

Federal Awarding Agency:	U.S. Environmental Protection Agency
Pass-Through Entity:	None
CFDA Number and Title:	66.605 Performance Partnership Grant
Federal Award Number:	BG-99086007
Applicable Compliance Component:	Activities Allowed/Cost Principles
Questioned Cost Amount:	$53,971.49

Background

The Washington State Department of Ecology administers the Performance Partnership Grant. This federal grant enhances the water and air quality work the Department performs. The Department spent approximately $10.5 million in Performance Partnership Grant funds in fiscal year 2013 and over $5.5 million was spent on employee salaries and benefits.

Federal regulations specify the documentation grantees must keep to support employee compensation charged to federal grants. Payroll costs for employees who work on multiple activities must be supported by personnel activity reports or equivalent documentation, such as timesheets. When an employee uses paid leave time it can be charged to a federal grant only in proportion to the average amount of regular work time charged to the grant. All Department employees whose direct salaries are paid with Performance Partnership Grant funds keep timesheets and record the amount of leave time to charge to the federal grant as a separate item on their timesheet.

Description of Condition

We identified five employees who did not charge paid leave time to the federal grant in proportion to the amount of regular time worked on the grant during the month of November. Because leave time should be charged based on the average amount of time charged to the grant, we expanded our testing for these five individuals to determine if November was representative of their normal division of work. We examined the total amount of time charged to the grant for fiscal years 2012 and 2013 and compared the percentage of regular time worked on the grant to the percentage of leave time charged to the grant. We identified the following:

Employee	Percentage of actual work time charged to the grant	Percentage of leave charged to PPG	Amount the grant was overcharged
Employee #1	7.3%	80.7%	$ 3,449.70
Employee #2	0.6%	65.5%	$ 15,263.43
Employee #3	0.5%	68.4%	$ 13,137.13
Employee #4	43.8%	81.6%	$ 8,374.41
Employee #5	19.7%	100.0%	$ 13,746.83
Total Amount the grant was overcharged			**$ 53,971.49**

Based on our testing we determined the five employees in question were charging leave to the grant at a much higher rate than their actual hours worked were charged.

Cause of Condition

For four employees the review of the time sheets by supervisory staff was insufficient to ensure the grant was properly charged. The Department stated a staff member had created an incorrect master time sheet template and had provided it to other staff members to use. While this may have caused the initial errors, the improper charging of time by the four employees occurred many times and was not detected during the supervisory review of time sheets.

The Department instructed one employee to charge all of their leave to the federal grant even though regular work hours were charged to other sources, including another federal program. The decision to charge the grant for all leave was made without knowledge that this method of allocation is not allowable.

The Department does not have written payroll policies in place to provide guidance on how time is to be charged to a federal grant.

Effect of Condition and Questioned Costs

The Department requested reimbursement for $53,971.49 in fringe benefits that were unallowable costs. We are questioning costs because the Department did not charge the grant in accordance with federal regulations.

We question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support an expenditure.

Recommendation

We recommend the Department ensure supervisors who are reviewing employee time sheets are knowledgeable to perform an accurate review and identify improper charges prior to approval. We also recommend the Department establish policies and procedures to ensure managers, supervisors and staff have guidance on how to properly charge work and leave time to federal grant programs.

Department's Response

The Department concurs with the finding. We will establish procedures to ensure managers, supervisors and staff have guidance on how to properly charge work and leave time to federal grant programs. Ecology will consult with the Environmental Protection Agency to determine if any questioned costs should be 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

2 CFR § 225, Appendix B, Circular No. A 87, Selected Items of Cost, states in part:

8. *Compensation for personal services.*
   d. Fringe benefits.
      (1) Fringe benefits are allowances and services provided by employers to their employees as compensation in addition to regular salaries and wages. Fringe benefits include, but are not limited to, the costs of leave, employee insurance, pensions, and unemployment benefit plans. Except as provided elsewhere in these principles, the costs of fringe benefits are allowable to the extent that the benefits are reasonable and are required by law, governmental unit employee agreement, or an established policy of the governmental unit.
      (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: (a) they are provided under established written leave policies; (b) the costs are equitably allocated to all related activities, including Federal awards; and, (c) the accounting basis (cash or accrual) selected for costing each type of leave is consistently followed by the governmental unit.

2013-009 The Office of the Superintendent of Public Instruction does not have sufficient internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act for the Migrant Education and Title IIA Improving Teacher Quality programs are filed.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.011 Migrant Education
	84.367 Tittle IIA Improving Teacher Quality
Federal Award Number:	S011A120048, S367A120045
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The Migrant Education program is administered by the Office of the Superintendent of Public Instruction. The Migrant Education program is responsible for the delivery of broad-based and diverse programming that targets the unique population of migrant youth.

The Office spent approximately $15.2 million in Migrant Education program funds in fiscal year 2013, of which approximately $12.1 million was distributed to subrecipients.

The Title IIA program is administered by the Office of the Superintendent of Public Instruction. The Title IIA program is responsible for providing funds to local education agencies to improve teacher and principal quality.

The Office spent approximately $41.4 million in the Title IIA program funds in fiscal year 2013, of which approximately $40.7 million was distributed to subrecipients.

Under the Federal Funding Accountability and Transparency Act, the Office is required to collect and report information on each sub-award of $25,000 or more in federal funds in the Federal Funding Accountability and Transparency Sub-award Reporting System. The reporting must be done by the end of the month following the month in which the sub-award was made. The intent of the Accountability Act is to empower citizens with the ability to hold the government accountable for spending decisions and, as a result, reduce wasteful spending in the government.

Description of Condition

The Office did not have internal controls in place to ensure all required sub-awards were reported through the Federal Funding Accountability and Transparency Sub-Award Reporting System for fiscal year 2013.

For the Migrant Education program, the employee responsible for Accountability Act reporting was not aware that all subrecipients paid over $25,000 had not been reported through the Federal Funding Accountability and Transparency Sub-award Reporting System. The employee had reported all 51 sub-awards related to school-year program funding, however, had overlooked the filing of sub-awards related to summer program funding.

The Office made 13 sub-awards for the summer program totaling $969,444. We determined that all 13 sub-awards were not filed during the audit period. The agency submitted the 13 sub-awards in February 2014.

Further, for the Title IIA program there were 182 sub-awards over $25,000 in the fiscal year. We found the Office did not file 87 sub-awards for the month of September 2012 and one sub-award for the month of December 2012 through the Federal Funding Accountability and Transparency Sub-award Reporting System. The agency subsequently submitted these 88 sub-awards in January 2014.

Cause of Condition

The Office did not have policies and procedures to ensure it was compliant with the Accountability Act reporting requirements.

The Office had one employee assigned to file the required reports, who is no longer with the agency. The employee currently assigned to this responsibility was not aware that sub-awards for the summer program had not been filed. There was no independent review of the employee's work to verify Accountability Act reports were being filed as required.

Effect of Condition

By not correctly submitting the required Accountability Act reports, the federal government's ability to ensure transparency and accountability of federal spending is diminished. Grant conditions allow the grantor to penalize the Office for noncompliance, suspending or terminating the award, and withholding future awards.

Recommendation

We recommend the Office establish policies and procedures to ensure all Accountability Act reports are submitted accurately and timely. We further recommend that a secondary review is conducted.

Office's Response

We concur that some sub-awards were not reported through the Federal Funding Accountability and Transparency Act Sub-Award Reporting System. An internal control will be put in place to ensure the monthly reporting of sub-awards is complete and accurate.

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.

Title 2, Code of Federal Regulations, APPENDIX A TO PART 170—AWARD TERM, states, in part:

> I. Reporting Subawards and Executive Compensation.
>
> a. Reporting of first-tier subawards.
>
> 1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111–5) for a subaward to an entity (see definitions in paragraph e. of this award term).
>
> 2. Where and when to report.
>
> i. You must report each obligating action described in paragraph a.1. of this award term to http://www.fsrs.gov.

ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)

3. What to report. You must report the information about each obligating action that the submission instructions posted at http://www.fsrs.gov specify.

Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS)

https://www.fss.gov/#a-faqs:

GRANTS

In accordance with 2 CFR Chapter 1, Part 170 REPORTING SUB-AWARD AND EXECUTIVE COMPENSATION INFORMATION, Prime Awardees awarded a federal grant are required to file a FFATA Sub-award report by the end of the month following the month in which the prime awardee awards any sub-grant equal to or greater than $25,000. The reporting requirements are as follows:

- This requirement is for both mandatory and discretionary grants awarded on or after October 1, 2010.

2013-010 The Office of the Superintendent of Public Instruction does not have sufficient controls over, and was not compliant with, the requirements for determining subawards for each school district's share of Migrant Education funding.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.011 Migrant Education-State Grant Program
Federal Award Number:	S011A120048
Applicable Compliance Component:	Special Tests and Provisions-Subgrant Process
Questioned Cost Amount:	None

Background

The Office of the Superintendent of Public Instruction administers the Migrant Education-State Grant Program in Washington State. The Migrant Education program is responsible for the delivery of broad-based and diverse programing that targets the unique population of migrant youth. Assistance can be used in many different ways and the funds are allocated to a State based on a consolidated application in which the applicant specifies how the funds will be used.

Federal regulations require states to incorporate four factors when determining the amount of Migrant Education funding to award to school districts. They are 1) the number of migrant children; 2) the needs of migrant children; 3) the statutory priority to first serve children who are failing, or most at risk of failing to meet the State's challenging State academic content standards and whose education has been interrupted during the regular school year; and 4) the availability of funds from other Federal, State and local programs.

In 2011 the U.S. Department of Education (ED) performed a site visit of the Office's Migrant Education program. During this visit, ED determined the Office was not properly calculating each district's funding amount. ED stated the Office was not taking into account multiple required criteria and was not following the process as outlined in its Consolidated State Application. In response to this finding the Office worked with ED to establish a funding formula that met federal regulations. This funding formula was then incorporated into the state consolidated application as an amendment dated August 1, 2012. In the amendment the Office explicitly states they will use this formula to calculate all subawards made with Migrant Education funds.

The Office spent approximately $15.2 million in Migrant Education program funds in fiscal year 2013. It awarded 94 subawards to districts totaling approximately $12.1 million; 66 of the subawards were for programs during the regular school year and 28 were for summer programs.

Description of Condition

The Office did not follow the funding formula specified in the Consolidated State Application when determining the amount of summer program subawards. The Office established a separate formula for determining the amount of subawards for the summer program and did not include all of the four federally required criteria. Because the Consolidated Application does not specify a separate formula for allocating summer program dollars we were unable to determine what the summer program awards should have been, or even if summer funds should have been awarded.

We also found the Office did not properly apply all of the criteria when calculating the regular year awards. Using the same supporting data the Office used to calculate the subawards, we were able to recalculate the amounts that should have been awarded for the regular school year programs. We determined that 17 subawards were over awarded by a total of $54,548. We also determined a total of 49 subawards were under awarded by the same amount. The average error for each subaward was $1,653 and the average error as a percentage of the award was 3 percent. The largest individual errors were an over award of $10,689 and an under award of $9,631.

Cause of Condition

The miscalculation of the summer program was a result of the Program Director believing a separate formula could be used for summer programs even though there is no mention of this in the State Consolidated Application or governing regulations.

The miscalculation of the regular school year program amounts was the result of an insufficient review of the subaward calculations prior to the awards being made. Program staff informed us the subaward formula was being defined at the same time the awards were being calculated. During this time the program was modifying the formula to determine what effects each factor would have and they did not readjust one of the factors after the final funding formula was determined. Once the calculations were completed they were reviewed by the Program Director and one staff member. The staff member reviewed for reasonableness and year to year variances, but not did not review the calculations. The Program Director also performed a review that included a sampling of some, but not all, of the calculations involved. Without a full secondary review the Office was unable to detect the error.

Effect of Condition

The funding formula requirements are designed to ensure the federal funding reaches those school districts and students with the most need. Not following the approved formula may have resulted in students receiving more services while others received less, resulting in inequitable services. Additionally, many eligible districts turn down the funds for this program after being told by the Office what their estimated funding level will be. When this calculation is not correct it may cause a district to reject an award it may have accepted if it was told the proper award amount.

We were unable to determine the effect of the improper calculation of the summer program funds because the data used for the calculations was not sufficient for us to recalculate.

By not calculating subawards in the manner stated in their application, the Office may be at risk the federal grantor will take actions that could adversely affect the program and/or the program funding.

R**ecommendation**

We recommend the Office calculate all subawards in accordance with their approved funding formula and federal regulations. If the Office wants to use a different formula to award funds for a summer program we recommend they work with their grantor and receive approval before using it

We also recommend the Office ensure the subaward calculations receive a secondary review that is sufficient to detect noncompliance with the approved funding formula.

Department's Response

We agree there was an error in the allocation of sub-awards for both regular and summer programs. The average error for each sub-award was $670 for the summer program and $1,653 for the regular program. An internal control will be put in place to ensure sub-awards are accurately calculated and comply with federal regulations.

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.

CFR Title 34: Education

PART 76—STATE-ADMINISTERED PROGRAMS

Subpart G—What Are the Administrative Responsibilities of the State and Its Subgrantees?

GENERAL ADMINISTRATIVE RESPONSIBILITIES

§76.700 Compliance with statutes, regulations, State plan, and applications.

A State and a subgrantee shall comply with the State plan and applicable statutes, regulations, and approved applications, and shall use Federal funds in accordance with those statutes, regulations, plan, and applications.

20 USC§ 6394, Elementary and Secondary Education Title 1, Part C – Education of Migratory Children. State applications; services, states in part:

(a) Application required – Any State desiring to receive a grant under this part for any fiscal year shall submit an application to the Secretary at such time and in such manner as the Secretary may require.

(b) Program information- Each such application shall include—

….

(5) a description of how the State will determine the amount of any subgrants the State will award to local operating agencies, taking into account the numbers and needs of migratory children, the requirements of subsection (d), and the availability of funds from other Federal, State, and local programs;

(d) PRIORITY FOR SERVICES- In providing services with funds received under this part, each recipient of such funds shall give priority to migratory children who are failing, or most at risk of failing, to meet the State's challenging State academic content standards and challenging State student academic achievement standards, and whose education has been interrupted during the regular school year.

Washington State Migrant Education, Amendment to the Consolidated State Application

b) Title 1, Part C: Education of Migrant Children

Process to Award Sub-grants

A. Determine the projected funding allocation based on the State funding formula.
   1. The numbers of migrant children with a qualifying Certificate-of-Eligibility (COE).
   2. The needs of migrant children: Need in one or more of the academic areas (reading, math,writing, and science).
   3. The statutory priority: Number of students identified as Priority for Service.
   4. Other funds available
   5. Rural School Factor.

3) Title 1, Part C Education of Migrant Children

c) Description of how the State will determine the amount of any sub-grants the State will award to local operating agencies, taking into account the numbers and needs of migrant children, the statutory priority for service in section 1304(d), and the availability of funds from other Federal, State and local programs. (Applicable only if not previously addressed in Part II, #2.)

Subgrants will be awarded to local operating agencies based on the SEA funding formula

The state has amended the funding formula for distributing MEP funds that meets the requirements in section 1304(b) (5) of the statute and to respond to OME's compliance item (Finding 1 – State Administration: Subgrant Formula). Funding to LOA will be determined by the following factors:

LEA FUNDING FORMULA

FACTORS	WEIGHT	DEFINITIONS
Factor 1	1.0	Number of students with a qualifying Certificate-of- Eligibility (COE).
Factor 2	0.25	Need in one or more of the academic areas (reading, math, writing, and science). Student counted only once regardless of areas not meeting state standards.
Factor 3	1.0	Number of students identified as Priority for Service ***Criterion #1*** *–Migratory children whose education has been interrupted during the regular school year,* ***and*** ***Criterion #2*** *– Migratory children who are failing, or most at risk of failing, to meet the State's challenging State academic content standards and challenging State student academic achievement standards.*
Factor 4	Other funds available	Other funding sources (Title I A, Title III, Transitional Bilingual Program (TBIP), Learning Assistance Program (LAP) and Title I C divided into total migrant dollars allocated. Formula: Title I A + Title III +TBIP + LAP + Title I C = Total dollars Title I C dollars / by total dollars = percent of total other dollars

Other Funds Proportion	Rank	Increase or Decrease Factor	Weight- % of total Other $
Districts with a larger portion of "other funding".	0% - 5%	-15% factor	.85
	5% - 10%	-5% factor	.95
Districts with a median percentage of Title I Part C funds.	10% - 15%	No factor	1
Districts with smallest portion of "other funding" available.	15% - 20%	+5% factor	1.05
	25% and above	+15% factor	1.15

Factor 5	0.10	School districts that meet the definition of rural and are geographically remote. Washington State encompasses a large geographical area with approximately 50% of migrant families residing in rural areas of the state. The cost factor for LEAs to access support services such as parent regional meeting, state required trainings, professional development, and opportunities for students to participate in activities outside of the LEA require more resources.

2013-011 The Department of Services for the Blind charged indirect costs related to the Vocational Rehabilitation program to its federal grant without an approved indirect cost rate.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Vocational Rehabilitation Grants to States
Federal Award Number:	H126A120072
Applicable Compliance Component:	Allowable Costs/ Cost Principles
Questioned Cost Amount:	$1,119,396

Background

The Vocational Rehabilitation program is designed to assess, plan, develop, and provide vocational rehabilitation services for individuals with disabilities. The Department of Services for the Blind administers the federal Vocational Rehabilitation program for visually impaired individuals. The Department received approximately 16.3 percent ($8.6 million) of total federal Vocational Rehabilitation funding received by the state during fiscal year 2013.

When designing federal programs, states typically have both direct and indirect costs associated with the program. Direct costs are those that are directly related to the goals of the program, and can be charged directly to the grant. Indirect costs are those incurred for a common purpose and that benefit multiple programs. These costs must be split and charged to each benefitting program. In order to charge indirect costs to a federal award, grantees must have an approved cost allocation plan or indirect cost rate in place. States may be granted temporary rates to use during the fiscal year, and then a final rate will be determined after the fiscal year.

Description of Condition

The Department inappropriately charged indirect costs to the Vocational Rehabilitation program. The Department was issued a finding during the fiscal year 2012 audit for charging indirect costs without an approved rate. The Department acknowledged the audit finding and submitted a rate proposal to their federal oversight agency on April 9, 2013. Rehabilitation Services Administration received a copy of this submission which included the proposed plan and rate. This initial submission lacked sufficient detail and was not approved.

Cause of Condition

The Department continued to charge indirect costs to the grant using a rate not approved by the federal grantor. Management stated that they continued to charge indirect costs, because conversations with their grantor led them to believe the rate will be approved in the future.

Effect of Condition and Questioned Costs

We identified $1,119,396 in indirect expenditures charged to the federal grant during fiscal year 2013. Without an approved indirect cost rate, the federal grantor cannot ensure indirect costs charged to the grant are allowable or appropriate. We are questioning the indirect costs charged to the federal grant of $1,119,396.

We question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support expenditures.

Recommendation

We recommend the Department work with its federal grantor to ensure an approved indirect cost proposal is established prior to submitting further indirect expenditures. We also recommend that once an indirect cost approval rate is received, that it be updated annually. The Department should ensure the approved correct rate is being applied to the program's indirect costs. The Department should consult with its grantor to determine if any questioned costs should be repaid.

Department's Response

The Department agrees with the audit finding. Upon the initial finding, the Department submitted an indirect cost rate proposal to the U.S. Department of Education/Indirect Cost Goup on February 26, 2013 and requested a negotiated settlement for questioned costs. In April, the Department contacted the Indirect Cost Goup to inquire on the status of the proposal and were informed that the proposal had not been received. The Department resubmitted the proposal and received confirmation of receipt on April 9, 2013. In May, the Department underwent a monitoring review by the U.S. Department of Education/Rehabilitation Services Administration. The report received from this review indicated that the Indirect Cost Group found the Department's proposal lacked sufficient detail to be approvable. The Department attempted on numerous occations to receive feedback on what was insufficient in the proposal. The Department met with a representative of the Rehabilitation Services Administration on August 29th and received feedback. Based on this information, the Department sent a revised plan to the Rehabilitation Services Administration to ascertain if the revised plan would be accepted by the Indirect Cost Group. On December 6th, the Department received additional feedback from the Rehabilitation Services Administration requesting additional information. The Department is currently revising the plan to meet the expectations of the U.S. Department of Education. It is hopeful that this will be resolved by January 31, 2014. Based on direction from the Rehabilitation Services Administration, the Department has ceased applying indirect costs to their federal grants.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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.

Code of Federal Regulations, Title 34 – Education, Part 76.560, states:

(a) The differences between direct and indirect costs and the principles for determining the general indirect cost rate that a grantee may use for grants under most programs are specified in the cost principles for—
   (1) Institutions of higher education, at 34 CFR 74.27;
   (2) Hospitals, at 34 CFR 74.27;
   (3) Other nonprofit organizations, at 34 CFR 74.27;
   (4) Commercial (for-profit) organizations, at 34 CFR 74.27; and
   (5) State and local governments and federally-recognized Indian tribal organizations, at 34 CFR 80.22.

(b) A grantee must have a current indirect cost rate agreement to charge indirect costs to a grant. To obtain an indirect cost rate, a grantee must submit an indirect cost proposal to its cognizant agency and negotiate an indirect cost rate agreement.

(c) The Secretary may establish a temporary indirect cost rate for a grantee that does not have an indirect cost rate agreement with its cognizant agency.

(d) The Secretary accepts an indirect cost rate negotiated by a grantee's cognizant agency, but may establish a restricted indirect cost rate for a grantee to satisfy the statutory requirements of certain programs administered by the Department.

2013-012 The Department of Health does not have sufficient internal controls to ensure it meets federal level of effort requirements for the Public Health Emergency Preparedness and National Bioterrorism Hospital 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 Program
Federal Award Number:	1U90TP000559; 2U90TP017010-10; 6U3REP090228
Applicable Compliance Component:	Level of Effort
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 public health emergencies.

The Department distributes money to hospitals, outpatient facilities, tribes, health centers, poison control centers, emergency management services and others. These entities oversee training, meetings, purchasing of supplies and equipment, and generate reports on the program. The Department spent approximately $12.3 million in Public Health Emergency Preparedness funds and $6.4 million in Hospital Preparedness Program funds in fiscal year 2013.

Under the Public Health Emergency Preparedness grant, the Department is required to maintain state-funded public health security spending at a level that is at least equal to the average of the previous two years spending. The Department is also required to maintain state-funded healthcare preparedness spending at a level that is at least equal to the average of the previous two years spending for the National Bioterrorism Hospital Preparedness grant.

We reported findings in our fiscal year 2011 and 2012 audits that noted the Department did not have sufficient internal controls to ensure compliance with level of effort requirements for either grant program.

Description of Condition

Through the end of fiscal year 2013 the Department had not enacted internal controls to monitor its level of effort requirements. Although a significant amount of state funds are spent on these two programs, the Department reported to the grantor that it spent $0 for its level of effort requirement. The Department received definitive guidance from the federal grantors in May of 2013 but did not enact new internal controls prior to the end of the fiscal year.

We determined the Department spent $ 268,690 less than what was required to meet its level of effort requirement for the National Bioterrorism Hospital Preparedness grant during fiscal year 2013.

Cause of Condition

The Department was not tracking level of effort spending because management previously determined the required expenditures under the federal level of effort requirement was $0. In May of 2013 the Department received clarification of its requirements from its federal grantors. While the Department now concurs, it was unable to establish controls prior to the end of the fiscal year to ensure it met level of effort requirements.

Effect of Condition

By not properly tracking, documenting and reporting that level of effort requirements are being met, the Department was not in compliance with this requirement for the National Bioterrorism Hospital Preparedness Program.

Recommendation

The Department should create and enact policies, procedures and other internal controls sufficient to ensure the tracking, documenting and reporting of all state preparedness dollars is performed accurately and completely. The Department should also actively monitor state-funded preparedness spending to ensure it spends at least the minimum required amount each year for both grants.

Department's Response

The Department concurs with the finding. We consulted with our federal partners in May 2013 and received guidance which helped to define internal controls necessary to establish and monitor maintenance of effort. The Department has established maintenance of effort levels for the current grant period and is developing policy and procedures to ensure that we are in compliance with the federal requirements on maintenance of effort tracking and reporting.

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 Compliance Supplement Subpart C--Auditees§___.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.

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

FY12 Cooperative Agreement TP 12-1201 HPP and PHEP Cooperative Agreements

Section IV – TP Special Terms and Conditions 1U90TP000559-01

Note 10: Maintenance of Funding (Maintain State Funding): Public Law 109-417 requires that the awardee maintain expenditures at a level that is not less than the average level of the preceding two years.

Awardees must be able to account for Maintenance of Funding (MOF) separate from accounting for federal funds and separate from accounting for any matching funds requirements; this accounting is subject to ongoing monitoring, oversight, and audit. MOF may not include any subawardee matching funds. MOF does not apply to future contingent emergency response awards that may be authorized

under 317(a) and 317(d) of the Public Health Service Act unless such a requirement were imposed by statute or administrative process at the time.

2013-013 The Department of Health does not have sufficient internal controls over, and did not comply with, the Federal Funding Accountability and Transparency Act reporting requirements for the Public Health Emergency Preparedness and National Bioterrorism Hospital 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 Program
Federal Award Number:	1U90TP000559; 2U90TP017010-10; 6U3REP090228
Applicable Compliance Component:	Reporting
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 public health emergencies.

The Department distributes money to hospitals, outpatient facilities, tribes, health centers, poison control centers, emergency management services and others. These entities oversee training, meetings, purchasing of supplies and equipment, and generate reports on the program. The Department spent approximately $12.3 million in Public Health Emergency Preparedness funds and $6.4 million in Hospital Preparedness Program funds in fiscal year 2013.

Under the Federal Funding Accountability and Transparency Act, the Department is required to collect and report information on each sub-award or amendment of $25,000 or more in federal funds in the Federal Funding Accountability and Transparency Sub-award Reporting System. The reporting must be done by the end of the month following the month in which the sub-award was made. The intent of the Accountability Act is to empower citizens with the ability to hold the government accountable for spending decisions and, as a result, reduce wasteful spending in the government.

In order for the Department to file an Accountability Act report, the federal grantor agency must first enter their award into the reporting system. The screen where the Department enters the award number to report includes a message that says if you are unable to find or report on an award that should be present in the system you are to contact your grant making official for help.

Description of Condition

During our review, we found the Department did not have sufficient internal controls in place to ensure the fiscal year 2013 Accountability Act reports were filed correctly. We attempted to test the reports but the supervisor responsible for submitting them said no reports were filed for either program during fiscal year 2013. He said the federal awards were not available in the system but he did not contact the grantor for help. The Department's procedure for this type of situation was to wait until the next report was due and see if the federal grantor had entered it since the last attempt to file.

We determined the Department awarded 28 subawards or amendments totaling $6,299,806 during fiscal year 2013 that should have been reported for the Public Health Emergency Preparedness Program. There were 24 subawards or amendments totaling $4,957,022 that should have been reported for the Hospital Preparedness Program.

Cause of Condition

The Department did not have sufficient policies and procedures to ensure it was compliant with the Accountability Act reporting requirements. The Department's procedures did not include a course of action to ensure compliance when a report could not be found in the Accountability Act reporting system.

Effect of Condition

By not correctly submitting the required Accountability Act reports, the federal government's ability to ensure transparency and accountability of federal spending is diminished. 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 establish policies and procedures to ensure all Accountability Act reports are submitted as required.

Department's Response

The Department collected the Accountability Act information and attempted to report this information, however the grant award was not added to the FFATA Subaward Reporting System (FSRS) by the grantor. The Department is not allowed to add missing awards.

Per SAO recommendations, we will revise our procedures and email the federal grantor when awards reportable under the Federal Funding Accountability and Transparency Act (FFATA) are not available to report on in the FSRS. We anticipate this change to be effective January 1, 2014.

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.
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> (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, APPENDIX A TO PART 170—AWARD TERM, states, in part:

> I. Reporting Subawards and Executive Compensation.
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> a. Reporting of first-tier subawards.
>
> 1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111–5) for a subaward to an entity (see definitions in paragraph e. of this award term).
>
> 2. Where and when to report.

i. You must report each obligating action described in paragraph a.1. of this award term to http://www.fsrs.gov.
ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)

3. What to report. You must report the information about each obligating action that the submission instructions posted at http://www.fsrs.gov specify.

2013-014 The University of Washington does not have monitoring controls to ensure subrecipients expending $500,000 or more in total federal dollars obtain an audit.

Federal Awarding Agencies:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.266	Health Systems Strengthening and HIV/AIDS Prevention, Care and Treatment under the President's Emergency Plan for AIDS Relief
	93.145	AIDS Education and Training Centers
	93.600	HeadStart
Federal Award Number:	U91HA06801	
	90HC0002	
Applicable Compliance Component:	Subrecipient Monitoring	
Questioned Cost Amount:	None	

Background

Federal regulations require the University of Washington to monitor the grant-funded activities of domestic and foreign subrecipients. This includes ensuring organizations that spend $500,000 or more in total from all sources of federal grant money during a fiscal year receive an audit of expenditures and internal controls over that money, in accordance with the federal Office of Management and Budget Circular A-133 for domestic subrecipients, as required. If the subrecipient is a foreign organization that is funded by the Department of Health and Human Services (DHHS), the DHHS requires the University of Washington to monitor the grant-funded activities of its foreign subrecipients. This includes ensuring the foreign organizations obtain a financial related audit or an audit that meets the requirements of OMB Circular A-133, in accordance with the DHHS Grant Policy Statement and the Code of Federal Regulations.

These requirements are designed to ensure grant money is used for authorized purposes in compliance with laws, regulations and the provisions of contracts or grant agreements. Domestic grant recipients must submit the results of these audits to the federal clearinghouse within nine months of their fiscal year end and foreign recipients must submit the results to the University.

We reported a finding in our last fiscal year audit that noted the University did not have monitoring controls to ensure subrecipients receiving less than $500,000 from the University obtain audits when required. As a result of that finding, the University started a process at the end of the current audit period to monitor this requirement for domestic subrecipients, but no actual monitoring was performed until after the end of the current fiscal year.

Description of Condition

We reviewed the University's process to ensure audit reports are obtained from subrecipients. We found the University is not ensuring that subrecipients who receive less than $500,000 from the University, but whose total expenditures of federal awards exceed $500,000 annually, obtain a required audit. We also found the University does not have monitoring controls to ensure domestic and foreign subrecipients receiving less than $500,000 from the University obtain audits when required. We found the University does ensure subrecipients awarded more than $500,000 from the University receive an audit each year.

Further, the University does not include the requirement to obtain an audit in the subcontract language with foreign subrecipients. The University does not have an alternative way of notifying foreign subrecipients of the requirement other than verbal correspondence, of which, we cannot verify. The University of Washington does not have monitoring controls to ensure foreign subrecipients that didn't obtain an audit were exempt from audit requirements.

During our discussion with the University, we were told that subcontract language was added in March, 2013 to inform foreign subrecipients of audit requirements. This will be reviewed during the fiscal year 2014 audit.

Cause of Condition

The University does not monitor subrecipient's compliance with federal audit requirements when the subrecipient's total award from the University is less than $500,000.

For domestic subrecipients, it relies on the subrecipient to adhere to the subcontract language, which requires the subrecipient to submit an A-133 report when their total spend exceeds $500,000.

Additionally, for foreign subrecipients the University has not included language related to A-133 audit requirements. A-133 is not applicable to foreign entities, however, the University has maintained a practice of obtaining other audit documentation from the foreign entities with subcontracts award exceeding $500,000. The University does not verify and document any subrecipients who do not receive more than $500,000 in total federal funds.

Effect of Condition

The University is not certain whether all of its subrecipients complied with federal grant requirements. We reviewed a total of 26 subrecipient files, thirteen from Health Systems HIV/AIDS-AIDS Education programs and thirteen from the Head Start program. Our testing results show the following:

Health Systems HIV/AIDS and AIDS Education programs

- Thirteen of the subrecipient files did not include language related to the audit requirement and we were unable to determine if they were notified of the audit requirement.
- Eight subrecipients did not submit audit reports. The University did not verify or document that they had received less than $500,000 in total federal dollars, which would have exempted the subrecipient from audit requirements.

HeadStart

- The university received copies of A-133 audit reports for all eleven subrecipients we tested. Due to lack of documentation, we were unable to determine whether or not the audits were reviewed within the federally required timelines.

Based on our testing, we are unable to determine if subrecipients are in compliance with grant requirements, which ultimately puts federal dollars at risk.

Recommendation

We recommend the University improve monitoring controls to track the federal audit status of all subrecipients regardless of the amount the University awards.

University's Response

During FY13 the University has taken steps to enhance, as well as perform, monitoring controls with respect to subrecipients under our prime federal awards. In addition to the existing monitoring controls that were already in place, the University:

- *Updated the audit notification language in our subcontracts regarding subrecipient audit requirements, including foreign entities and regardless of the amount of total federal USD that the entity expends;*
- *Conducted a review of all FY13 active and current subcontracts to ensure we had obtained and reviewed subrecipient audits, as required; and*
- *Enhanced our tracking and process documentation related to subrecipient monitoring including documentation of dates audit reports were received or obtained and reviewed.*
- *Implemented a Subrecipient Financial Questionnaire used at initiation of each subcontract to assist in determining the audit status of each entity as well as to operate as a risk assessment tool; and*

- *Developed a master listing of all subrecipients and related audit information; and developed a Subrecipient Entity Review Form to document information related to the subrecipient's audit report and review.*

Starting in FY14, we developed a Subrecipient Annual Certification Form to be sent to and certified by each subrecipient entity annually to update the audit status of the entity;

Auditor's Concluding Remarks

We thank the University for their diligence in addressing the internal control issues discussed. These actions will enhance the University's process for monitoring subrecipients and increase accountability for subrecipients to use grant funds according to the purpose intended."

We further 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*, states in part:

Section 300

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:

(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 2012*, Part 3 – Compliance Requirements states in part:

Section M. Subrecipient Monitoring:

Compliance Requirements

A pass-through entity is responsible for: …

- Subrecipient Audits – (1) Ensuring that subrecipients expending $500,000 or more in Federal awards during the subrecipient's fiscal year for fiscal years ending after December 31, 2003 as provided in OMB Circular A-133 have met the audit requirements of OMB Circular A-133 and that the required audits are completed within 9 months of the end of the subrecipient's audit period; (2) issuing a management decision on audit findings within 6 months after receipt of the subrecipient's audit report; and (3) ensuring that the subrecipient takes timely and appropriate corrective action on all audit findings. In cases of continued inability or unwillingness of a subrecipient to have the required audits, the pass-through entity shall take appropriate action using sanctions.

U.S. Department of Health and Human Services (HHS) Grants Policy Directives Part 4: After-the-Grant states in part:

Section B. General Policy Requirements

Part 3:

- Commercial organizations and foreign entities are not directly subject to the requirements of OMB Circular A-133 and have the option of conducting an A-133 or a grant-specific audit as provided in 45 CFR 74.26.

45 CFR Section 74.26 Non-Federal Audits, states in part:

(d) (1) Recipients and subrecipients that are commercial organizations (including for-profit hospitals) have two options regarding audits:

(i) A financial related audit (as defined in the Government Auditing Standards, GPO Stock #020-000-00-265-4) of a particular award in accordance with Government Auditing Standards, in those cases where the recipient receives awards under only one HHS program; or, if awards are received under multiple HHS programs, a financial related audit of all HHS awards in accordance with Government Auditing standards; or

(ii) An audit that meets the requirements contained in OMB Circular A-133.

2013-015 The Department of Early Learning does not have sufficient internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act for the Child Care Development Fund program are filed.

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
Federal Award Number:	G1301WACCDF
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The Washington State Department of Early Learning administers the Child Care Development grant. This federal grant gives the state funding to develop child care programs and provide financial assistance to low-income families. It also assists the state in establishing health, safety, licensing and registration standards for child care required by state law.

The Department spent $196 million in Child Care Development funds in fiscal year 2013, of which approximately $6 million was distributed to subrecipients.

Under the Federal Funding Accountability and Transparency Act, the Department is required to collect and report information on each sub-award of $25,000 or more in federal funds in the Federal Funding Accountability and Transparency Sub-award Reporting System. The reporting must be done by the end of the month following the month in which the sub-award was made. The intent of the Accountability Act is to empower citizens with the ability to hold the government accountable for spending decisions and, as a result, reduce wasteful spending in the government.

Description of Condition

During our review, we found the Department did not have internal controls in place to ensure the fiscal year 2013 Accountability Act reports were filed correctly.

The employee responsible for Accountability Act reporting was not aware that all subrecipients paid over $25,000 need to be reported through the Federal Funding Accountability and Transparency Sub-award Reporting System. The employee had an understanding that subrecipients paid with discretionary funds did not need to be reported. However, federal guidance clearly states that the reporting requirements apply to both mandatory and discretionary funds.

The Department made five discretionary sub-awards for the program totaling $12,357,555. We determined that all five sub-awards were not filed.

Cause of Condition

The Department did not have policies and procedures to ensure it was compliant with the Accountability Act reporting requirements.

The Department had one employee assigned to file the required reports. This employee was not aware of proper Accountability Act reporting requirements. There was no independent review of the employee's work to verify Accountability Act reports were being filed as required.

Effect of Condition

By not correctly submitting the required Accountability Act reports, the federal government's ability to ensure transparency and accountability of federal spending is diminished. 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 establish policies and procedures to ensure all Accountability Act reports are submitted accurately and timely. We further recommend that a secondary review is conducted prior to reports being submitted.

Department's Response

The department is well aware of the requirement to report subrecipient contracts within the FFATA Reporting System (FSRS), and in fact did report over $33M in subrecipient awards under 93.596 Child Care Development Fund (CCDF) Mandatory and Matching funds, as well as $9.6M under 93.505 Maternal, Infant, Early Childhood Home Visiting (MIECHV), $30.8M under 84.412 Race to the Top-Early Learning Challenge (RTT-ELC), and $7.4M under 84.181 Individuals with Disabilities Education Act (IDEA). Subrecipient awards under 93.575 CCDF Discretionary Funds were not reported because information given to the department from the FSRS help desk in early SFY13, as well as the lack of the option to report CFDA 93.575 awards in FSRS, led the department to believe this was not a requirement. The department has made several attempts to get the CFDA coding added to FSRS and get further clarification on reporting requirements by contacting three different support desk personnel, our CCDF federal liaison, and the Office of Management and Budget (OMB). At this time we are still unable to report subrecipient information in FSRS under CFDA 93.575, but as soon as the condition is rectified, the department will report as required.

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.

Title 2, Code of Federal Regulations, APPENDIX A TO PART 170—AWARD TERM, states, in part:

> I. Reporting Subawards and Executive Compensation.
>
> a. Reporting of first-tier subawards.

1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111–5) for a subaward to an entity (see definitions in paragraph e. of this award term).
2. Where and when to report.
   i. You must report each obligating action described in paragraph a.1. of this award term to http://www.fsrs.gov.
   ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)
3. What to report. You must report the information about each obligating action that the submission instructions posted at http://www.fsrs.gov specify.

Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS)

https://www.fss.gov/#a-faqs:

GRANTS

In accordance with 2 CFR Chapter 1, Part 170 REPORTING SUB-AWARD AND EXECUTIVE COMPENSATION INFORMATION, Prime Awardees awarded a federal grant are required to file a FFATA Sub-award report by the end of the month following the month in which the prime awardee awards any sub-grant equal to or greater than $25,000. The reporting requirements are as follows:

- This requirement is for both mandatory and discretionary grants awarded on or after October 1, 2010.

2013-016 The Department of Early Learning does 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
Federal Award Number:	G1301WACCDF	
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 grant to assist eligible working families in paying for child care. In fiscal year 2013, DEL paid approximately $200 million to child care centers and providers.

The Department of Social and Health Services (DSHS) determines client eligibility and pays child care providers under an agreement with DEL. In previous years, DSHS was responsible for reconciling child care payments to providers with attendance records.

In January 2012, DEL and DSHS began taking steps to improve controls over child care payments, and DEL took over the reconciliation process. DEL also hired staff to perform monthly reconciliations of attendance records and child care payments for fiscal year 2012.

In October 2012, our office issued a report, "Audit of State Payments to Child Care Providers," report number 1008493, covering the period from July 1, 2010 to June 30, 2011. Using a statistical sample of 153 providers, the audit identified actual overpayments of $1.6 million and total estimated overpayments of $73.9 million. The audit also identified payments of $2.9 million as having questionable documentation, with total estimated payments with this same issue of $34.9 million. The payments involved in the audit included a mix of federal and state funding.

The Departments are aware providers have claimed more than authorized and that overpayments have been made.

Description of Condition

Since fiscal year 2005, our audits have reported the Departments did not adequately monitor payments to child care providers. During fiscal years 2010 and 2011 we found DSHS did not perform reconciliations between attendance records and child care payments. In fiscal year 2012, DEL only reconciled one month of child care payments to attendance records.

We requested and reviewed tracking sheets for reconciliations performed during state fiscal year 2013. We found no reconciliations were performed for months within state fiscal year 2013; all reconciliations performed were for attendance records from 2011 and 2012. The last reconciliation performed during state fiscal year 2013 was for March 2012 attendance records and was performed on May 13, 2013.

Cause of Condition

As of January 2014, the Department has only reconciled attendance records through June 2012. In an effort to get caught up, DEL began auditing retroactively starting with July 2011 and working forward.

Effect of Condition

Because DEL has not fully reconciled payments to source documentation it remains at risk for not identifying or recovering overpayments to providers in a timely manner.

Our current audit was for the purpose of determining compliance with federal laws and grants requirements, and we did not perform tests to quantify provider overpayments as was performed in our "Audit of State Payments to Child Care Providers". Therefore, we are not questioning costs in this finding.

Recommendation

We recommend the Department follow detailed monitoring procedures for provider payments that include reconciliations of provider attendance records to payments. We further recommend that DEL perform a more timely review of attendance records to increase the likelihood that any overpayments identified can be collected.

The Department should also implement the recommendations provided by our office in the "Audit of State Payments to Child Care Providers" report.

Departments' Response

The Department of Early Learning partially concurs with this finding.

The Department of Early Learning and Department of Social and Health Services continue to make consistent progress in actively auditing and recovering overpayments.

The State of Washington is potentially at risk of not collecting overpayments due to the passage of time on older records, therefore the Department of Early Learning (DEL) prioritized auditing those records that proceeded from the last date audited by the State Auditor's Office (SAO).

The Department stands by its response to the October 2012 audit referenced in the background section of this finding. In reviewing and establishing the overpayments found during this audit, DEL and DSHS discovered errors in the overpayment calculations, which have necessitated additional review time and adjustments to the overall overpayment totals. Any knowledge of providers who have claimed more than authorized and/or have been overpaid are being pursued or have been pursued through the overpayment processes.

The overpayment process can vary in length - once DSHS' Office of Financial Recovery (OFR) receives notice of an overpayment, they notify the provider of the overpayment details, their due process (hearing) rights, the associated time frames and contact information. Providers have 28 days from the date of service to request a hearing. During that time period, the provider may contact OFR to make a payment, they may request a hearing, or the provider may not respond at all. If the provider contacts OFR immediately, a reasonable monthly payment is negotiated and OFR begins collecting that payment. Providers have the right to appeal an overpayment and to request a hearing before an administrative law judge. If the provider requests a hearing, collection is delayed until the matter is settled in the hearings process. If the provider does not respond in the allotted time period of approximately 30 days, OFR begins enforcement.

OFR is working to streamline the overpayment process. OFR and the DSHS Information Systems Services Division (ISSD) are working together to automate the paper overpayment referral process. DSHS expects this electronic process will increase the speed at which overpayments are established as well as decrease the potential for errors.

The DSHS Provider Team reviews all potential provider overpayments. During SFY13, the Provider Team requested and reviewed over 5,900 provider attendance records. Attendance records are requested by the Provider

Team, and the Provider Team reviews these attendance records against the provider billing. In appropriate cases, the Provider Team establishes an overpayment and OFR initiates collection action.

As of February 2014, DEL has initiated work on state fiscal year 2013 (July 2012). DEL anticipates that the audit team will be able to adequately sample and audit SFY 2013 & SFY 2014, consistent with the recommendation. Part of the audit team will work on SFY 2013, and the remaining team will work on SFY 2014, along with the federal Improper Payment Audit so that both years are audited.

The Departments will continue to actively audit for potential overpayments and seek timely reimbursement for overpayments.

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.

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

Attachment A, Section C, Basic Guidelines, states in part:

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) Paper and electronic attendance records and invoices for state subsidized children must be kept on the premises for at least five years after the child leaves the licensee's care as provided in WAC 170-295-7031.

Washington Administrative Code 170-296A-2125, states in part:

The licensee must also keep records of:

1. Daily attendance for each child counted in capacity that includes the:
   (a) Child's dates of attendance;

Washington Administrative Code 170-296A-2000, states in part:

The licensee must keep all records required in this chapter for a minimum of five years:

(1) Current records, including records from the previous twelve months, must be kept in the licensed space as defined in WAC 170-296A-0010 and be available for the department's review.

Washington Administrative Code 170-290-0034, states in part:

Child care providers who accept child care subsidies must do the following:

(3) Keep complete and accurate daily attendance records for children in their care, and allow access to DEL to inspect attendance records during all hours in which authorized child care is provided as follows:
   (a) Current attendance records (including records from the previous twelve months) must be available immediately for review upon request by DEL.
   (b) Attendance records older than twelve months to five years old must be provided to DSHS or DEL within two weeks of the date of a written request from either department.
   (c) Failure to make available attendance records as provided in this subsection may:
      (i) Result in the immediate suspension of the provider's subsidy payments; and
      (ii) Establish a provider overpayment as provided in WAC 170-290-0268;

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."

2013-017 The Department of Social and Health Services does not have adequate internal controls over client eligibility for the Child Care Development Fund.

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
Federal Award Number:	G1301WACCDF	
Applicable Compliance Component:	Cost Principles/Eligibility	
Questioned Cost Amount:	None	

Background

The state Department of Early Learning (DEL) administers the federal Child Care and Development grant, which is meant to assist eligible working families in paying for child care and also to support efforts to offer high-quality early learning opportunities. In fiscal year 2013, DEL paid approximately $200 million to child care centers and providers in Working Connections Child Care subsidies.

The Department of Social and Health Services (DSHS) determines client eligibility and pays child care providers under an agreement with DEL. DEL then reimburses DSHS with federal grant funds.

In order for a family to be eligible for child care assistance, children receiving care must be under age 13 (or up to age 19 if incapable of self care or under court supervision); must reside with parents who are working or attending job-training or education programs; or need to receive protective services and reside with a parent or parents and have a family income not exceeding 85 percent of the state's median income for a family of the same size.

Client eligibility serves as the basis for determining whether a payment is allowable; if an ineligible client receives assistance, the payment made to the child care provider cannot be considered allowable under the program.

Description of Condition

The Department has not established internal controls designed to ensure it correctly determines and documents eligibility prior to services being provided and payment being issued. We found the following weaknesses:

- In most cases, a DSHS caseworker processes client eligibility information and authorizes services without any secondary review or approval.
- Caseworkers can authorize services in the eligibility system without verifying client household income or employment activity.
- Caseworkers have the system access that is needed to directly alter payment information in the payment system.
- DSHS audits child care payments monthly, but reviews only 1.6 percent of open authorizations after payment has already been made. This does not provide assurance that payments are not made to ineligible clients.

Cause of Condition

DSHS is aware of weaknesses in preventative controls over eligibility determination, but has not taken action to address them.

Effect of Condition

These conditions increase the risk that DEL might be paying for child care services for ineligible clients.

Since DSHS does not conduct regular reviews prior to payment, it puts the program at risk of improperly paying out Child Care Development Fund dollars. In addition, if ineligible payments are identified, the overpayment would need to be recovered.

Recommendations

We recommend the DSHS and DEL work together to develop internal controls that will ensure eligibility is established and supported prior to authorizing child care services to clients. We recommend this includes a segregation of duties between staff who determine eligibility and staff who authorize payments. We further recommend that DSHS and DEL improve the current review process to cover a larger population of authorized payments and ensure eligibility is determined prior to payments being made.

Departments' Response

SAO finding *- In most cases, a DSHS caseworker processes client eligibility information and authorizes services without any secondary review or approval.*

The Department of Social and Health Services partially concurs with the finding. Current childcare program policy, as established and maintained by the Department of Early Learning, supports approval for benefits and authorization for payment by the same worker. However, DSHS employs the following controls to ensure workers are not misusing their authority:

- *A supervisory review is required for payment requests that exceed certain parameters. The supervisor reviews the need for the additional payment and either approves the payment by submitting the authorization to SSPS or denies the payment if the consumer is not eligible. All special authorizations require supervisor review for approval.*
- *New workers have 100% of their work audited by Leadworkers, these audits may be conducted either pre or post-authorization.*
- *The Department has instituted a separation of duties protocol that does not allow a staff member who activates a license-exempt provider to make any authorizations for that provider.*

SAO finding *- Caseworkers can authorize services in the eligibility system without verifying client household income or employment activity.*

The Department of Social and Health Services partially concurs with this finding. Washington Administrative Code, established and maintained by the Department of Early Learning, requires workers to request verification if not provided by the consumer. Childcare program training supports and reinforces these requirements. DEL WAC 170-290-0012 requires a consumer to provide verification of employment or employment activity including income, hours of work and work schedule to receive childcare subsidy payments, however, if a consumer does not provide all of the verification requested, DEL WAC requires DSHS to determine eligibility based on the information provided to DSHS.

SAO finding *- Caseworkers have the system access that is needed to directly alter payment information in the payment system.*

The Department of Social and Health Services partially concurs with this finding. While it is true that caseworkers have access to alter payment information, it is important to note the Department has implemented consistent monitoring protocols to maintain payment integrity including:

- *An Integrity Report (identifying cases that where the same staff member has authorized four or more payments in a 15 month period without authorization activity from other staff members) is reviewed by*

regional staff periodically. To date, the report has not identified any cases resulting in a finding of improper authorization activities.

- *The Department has instituted a separation of duties protocol that does not allow a staff member who activates a license-exempt provider to make any authorizations for that provider.*
- *Staff activating or reactivating a provider's SSPS number are electronically linked to that provider number, and are not able to create or alter authorizations on behalf of that provider number. The activation of a license-exempt provider's file occurs when the provider's SSPS number is created, and reactivation occurs when the provider has had no payment authorizations for the previous 90 days. Staff must manually activate, or reactivate, a license-exempt provider's SSPS number prior to authorizations/payments being submitted through SSPS.*

SAO finding *- DSHS audits child care payments monthly, but reviews only 1.6 percent of open authorizations. This does not provide enough coverage to address the internal control weaknesses to ensure payments are not made to ineligible clients.*

The Department of Social and Health Services partially concurs with this finding. In addition to auditing 1.6% of open authorizations, DSHS takes the following steps to ensure program integrity:

- *Requires exceptional payment authorizations to be reviewed and approved by a supervisor before payment can be made. An example of an exceptional payment would be when a child requires (and is authorized for) more than 230 hours of care per month due extenuating circumstances such as a parent with multiple approved activities (school and work, etc.).*
- *Works with data provided monthly by the Health Care Authority to audit additional childcare eligibility activity to identify error prone cases and areas where policy clarification, training or systems support can increase accuracy.*
- *Performs 100% pre/post authorization audits for all new childcare workers.*

The DSHS "Provider Team" is a specialized unit that reviews all potential consumer and provider overpayments as identified by staff and the general public. The Provider Team requests and reviews attendance records and reconciles these with corresponding payments to determine provider billing accuracy. In appropriate cases, the Provider Team establishes an overpayment and the DSHS Office of Financial Recovery (OFR) initiates collection action. During SFY13, the Provider Team received over 5,900 provider attendance records and wrote over 7,600 overpayments.

In addition to DSHS audits, DEL performs audits focusing on provider billing. DEL anticipates that the DEL audit team will be able to adequately sample and audit SFY 2013 & SFY 2014.

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.

45 CFR 98.20 A child's eligibility for child care services, states:

(a) In order to be eligible for services under § 98.50, a child shall:
  (1) (i) Be under 13 years of age; or,
    (ii) At the option of the Lead Agency, be under age 19 and physically or mentally incapable of caring for himself or herself, or under court supervision;
  (2) Reside with a family whose income does not exceed 85 percent of the State's median income for a family of the same size; and
  (3) (i) Reside with a parent or parents (as defined in § 98.2) who are working or attending a job training or educational program; or
    (ii) Receive, or need to receive, protective services and reside with a parent or parents (as defined in § 98.2) other than the parent(s) described in paragraph (a)(3)(i) of this section.
      (A) At grantee option, the requirements in paragraph (a)(2) of this section and in § 98.42 may be waived for families eligible for child care pursuant to this paragraph, if determined to be necessary on a case-by-case basis by, or in consultation with, an appropriate protective services worker.
      (B) At grantee option, the provisions in (A) apply to children in foster care when defined in the Plan, pursuant to § 98.16(f)(7).

(b) Pursuant to § 98.16(g)(5), a grantee or other administering agency may establish eligibility conditions or priority rules in addition to those specified in this section and § 98.44 so long as they do not:
  (1) Discriminate against children on the basis of race, national origin, ethnic background, sex, religious affiliation, or disability;
  (2) Limit parental rights provided under Subpart D; or
  (3) Violate the provisions of this section, § 98.44, or the Plan. In particular, such conditions or priority rules may not be based on a parent's preference for a category of care or type of provider. In addition, such additional conditions or rules may not be based on a parent's choice of a child care certificate.

OMB Circular A-133 Compliance Supplement, part 4 information for the Child Care and Development Fund (CCDF) Cluster, states in part:

E. Eligibility
  1. Eligibility for Individuals
     Lead Agencies must have in place procedures for documenting and verifying eligibility in accordance with the following Federal requirements, as well as the specific eligibility requirements selected by each State/Territory/Tribe in its approved Plan.
     a. Children must be under age 13 (or up to age 19, if incapable of self care or under court supervision), who reside with a family whose income does not exceed 85 percent of State/territorial/tribal median income for a family of the same size, and reside with a parent (or parents) who is working or attending a job-training or education program; or are in need of, or are receiving, protective services. Tribes may elect to use State or tribal median income (42 USC 9858n(4); 45 CFR sections 98.20(a) and 98.80(f)).

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

Attachment A, Section C.- Basic Guidelines, 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.

2013-018 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
Federal Award Number:	G1201WA1407
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	$ 6,044
Likely Questioned Cost:	$133,042

Background

The Children's Administration of the Department of Social and Health Services administers the Adoption Assistance Program. The Department paid approximately $46 million in federal dollars for adoption assistance in fiscal year 2013, for support of almost 12,000 children.

The federal Adoption Assistance program provides money to states for parents who adopt children with special needs by providing ongoing financial and medical benefits to qualified children. To qualify for federal funding in this program, a child must be determined eligible. Once a child is determined to be eligible to receive adoption assistance, he or she remains eligible until: 1) the age of 18 and the parents are no longer responsible for the support of the child; 2) death of the child's adoptive parents; or 3) death of the child.

State law allows the parent of a child who is a least 18, but less than 21 years old, to continue receiving adoption assistance benefits if it is confirmed the child 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). Under no circumstances may benefits extend beyond the adoptive child's 21st birthday.

During the last four audits (fiscal years 2009, 2010, 2011 and 2012) we reported the Department was not following controls 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, and conduct quarterly spot checks of payments. In February 2013, the Department added automated controls to their case management system to suspend benefit payments of children who turn 18, only allowing payments to resume after staff confirmed the child warrants continuation of benefits.

Description of Condition

We reviewed the Department's process to ensure the eligibility of clients receiving Adoption Assistance payments.

Children Age 18

For the first seven months of the fiscal year, the Department lacked the necessary internal controls to ensure recipients with children who reach the age of 18 are still eligible to receive monthly benefit payments. During this review we found the Department did not have system or manual controls to identify children turning age 18 in order to establish continued eligibility or cancel benefits, for payments made in the first seven months of the fiscal year.

Children Age 21

For the first seven months of the fiscal year, the Department did not have a system or manual controls in place to effectively end benefits of children turning age 21.

Cause of Condition

Children Age 18

The Department recognized it lacked an automated process or standard manual practice to identify children reaching the age of 18; every region maintains and monitors case files differently. Although the Department instituted quarterly spot checks of adoption payments by regional managers, the frequency of monitoring payments and updating case files did not improve for the first seven months of the year.

Children Age 21

The Department did not have an automated process to ensure payments were halted for recipients over the age of 21. It relied on manual identification of adoptees aging out of the program and had no division wide policies or procedures to guide this process.

In February 2013, the Department established automated controls to identify, flag and suspend payments to adoptive parents of children age 18 and to stop payments for children age 21. We reviewed the changes to the system during our audit and found them to be working as intended.

Effect of Condition and Questioned Costs

We found the Department paid benefits for children who were not eligible.

Children Age 18

To follow up on the concerns noted in prior audits, we performed testing of randomly selected recipient benefit payments issued in fiscal year 2013 to determine if the Department collected appropriate supporting documentation for children over 18 years of age. To be eligible to continue receiving program benefits, the adopted child (over 18) must be enrolled in school. Our sample test of payments to adoptive parents of children over the age of 18 in region 6 found that 17% did not have current documentation on file proving continued eligibility for adoption assistance benefits. Based on our sample, we are questioning costs of $3,913 and project an estimated $133,042 in additional questioned costs in the region. No issues were noted in regions 1 through 5

Children Age 21

State law prohibits support payments to recipients for any adoptee once they reach age 21. We reviewed all adoption payments for fiscal year 2013 and found three recipients with adoptees over 21 who received payments totaling $2,131 during the year. A recipient with a child over 21 is not eligible to receive federal funds; therefore we are questioning this entire amount.

We question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support expenditures.

Recommendation

We recommend the Department:

- Follow newly established internal controls for monitoring case files to ensure eligibility is met and payments are fully supported for recipients with children between the ages of 18 and 21.
- Perform a secondary review confirming documentation supporting eligibility is completed and on file, and data entries are accurate for Adoption Assistance payments.
- Communicate with the federal grantor to determine whether questioned costs need to be repaid.

Department's Response

The Department concurs with this finding.

The implementation of the automated process to ensure payments are suspended for children at age 18, until verification of eligibility is provided which would allow continued payments, and to stop payments for children at the age of 21 has effectively stopped overpayments caused by the manual process previously used by the Administration. We will monitor this functionality's effectiveness periodically through independent algorithms run on payment data.

For all amounts identified as questioned costs, the Children's Administration will review each payment and return any federal share associated with inappropriate payments. These amounts will be sent for collections and communicated to our federal partners at the time they are returned.

Auditor's Concluding Remarks

The Department concurs with this finding.

The implementation of the automated process to ensure payments are suspended for children at age 18, until verification of eligibility is provided which would allow continued payments, and to stop payments for children at the age of 21 has effectively stopped overpayments caused by the manual process previously used by the Administration. We will monitor this functionality's effectiveness periodically through independent algorithms run on payment data.

For all amounts identified as questioned costs, the Children's Administration will review each payment and return any federal share associated with inappropriate payments. These amounts will be sent for collections and communicated to our federal partners at the time they are returned.

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.

Revised Code of Washington (RCW) 74.13.031
Duties of department — Child welfare services — Children's services advisory committee. (*Effective until December 1, 2013.*) states in part:

> (10) The department and supervising agencies shall have authority to provide continued extended foster care services to youth ages eighteen to twenty-one years to participate in or complete a secondary education program or a secondary education equivalency program, or a postsecondary academic or postsecondary vocational education program. The department shall develop and implement rules regarding youth eligibility requirements.
>
> (11) The department shall have authority to provide adoption support benefits, or relative guardianship subsidies on behalf of youth ages eighteen to twenty-one years who achieved permanency through adoption or a relative guardianship at age sixteen or older and who meet the criteria described in subsection (10) of this section.

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.

4.G. Eligibility for Adoption Support After Age 18:

Adoption support may continue for a youth after age 18 under any of the following categories:

1. AFDC Provision (IV-E eligible youth only)
2. Student with Mental or Physical Disability
3. Extended Foster Care Program

4.G.1. AFDC Provision (IV-E Eligible Youth Only)

A IV-E eligible youth who is in school full-time to complete high school, GED, or equivalent secondary education program, may continue to receive adoption support up to age 19 under the State's AFDC provision in effect July 16, 1996, as long as the youth continues in the secondary education program and is expected to graduate by his/her 19th birthday. In this case, IV-E-funded Adoption Support would continue until the youth completes the secondary education program before age 19.

If a youth turns 18 and is either not in school, or is in a secondary educational program but is not expected to graduate by age 19, then IV-E adoption support would end at the end of the month in which the youth turns 18. Alternately, if adoption support continues because a youth is at first expected to graduate by age 19, but the Department later learns the youth will not graduate by age 19, IV-E Adoption Support would end at the end of the month in which the Department first learned that the youth would not graduate by age 19.

Consider a youth on summer break or other official school break who is still enrolled in his/her secondary educational program to meet the school requirement during the break.

4.G.2. Mental or Physical Disability

A youth may continue on the adoption support program beyond age 18 if the state has determined that the youth has a mental or physical disability that warrants continuation of assistance to age 21, and the youth is a full-time student in high school, GED or equivalent secondary education program.

This option is available to all youth who meet the mental or physical disability criteria and school requirements, regardless of IV-E eligibility status, though IV-E funds may only be claimed for those youth who are IV-E eligible for adoption support. For IV-E eligible youth, IV-E funds may be claimed through the end of the month in which the youth completes the secondary education program or reaches age 21, whichever is earlier. If the youth in this situation does not meet the school requirements, adoption support ends at the end of the month in which the youth turns 18.

2013-019 The Department of Health did not survey all hospitals and home health agencies in accordance with the frequency stipulated by state and federal laws, which could increase the risk of Medicaid clients receiving substandard care.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM	
Applicable Compliance Component:	Provider Health and Safety Standards	
Questioned Cost Amount:	None	

Background

The state has 102 active hospitals in three categories: acute care/general hospitals, chemical dependency hospitals, and psychiatric hospitals. State regulations require the Department of Health or an accreditation agency such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to survey all hospitals on average at least every eighteen months, and psychiatric hospitals on 12 month intervals. The survey focuses on the hospital's administration and patient services. The survey also assesses compliance with federal health, safety and quality standards designed to ensure patients receive safe and quality care services.

The state has 61 Medicare certified home health agencies which provide necessary support services to allow clients to get the care they need in their own home setting. Services provided by home health agencies can range from companion care provided by trained providers to advanced skilled care provided by registered or licensed practical nurses (RN/LPN). State and federal regulations require the Department of Health or accreditation agencies such as the Community Health Accreditation Program (CHAP) or the Joint Commission to survey all Home Health Agencies at least every 36.9 months to maintain Medicare certification and accept Medicaid clients.

Federal regulations require states to ensure home health agencies and health-care facilities such as hospitals meet prescribed health and safety standards in order to be eligible for federal reimbursement.

Description of Condition

During fiscal year 2013, the Department of Health did not ensure hospital surveys were performed in accordance with the frequency stipulated by state and federal laws. Of the state's 102 current hospitals, 60 were evaluated by the Department. Of that group 31 (52 percent) active hospitals did not receive the required survey within the frequency stipulated by state and federal laws. The Department also did not ensure hospitals received the required survey within the frequency stipulated by state and federal laws when Accreditation agencies did not perform the survey as required. Nine out of 42 hospitals (21 percent) surveyed by Accreditation agencies did not receive surveys in a timely manner.

The table below summarizes the results of our testing for hospital survey.

Hospital Surveys More Than One Month Overdue			
Months	**Department of Health**	**Accreditation Agencies**	**Total**
One month	2	4	6
Two months	4	0	4
Three Months	3	1	4
Four months or more	22	4	26
Total	31	9	40

During fiscal year 2013, the Department of Health did not ensure surveys of home health agencies were performed as required by state and federal laws. Of the state's 61 Medicare certified home health agencies there were seven (11 percent) that did not receive the required survey within the 36.9 month interval.

The table below summarizes the results of our testing for home health agency survey.

Home Health Agency Surveys More than One Month Overdue	
Months	**Department of Health**
One month	4
Three Months or more	3
Total	7

Cause of Condition

The Department stated the increase in intervals between hospital surveys during fiscal year 2013 is attributed to retasking investigators to work on a re-design of the onsite survey worksheet tools and training rather than performing surveys. The Department also stated that it recognized a need for more surveyors but had been unable to hire sufficient staff due to a shortage of qualified candidates.

The Department stated the reason for the home health agency surveys not being completed in a timely manner is attributed to a vacancy and new hire during the first half of the audit period that left only two qualified staff to perform Centers for Medicare and Medicaid Services (CMS) surveys during that time.

Effect of Condition

When the Department does not survey hospitals and home health agencies as required, the state is paying these facilities for services to Medicaid clients without assurance they are providing services that meet state and federal health standards and regulations.

Recommendation

We recommend the Department conduct hospital and home health agency surveys in accordance with the frequency stipulated by state and federal laws.

Agency's Response

The Department concurs with the finding. We have completed staff training in the new hospital survey process and implemented this process for most state hospital surveys. This will help shorten the time needed to complete surveys

and reduce the number of staff needed to conduct a survey. The Department also now has fully trained staff to conduct Medicaid surveys.

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

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 of the Code of Federal Regulations, Section 430.10 states:

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

RCW 70.41.120, states in part:

(1) The department shall make or cause to be made an unannounced inspection of all hospitals on average at least every eighteen months. Every inspection of a hospital may include an inspection of every part of the premises. The department may make an examination of all phases of the hospital operation necessary to determine compliance with the law and the standards, rules and regulations adopted there under.

RCW 70.41.122 states:

Surveys conducted on hospitals by the joint commission on the accreditation of health care organizations, the American osteopathic association, or Det Norske Veritas shall be deemed equivalent to a department survey for purposes of meeting the requirements for the survey specified in RCW 70.41.120 if the department determines that the applicable survey standards are substantially equivalent to its own.

(1) Hospitals so surveyed shall provide to the department within thirty days of learning the result of a survey documentary evidence that the hospital has been certified as a result of a survey and the date of the survey.
(2) Hospitals shall make available to department surveyors the written reports of such surveys during department surveys, upon request.

WAC 246-320-016, states in part:

This section outlines the department's on-site survey and complaint investigation activities and roles.

(1) Surveys. The department will:
   (a) Conduct on-site surveys of each hospital on average at least every eighteen months or more often using the health and safety standards in this chapter and chapter 70.41 RCW;
   (b) Coordinate the on-site survey with other agencies, including local fire jurisdictions, state fire marshal, state pharmacy board, and report the survey findings to those agencies;
   (c) Notify the hospital in writing of the survey findings following each on-site survey;

(d) Require each hospital to submit a corrective action plan addressing each deficient practice identified in the survey findings;
(e) Notify the hospital when the hospital submitted plan of correction adequately addresses the survey findings; and
(f) Accept on-site surveys conducted by the Joint Commission or American Osteopathic Association as meeting the eighteen-month survey requirement in accordance with RCW 70.41.122.

42 U.S.C. § 1395bbb. Conditions of participation for home health agencies; home health quality, states in part:

(c) Surveys of home health agencies
(1) Any agreement entered into or renewed by the Secretary pursuant to section 1395aa of this title relating to home health agencies shall provide that the appropriate State or local agency shall conduct, without any prior notice, a standard survey of each home health agency. Any individual who notifies (or causes to be notified) a home health agency of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a of this title. The Secretary shall review each State's or local agency's procedures for scheduling and conduct of standard surveys to assure that the State or agency has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.
(2) (A) Except as provided in subparagraph (B), each home health agency shall be subject to a standard survey not later than 36 months after the date of the previous standard survey conducted under this paragraph. The Secretary shall establish a frequency for surveys of home health agencies within this 36-month interval commensurate with the need to assure the delivery of quality home health services.
(B) If not otherwise conducted under subparagraph (A), a standard survey (or an abbreviated standard survey) of an agency—
(i) may be conducted within 2 months of any change of ownership, administration, or management of the agency to determine whether the change has resulted in any decline in the quality of care furnished by the agency, and
(ii) shall be conducted within 2 months of when a significant number of complaints have been reported with respect to the agency to the Secretary, the State, the entity responsible for the licensing of the agency, the State or local agency responsible for maintaining a toll-free hotline and investigative unit (under section 1395aa(a) of this title), or any other appropriate Federal, State, or local agency.
(C) A standard survey conducted under this paragraph with respect to a home health agency—
(i) shall include (to the extent practicable), for a case-mix stratified sample of individuals furnished items or services by the agency—
(I) visits to the homes of such individuals, but only with the consent of such individuals, for the purpose of evaluating (in accordance with a standardized reproducible assessment instrument (or instruments) approved by the Secretary under subsection (d) of this section) the extent to which the quality and scope of items and services furnished by the agency attained and maintained the highest practicable functional capacity of each such individual as reflected in such individual's written plan of care required under section 1395x(m) of this title and clinical records required under section 1395x(*o*)(3) of this title; and
(II) a survey of the quality of care and services furnished by the agency as measured by indicators of medical, nursing, and rehabilitative care;

(ii) shall be based upon a protocol that is developed, tested, and validated by the Secretary not later than January 1, 1989; and

(iii) shall be conducted by an individual—

(I) who meets minimum qualifications established by the Secretary not later than July 1, 1989,

(II) who is not serving (or has not served within the previous 2 years) as a member of the staff of, or as a consultant to, the home health agency surveyed respecting compliance with the conditions of participation specified in or pursuant to section 1395x(*o*) of this title or subsection (a) of this section, and

(III)who has no personal or familial financial interest in the home health agency surveyed.

(D) Each home health agency that is found, under a standard survey, to have provided substandard care shall be subject to an extended survey to review and identify the policies and procedures which produced such substandard care and to determine whether the agency has complied with the conditions of participation specified in or pursuant to section 1395x(*o*) of this title or subsection (a) of this section. Any other agency may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey). The extended survey shall be conducted immediately after the standard survey (or, if not practical, not later than 2 weeks after the date of completion of the standard survey).

(E) Nothing in this paragraph shall be construed as requiring an extended (or partial extended) survey as a prerequisite to imposing a sanction against an agency under subsection (e) of this section on the basis of the findings of a standard survey.

State Operations Manual: Chapter 2, Section 2195 - Guidelines for Determining Survey Frequency (Rev. 1, 05-21-04)

Section 1891(c)(2)(A) of the Act states that standard surveys will occur not later than 36 months after the previous standard survey, and that the Secretary shall establish a frequency for surveys within this 36-month interval commensurate with the need to assure the delivery of quality home health services.

WAC 246-335-045, states in part:

(2) The department may:

(a) Conduct surveys at any time and at least once during a licensure period to determine compliance with chapter 70.127 RCW and this chapter, except for agencies with deemed status under WAC 246-335-050 (2) and (3);

(b) Conduct one licensing survey inclusive of all in-home services categories;

(c) Investigate any person suspected of:

(i) Advertising, operating, managing, conducting, opening or maintaining an in-home services agency or providing in-home services, including hospice care center services, without a license unless exempt from licensure under RCW 70.127.040 and 70.127.050; or

(ii) Survey a licensee at anytime if the department has reason to believe the licensee is providing unsafe, insufficient, inadequate or inappropriate care;

(d) Investigate allegations of noncompliance with RCW 43.43.830 through 43.43.845, when necessary, in consultation with law enforcement personnel;

(e) Require licensees to complete additional disclosure statements and background inquiries for an individual associated with the licensee or having direct contact with children under sixteen years of age, people with developmental disabilities, or vulnerable adults if the department has reason to

believe that offenses specified under RCW 43.43.830 have occurred since completion of the previous disclosure statement and criminal background inquiry;

(f) Approve, deny or revoke requests by home health, hospice or home care agencies for initial service area or service area expansion based on:

(i) The licensee's demonstrated ability or inability to comply with this chapter as illustrated by substantiated complaint history, survey outcomes or enforcement action; and

(ii) Evidence of the licensee's ability or inability to manage and supervise services throughout the approved service area under criteria listed in WAC 246-335-055 (1)(a)(vi);

(g) Approve, deny, restrict, condition, modify, suspend, or revoke a license under this chapter under RCW 70.127.170 and 70.127.180(3);

(h) Issue a statement of deficiencies following a survey which identifies noncompliance with chapter 70.127 RCW and this chapter; and

(i) Prepare and serve upon the licensee or applicant at the earliest practical time a statement of charges following a survey which identifies noncompliance with chapter 70.127 RCW and this chapter. The statement of charges shall be accompanied by a notice that the licensee or applicant may request a hearing to contest the charges.

2013-020 The Health Care Authority does not comply with the data-sharing requirements of 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:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM	
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles	
Questioned Cost Amount:	None	

Background

Medicaid is the "payer of last resort," meaning the Health Care Authority (Authority) 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.

In 2007, the state Legislature amended chapter 74.09A RCW and these statutes require the Authority 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 Authority. 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 and save scarce public resources.

In our past five audits, 2008 through 2012, we reported findings regarding the Authority's noncompliance with the federal Deficit Reduction Act of 2005 and the state law.

The state had Medicaid expenditures of approximately $7.7 billion in fiscal year 2013.

Description of Condition

The Authority took steps to comply with the data-sharing requirements of State law and the federal Deficit Reduction Act of 2005 by implementing the Payer Initiated Eligibility/Benefit (PIE) transaction format into

ProviderOne, the State's Medicaid Management Information System. The Authority also sent letters to 10 health insurers notifying them that it is ready to begin data exchanges with them.

However, the exchange of data from health insurers to ProviderOne was not fully implemented during the audit period.

Cause of Condition

The exchange of data was not operationalized during the audit period as trading partner agreements between the Authority and health insurers were not signed and health insurers did not implement the new transaction format recently implemented in ProviderOne.

Effect of Condition

When Medicaid-eligible individuals with third-party liability coverage are not identified, the Authority is at risk of paying claims that should have been paid by liable third parties, placing millions of state and federal dollars at risk for being inappropriately paid.

Recommendation

We recommend the Authority provide routine and periodic computerized information to health insurers regarding client eligibility and coverage information and receive joint beneficiary information in order to better identify all third parties liable for Medicaid beneficiary claims.

Agency's Response

The Health Care Authority continues to disagree with this finding.

The agency is in compliance with the Deficit Reduction Act of 2005 and applicable state law, and has been since the federal act was passed into law in April 2007. The Health Care Authority meets this standard by making data available to all insurers to use for third-party liability reporting and by matching data directly with those insurers most likely to provide third-party coverage to Medicaid recipients.

Although the Health Care Authority maintains its compliance with the Deficit Reduction Act, it has also taken steps to enhance data sharing to assure that it continues to have a strong third-party liability program. Those steps include:

- *Implementation of the Payer-Initiated Eligibility/Benefit Transaction (PIE) in July 2013 and subsequent communication with major insurers in Washington requesting their participation in implementation of the PIE transaction and electronic sharing of TPL data. While other states have adopted other formats for data sharing, PIE is the actual manner and national standard format for data sharing. Although HCA has successfully implemented the PIE transaction and will continue to encourage carrier adoption, it is important to note that HCA has no authority to compel carriers to participate in use of the transaction for electronic data exchange. The Health Care Authority's successful implementation is viewed by the federal Centers for Medicare and Medicaid Services as a model implementation and best practice.*
- *In addition, the agency has had a contract with a vendor named Health Management Systems Inc. (HMS) since February 2011 to provide enhanced data matching and identification of a client's primary medical insurance coverage. The contracted activities include conducting electronic data exchanges with health insurers, and verifying and updating the insurance eligibility of Medicaid recipients for billing liable third parties on behalf of the Health Care Authority.*

Auditor's Concluding Remarks

We thank the Authority for its response. However, it does not conduct the semi-annual data share with insurers as required by state law. We reaffirm our finding.

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, United States Code, Part 1396a(a)(25) indicates that a State plan for medical assistance must "provide":

(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 U.S.C. 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 [29 U.S.C. 1167(1)], 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 subchapter 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 [29 U.S.C. 1167(1)]), 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 section 1396a(e)(13)(D) of this title) for, or are provided, medical assistance under the State plan under this subchapter (and, at State option, child health assistance under subchapter XXI), 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 authority and accept the authority'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 health care authority and health insurers to ensure that medical insurance benefits are properly utilized, a transfer of information between the authority and health insurers should be instituted, and the process for submitting requests for information and claims should be simplified.

RCW 74.09A.020 states:

Computerized information — Provision to health insurers.

(1) The authority 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 authority. The authority 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 authority. The authority 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 authority 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 authority programs.

(5) The frequency of updates will be mutually agreed to by each health insurer and the authority based on frequency of change and operational limitations. In no event shall the computerized data be provided less than semiannually.

(6) The health insurers and the authority 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 authority shall target implementation of this section to those health insurers with the highest probability of joint beneficiaries.

2013-021 The Health Care Authority did not have adequate controls in place to ensure all critical access hospitals were paid accurately.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM	
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles	
Questioned Cost Amount:	None	

Background

The Critical Access Hospital (CAH) Program was created by the 1997 federal Balanced Budget Act as a safety net device to ensure rural beneficiaries are able to access healthcare services. In the State of Washington, the certification of CAH is administered by the Department of Health. Currently, the state has 38 DOH Medicare-certified and Authority approved CAHs, which will receive cost-based reimbursement, instead of the rates set by prospective payment systems or fee schedules. The cost-based reimbursement method is designed to allow more flexible staffing options relative to community need, simplify billing methods and create incentives to develop local integrated health delivery systems, including acute, primary, emergency and long-term care.

Throughout the course of the year, the CAHs receive estimated payments that are calculated based on historical cost. The estimated payments are provisional in nature and subject to interim and final settlement after the end of hospital fiscal year.

All CAHs are required to submit cost reports to the Medicare fiscal intermediary within six months after the end of the cost reporting period or after the end of each fiscal year. CAHs are also required to submit a copy of the "as-filed" version of the Medicare cost report and its corresponding revenue codes to the Health Care Authority (HCA) for the cost settlement of its most recently completed hospital fiscal year. In addition, CAHs are required to submit the "final settled" Medicare cost report received from the Medicare fiscal intermediary to the Authority by the sixtieth day of the hospital's receipt of the approved Medicare cost report. Interim and final cost settlements are performed to reconcile claim payments to first the "as-filed" and then the "finalized" Medicare cost reports.

CAHs are paid current claims based on estimated cost-to-charge ratios derived from two year old cost report data. The interim and final settlements are intended to ensure CAHs are paid accurately.

In fiscal year 2013, the HCA paid more than $65 million to critical access hospitals.

Description of Condition

During our testing we noted the Authority performed all interim settlements when the "as-filed" version of the Medicare cost reports are available.

However, the Authority has not performed a significant number of final settlements even when Medicare approved cost reports are available. We accessed the Centers for Medicare & Medicaid Services (CMS) Healthcare Cost Report Information System **(**HCRIS) database and verified that there were a total of 149 Medicare approved CAH cost reports available from report years 2007- 2011. Since interim settlements are based on "as filed" cost reports, it is important to conduct final settlements to ensure interim payments are reconciled to the final approved costs to reflect the true costs of providing services to Medicaid patients.

The table below summarizes the results of our testing.

Status	Report Year					Total	
	2007	2008	2009	2010	2011	Number	Percent
Final CMS-approved reports available in HCRIS	39	38	36	30	6	**149**	**100%**
Final settlements performed by HCA (as of 10/2013)	34	25	20	0	0	**79**	**53%**
Approved cost reports (unsettled)	5	13	16	30	6	**70**	**47%**

During this 5-year period, the HCA did not perform final settlements on 47 percent of the total Medicare approved cost reports available.

Cause of Condition

The Authority solely relies on CAHs to submit their Medicare approved cost reports without verifying they have been submitted to the HCA within 60 days of receipt from the Medicare fiscal intermediary for final settlement.

Effect of Condition

If payments already made to CAHs are greater than total reimbursable costs, the lack of final settlements could tie up limited Medicaid resources that could be better used in other Medicaid services. Conversely, if payments already made to CAHs are less than total reimbursable costs, underpayments for a prolonged period could affect the quality of services CAHs provide to Medicaid clients.

Recommendation

We recommend the Authority:

- Implement adequate internal controls to monitor cost report submissions and the status of final Medicare approved cost reports.
- Perform final settlements on 70 Medicare approved cost reports.

Agency's Response

The Authority partially disagrees with this finding.

The Authority follows its current Washington Administrative Code (WAC) as it relates to the requirement for CAHs to submit their 'as filed' and 'final settled' versions of their medicare cost report to the department. See WAC 182-550-2598 (11) citation below:

> *11) "The department performs finalized cost settlements using the same methodology as outlined in subsection (10) of this section, except that the department uses the hospital's "final settled" medicare cost report instead of the initial "as filed" medicare cost report for the HFY being cost settled. The "final settled" medicare cost report received from the medicare fiscal intermediary must be submitted by the CAH to the department by the sixtieth day of the hospital's receipt of that medicare cost report."*

- *The Authority will ensure timely cost settlement for these hospitals.*

Auditor's Concluding Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We 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.

WAC 182-550-2598, Critical access hospitals (CAHs), states:

> (1) The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to this section:
>
> (a) "CAH," see "critical access hospital."
>
> (b) "Cost settlement" means a reconciliation of the fee-for-service interim CAH payments with a CAH's actual costs determined in conjunction with the use of the CAH's final settled medicare cost report (Form 2552-96) after the end of the CAH's HFY.
>
> (c) "Critical access hospital (CAH)" means a hospital that is approved by the department of health (DOH) for inclusion in DOH's critical access hospital program.
>
> (d) "Departmental weighted costs-to-charges (DWCC) rate" means a rate the department uses to determine a CAH payment. See subsection (5) of this section for how the department calculates a DWCC rate.
>
> (e) "DWCC rate" see "departmental weighted costs-to-charges (DWCC) rate."
>
> (f) "HFY" see "Hospital fiscal year."
>
> (g) "Hospital fiscal year" means each individual hospital's medicare cost report fiscal year.
>
> (h) "Interim CAH payment" means the actual payment the department makes for claims submitted by a CAH for service provided during its current HFY, using the appropriate DWCC rate, as determined by the department.

(i) "Revenue codes and procedure codes to cost centers crosswalk" means a document that indicates the revenue codes and procedure codes that are assigned by each hospital to a specific cost center in each hospital's medicare cost report.

(2) To be paid as a CAH by the department, a hospital must be approved by the department of health (DOH) for inclusion in DOH's critical access hospital program. The hospital must provide proof of CAH status to the department upon request. A CAH paid under the CAH program must meet the general applicable requirements in chapter 388-502 WAC. For information on audits and the audit appeal process, see WAC 388-502-0240.

(3) The department pays an eligible CAH for inpatient and outpatient hospital services provided to fee-for-service medical assistance clients on a cost basis (except when services are provided in a distinct psychiatric unit, a distinct rehabilitation unit, or detoxification unit), using departmental weighted costs-to-charges (DWCC) rates and a retrospective cost settlement process. The department pays CAH fee-for-service claims subject to retrospective cost settlement, adjustments such as a third party payment amount, any client responsibility amount, etc.

(4) For inpatient and outpatient hospital services provided to clients enrolled in a managed care organization (MCO) plan, DWCC rates for each CAH are incorporated into the calculations for the managed care capitated premiums. The department considers managed care Health Options and MHD designee DWCC payment rates to be cost. Cost settlements are not performed by the department for managed care claims.

(5) The department prospectively calculates fee-for-service and managed care inpatient and outpatient DWCC rates separately for each CAH.

(a) Prior to the department's calculation of the prospective interim inpatient DWCC and outpatient DWCC rates for each hospital participating in the CAH program, the CAH must timely submit the following to the department:

(i) Within twenty working days of receiving the request from the department, the CAH's estimated aggregate charge master change for its next HFY;

(ii) At the time that the "as filed" version of the medicare cost report the CAH initially submits to the medicare fiscal intermediary for the cost settlement of its most recently completed HFY, a copy of that same medicare cost report;

(iii) At the same time that the "as filed" version of the medicare cost report the CAH has submitted to the medicare fiscal intermediary for cost settlement of its most recently completed HFY, the CAH's corresponding revenue codes and procedure codes to cost centers crosswalk that indicates the revenue codes and procedure codes that are assigned by each hospital to a specific cost center in the hospital's medicare cost report;

(iv) At the same time that the "as filed" version of the medicare cost report the CAH has submitted to the medicare fiscal intermediary for cost settlement of its most recently completed HFY, a document indicating any differences between the CAH's revenue codes and procedure codes to cost centers crosswalk and the standard revenue codes and procedure codes to cost centers crosswalk that the department provides to the CAH from the department's CAH DWCC rate calculation model. (For example, a CAH hospital might indicate when it submits its crosswalk to the department, that a difference exists in the CAH's placement of statistics for the anesthesia revenue code normally identified to the anesthesia cost center in the department's CAH DWCC rate calculation model, but identified to the surgery cost center in the CAH's submitted medicare cost report.)

(b) The department:

(i) Determines if differences between the CAH's crosswalk and the crosswalk in the CAH DWCC rate calculation model will be allowed when the CAH timely submits the document identified in (a)(iii) and (a)(iv) of this subsection. If the CAH does not timely

submit the document, the department may use the CAH DWCC rate calculation model without considering the differences.

(ii) Does not allow unbundling or merging of the standard cost centers identified in the CAH DWCC rate calculation model when the department calculates the DWCC rates. This is a standard the department follows during the rate calculation process even though the CAH hospital may have in contrast to the CAH DWCC rate calculation model indicated multiple cost centers, or merged into fewer costs centers, when reporting in the medicare cost report. (For example, a CAH reports to the department that in the department's standard radiology cost center grouping in the CAH DWCC rate calculation model, the hospital has established three costs centers in the medicare cost report, which are radioisotopes, radiology therapeutic, and radiology diagnostic. During the rate calculation process, the department combines these three cost centers under the standard radiology cost center grouping. No unbundling of the standard cost center grouping is allowed.)

(c) The department:

(i) Obtains from its medicaid management information system (MMIS), the following fee-for-service summary claims data submitted by each CAH for services provided during the same HFY identified in (a)(ii) of this subsection:

(A) Medical assistance program codes;

(B) Inpatient and outpatient hospital claim types;

(C) Procedure codes (for outpatient hospital claims only), revenue codes, and diagnosis related group (DRG) codes (for inpatient claims only);

(D) Claim allowed charges, third party liability, client paid amounts, and department paid amounts; and

(E) Units of service.

(ii) Obtains Level III trauma payment data from the department of health (DOH).

(iii) Obtains the costs-to-charges ration (CCR) of each respective cost center from the "as filed" version of the medicare cost report identified in (a)(ii) of this subsection, supplemented by any crosswalk information as described in (a)(iii) and (a)(iv) of this subsection.

(iv) Obtains from the managed care encounter data the following data submitted by each CAH for services provided during the same HFY identified:

(A) Medical assistance program codes;

(B) Inpatient and outpatient hospital claim types;

(C) Procedure codes (for outpatient hospital claims only), revenue codes, and diagnosis related group (DGR) codes (for inpatient claims only); and

(D) Claim allowed charges.

(v) Separates the inpatient claims data and outpatient hospital claims data;

(vi) Obtains the cost center claim allowed charges by classifying inpatient and outpatient hospital claim allowed charges from (c)(i) and (c)(iv) of this subsection billed by a CAH (using any one of, or a combination of, procedure codes, revenue codes, or DRG codes) into the related cost center in the CAH's "as filed" medicare cost report the CAH initially submits to the department.

(vii) Uses the claims classifications and cost center combinations as defined in the department's CAH DWCC rate calculation model;

(viii) Assigns a CAH that does not have a cost center ratio that CAH's cost center average;

(ix) Allows changes only if a revenue codes and procedure codes to cost centers crosswalk has been timely submitted (see (a)(iii), (a)(iv), and (b)(i) of this subsection) and a cost center average is being used;

(x) Does not allow an unbundling of cost centers (see (b)(ii) of this subsection);

(xi) Determines the departmental-weighted costs for each cost center by multiplying the cost center's claim allowed charges from (c)(i) and (c)(iv) of this subsection for the appropriate inpatient or outpatient claim type by the related service costs center ratio;

(xii) Sums all:

(A) Claim allowed charges from (c)(i) and (c)(iv) of this subsection separately for inpatient hospital claims.

(B) Claim allowed charges from (c)(i) and (c)(iv) of this subsection separately for outpatient hospital claims.

(xiii) Sums all:

(A) Departmental-weighted costs from (c)(xi) of this subsection separately for inpatient hospital claims.

(B) Departmental-weighted costs from (c)(xi) of this subsection separately for outpatient hospital claims.

(xiv)Multiplies each hospital's total departmental-weighted costs from (c)(xiii) of this subsection by the centers for medicare and medicaid services (CMS) medicare market basket inflation rate to update costs from the HFY to the rate setting period. The medicare market basket inflation rate is published and updated by CMS periodically;

(xv) Multiplies each hospital's total claim allowed charges from (c)(xii) of this subsection by the CAH estimated charge master change from (a)(i) of this subsection. If the charge master change factor is not submitted timely by the hospital (see (a)(i) of this subsection), the department will apply a reasonable alternative factor; and

(xvi) Determines:

(A) The inpatient DWCC rates by dividing the calculation result from (c)(xiv) of this subsection by the calculation result from (c)(xv) of this subsection.

(B) The outpatient DWCC rates by dividing the calculation result from (c)(xiv) of this subsection by the calculation result from (c)(xv) of this subsection.

(6) For a currently enrolled hospital provider that is new to the CAH program, the basis for calculating initial prospective DWCC rates for inpatient and outpatient hospital claims for:

(a) Fee-for-service clients is:

(i) The hospital's most recent "as filed" medicare cost report; and

(ii) The appropriate MMIS summary claims data for that HFY.

(b) MCO clients is:

(i) The hospital's most recent "as filed" medicare cost report; and

(ii) The appropriate managed care encounter data for that HFY.

(7) For a newly licensed hospital that is also a CAH, the department uses the current statewide average DWCC rates for the initial prospective DWCC rates.

(8) For a CAH that comes under new ownership, the department uses the prior owner's DWCC rates until:

(a) The new owner submits its first "as filed" medicare cost report to the medicare fiscal intermediary, and at the same time to the department, the documents identified in (5)(a)(i) through (a)(iv) of this section; and

(b) The department has calculated new DWCC rates based on the new owner's "as filed" medicare cost report and other timely submitted documents.

(9) In addition to the prospective managed care inpatient and outpatient DWCC rates, the department:

(a) Incorporates the DWCC rates into the calculations for the department's MCO capitated premium that will be paid to the MCO plan; and

(b) Requires all MCO plans having contract relationships with CAHs to pay inpatient and outpatient DWCC rates applicable to managed care claims. For purposes of this section, the department considers the DWCC rates used to pay CAHs for care given to clients enrolled in

an MCO plan to be cost. Cost settlements are not performed for claims that are submitted to the MCO plans.

(10) For fee-for-service claims only, the department uses the same methodology as outlined in subsection (5) of this section to perform an interim retrospective cost settlement for each CAH after the end of the CAH's HFY, using "as filed" medicare cost report data from that HFY that is being cost settled, the other documents identified in subsection (5)(a)(i), (a)(iii) and (a)(iv) of this section, when data from the MMIS related to fee-for-service claims. Specifically, the department:

(a) Compares actual department total interim CAH payments to the departmental-weighted CAH fee-for-service costs for the period being cost settled. (Interim payments are the sum of third party liability/client payments, department claim payments, and Level III trauma payments); and

(b) Pays the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to exceed the total interim CAH payments for that period. The department recoups from the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to be less than total interim CAH payments.

(11) The department performs finalized cost settlements using the same methodology as outlined in subsection (10) of this section, except that the department uses the hospital's "final settled" medicare cost report instead of the initial "as filed" medicare cost report for the HFY being cost settled. The "final settled" medicare cost report received from the medicare fiscal intermediary must be submitted by the CAH to the department by the sixtieth day of the hospital's receipt of that medicare cost report.

(12) A CAH must have and follow written procedures that provide a resolution to complaints and grievances.

(13) To ensure quality of care:

(a) A CAH is responsible to investigate any reports of substandard care or violations of the hospital's medical staff bylaws; and

(b) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(i) Department of health (DOH); or

(ii) Other agencies with review authority for department programs.

(14) The department pays detoxification units, distinct psychiatric units, and distinct rehabilitation units operated by CAH hospitals using inpatient payment methods other than DWCC rates and cost settlement.

(a) For dates of admission before August 1, 2007, the department uses the RCW payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units. The exception is for state-administered programs' psychiatric claims, which are paid using:

(i) The DRG payment method for claims grouped to stable DRG relative weights (unless the claim has an HIV-related diagnosis), and in conjunction with the base community psychiatric hospitalization payment method; or

(ii) The RCW payment method for other psychiatric claims (except for DRGs 469 and 470), in conjunction with the base community psychiatric hospitalization payment method.

(b) For dates of admission on and after August 1, 2007, the department uses the per diem payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units.

(15) The department may conduct a post pay or on-site review of any CAH.

2013-022 The Health Care Authority did not ensure that all individuals who received Medicaid benefits had valid Social Security numbers.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM	
Applicable Compliance Component:	Eligibility	
Questioned Cost Amount:	$177,568	

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 $7.68 billion during fiscal year 2013, more than $4.11 billion of which was federal dollars.

Federal regulations require the Health Care Authority (Authority) to obtain a Social Security number from each individual, including children, applying for Medicaid. Federal regulations also require the agency to verify the number with the Social Security Administration to ensure it was issued to the individual who supplied it and whether any other number had been issued for the individual. If an applicant has not been issued a number, the agency must assist the individual in applying for one. Under these circumstances, the agency 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 agency to verify the validity of a Social Security number at the time of application for Medicaid. Agency's 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 error message to the system.

Description of Condition

We reviewed Medicaid beneficiaries in the Authority's Medicaid Management Information System (ProviderOne) and performed tests to determine if the Medicaid beneficiaries have valid Social Security numbers.

We found 512 individuals who did not have a valid Social Security number.

The table below summarizes the results of our work:

Description	Number of clients	Payments	Federal Share[1]	State Share
No Social Security number	500	$344,790.06	$172,395.03	$172,395.03
Number belongs to deceased person	12	$10,346.63	$5,173.31	$5,173.32
Total	**512**	**$355,136.69**	**$177,568.34**	**$177,568.35**

Cause of Condition

The Authority has continuously made improvements in its training and monitoring, and maintains adequate Social Security number verification procedures. However, it is still not preventing or detecting all unallowable payments.

Effect of Condition and Questioned Costs

When the Authority provides services to ineligible individuals, or the services are unallowable and/or unsupported, the service cannot be claimed for federal reimbursement. Payments for services for these 512 clients were $355,136.69. We are questioning $177,568.34, which is the federal portion of the unallowable costs.

We question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support expenditures.

Recommendation

We recommend the Authority:

- Follow up on the 512 clients for whom the Authority 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 Authority's Social Security number verification procedures.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Agency's Response

The Authority concurs that there were instances of missing social security numbers due to worker errors. We will review training opportunities with staff whose primary duties include processing of Medicaid applications. This training will include policy, procedures, and proper use of automated systems.

The Authority will review all cases and consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Auditor's Concluding Remarks

We thank the Authority for its cooperation and assistance throughout the audit.

[1] The federal share is calculated using the state's 2013 FMAP rate of 50 percent.

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.

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

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

Section 510 - Audit findings.

(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. In reporting questioned costs, the auditor shall include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Title 42, Code of Federal Regulations, Section 435.910(a) Use of social security number, states in part:

[T]he agency must require, as a condition of eligibility, that each individual (including children) seeking Medicaid furnish each of his or her Social Security numbers (SSN). . . .

Title 42, Code of Federal Regulations, Section 435.910 (g) states:

The agency must verify the SSN furnished by an applicant or beneficiary to insure the SSN was issued to that individual, and to determine whether any other SSNs were issued to that individual.

Title 42, Code of Federal Regulations, Section 435.910 (e) states:

If an applicant cannot recall his SSN or SSNs or has not been issued a SSN 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 beneficiaries, 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 beneficiary'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 beneficiary to furnish them and meet other requirements of 435.910.
(c) For any beneficiary whose SSN was established as part of the case record without evidence required under the SSA regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with 435.910.

2013-023 The Health Care Authority does not have adequate controls to ensure inpatient high outlier payments to hospitals are accurate.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM	
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles	
Questioned Cost Amount:	$42,196.43	

Background

Medicaid is a jointly funded state and federal partnership providing health coverage for certain low-income individuals who otherwise might go without medical care. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program, and in the state of Washington the Health Care Authority is the single state agency to administer the state's Medicaid program.

From the Medicaid program, hospitals receive either case-based payments (Diagnosis-Related Group based prospective payments), a set amount of dollars per day of inpatient stay (per-diem payments) or fees for individual services (fee-for-services). The DRG payments are unilaterally set by the state governments, usually as a percentage of Medicare DRGs.

High outlier payments are additional supplemental payments to hospitals to compensate hospitals for cases incurring extraordinarily high costs. These payments are designed to protect the hospital from large financial losses due to unusually expensive cases. High outlier payments are to be made only in situations where the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. The actual determination of whether a case qualifies for outlier payments takes into account both operating and capital costs (estimated cost of claim) and DRG (Diagnosis Related Group) payments. High outlier payments are payments approved by the CMS under section 1886(d)(5)(A) of the Social Security Act.

An inpatient claim qualifies for a high outlier if the inpatient claim cost is greater than the following two high outlier thresholds:

- $50,000, and
- An amount calculated by multiplying the inpatient claim's predetermined allowed amount by the outlier threshold factor or marginal cost factor

Description of Condition

During our audit, we found that the Authority did not have adequate controls to ensure inpatient high outlier payments to hospitals are accurate. The Authority included noncovered service charges to claims when determining high outlier payments.

We also found that the Authority did not have controls in place to ensure rate changes are applied to all eligible inpatient claims. The Authority submitted a State Plan Amendment (SPA) to adjust high outlier factors effective for hospital admissions on or after August 1, 2012. CMS approved the plan and the Authority implemented the adjusted high outlier factors into ProviderOne system, Medicaid Management Information System, in March 2013. However, the Authority failed to apply the new adjusted high outlier factors retroactively to inpatient claims that were already paid.

Cause of Condition

The Authority was unaware that noncovered services were included in high outlier payment calculation.

The Authority was unaware that the new adjusted high outlier factors were not applied retroactively to inpatient claims that were already paid.

Effect of Condition and Questioned Costs

During our testing, we selected the top 154 high outlier inpatient claims. We identified 48 claims where noncovered charges were included when calculating the high outlier payment, resulting in a total overpayment of $84,392.85. We are questioning $42,196.43, which is the federal portion[1] of the unallowable expenditures.

We question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support expenditures.

We also identified 66 high outlier claims that were calculated using outdated high outlier factors, resulting in a total underpayment of $642,657.38 to hospitals.

Recommendation

We recommend the Authority:

- Establish adequate controls to ensure noncovered services are removed prior to calculating high outlier payments.
- Establish adequate controls to ensure rate changes are implemented accurately.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.
- Follow up on 66 claims and identify all high outlier payments that were paid based on outdated high outlier factors.

[1] The federal share is calculated using the state's 2013 FMAP rate of 50 percent.

Agency's Response

The Authority partially disagrees with this finding.

The Authority follows its current Washington Administrative Codes (WACs) correctly in calculating outlier costs. It removed noncovered charges as they are defined in the below WACs:

- *WAC 182-550-3700 (14) "…. The estimated costs of the claim are calculated by multiplying the total submitted charges, minus the noncovered charges on the claim, by the hospital's ratio of costs-to-charges (RCC) rate…"*
- *WAC 182-550-1050 '….."Noncovered charges" means billed charges submitted to the department by a provider on a claim that are indicated by the provider on the claim as noncovered."*

The Authority ensured claims were paid correctly and took steps to recoup incorrect payments as soon as they were discovered.

The Authority is/has taken the following steps for addressing the findings:

- *The Authority is currently working to change its WAC and payment system to align with the auditor's recommendation. Both are scheduled to be in place and effective for claims with admit dates on or after August 1, 2014. At that time, denied lines will no longer be included in the part of the outlier calculation related to costs.*
- *The Authority has reallocated the inpatient program workload in order to allow additional capacity for monitoring system and rate changes.*
- *The Authority initiated action to recoup and repay some of the claims identified by the auditor that were paid with outdated high outlier factors. For the other claims as stated above, current WAC does not allow the agency to remove charges other than those that the WAC defines as noncovered when the agency calculates costs for outlier payments.*

Auditor's Concluding Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We 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.

42 US Code § 1395ww (5)(A)(i) states,

> For discharges occurring during fiscal years ending on or before September 30, 1997, the Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days, or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

42 CFR 412.80, Outlier cases: General provisions, (a) Basic rule, states in part:

(3) *Discharges occurring on or after October 1, 2001.* For discharges occurring on or after October 1, 2001, except as provided in paragraph (b) of this section concerning transfers, CMS provides for additional payment, beyond standard DRG payments and beyond additional payments for new medical services or technology specified in §§412.87 and 412.88, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services, adjusted to operating costs and capital costs by applying cost-to-charge ratios as described in §412.84(h), exceed the DRG payment for the case (plus payments for indirect costs of graduate medical education (§412.105), payments for serving a disproportionate share of low-income patients (§412.106), and additional payments for new medical services or technologies) plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

42 CFR 412.84, Payment for extraordinarily high-cost cases (cost outliers), states in part:

(a) A hospital may request its intermediary to make an additional payment for inpatient hospital services that meet the criteria established in accordance with §412.80(a).
(b) The hospital must request additional payment—
  (1) With initial submission of the bill; or
  (2) Within 60 days of receipt of the intermediary's initial determination.
(c) Except as specified in paragraph (e) of this section, an additional payment for a cost outlier case is made prior to medical review.
(d) As described in paragraph (f) of this section, the QIO reviews a sample of cost outlier cases after payment. *The charges for any services identified as noncovered* through this review are denied and any outlier payment made for these services are recovered, as appropriate, after a determination as to the provider's liability has been made.

WAC 182-550-3700, DRG high-cost and low-cost outliers, and new system DRG and per diem high outliers, states in part:

(14) For dates of admission on and after August 1, 2007, the department allows a high outlier payment for claims paid using the DRG payment method when high outlier qualifying criteria are met. The estimated costs of the claim are calculated by multiplying the total submitted charges, *minus the noncovered charges on the claim*, by the hospital's ratio of costs-to-charges (RCC) rate. The department identifies a DRG high outlier claim based on the claim's estimated costs. to qualify as a DRG high outlier claim, the department's estimated costs for the claim must be greater than both the fixed outlier cost threshold of fifty thousand dollars, and one hundred seventy-five percent of the applicable base DRG allowed amount for payment. These criteria are also used to determine if a transfer claim qualifies for high outlier payment when a transfer claim is submitted to the department by a transferring hospital.

WAC 296-23A-0500, When does a case qualify for high outlier status?, states in part:

Outlier payments apply only to diagnosis-related-group (DRG) reimbursed cases with unusually high or low costs. Outlier status does not apply to cases paid using a percent of allowed charges (POAC) factor or per diem rates.

A case is considered a high cost outlier if the costs for the case exceed the outlier threshold for the assigned diagnosis-related-group. The costs for a case are determined by multiplying the allowed charges for the case by the hospital specific POAC factor. The threshold used to define a high outlier case is the greater of a dollar threshold of twelve thousand dollars or two standard deviations above the statewide average cost for each DRG paid by the department.

The dollar threshold may be adjusted annually for inflation or other factors as determined by the department. The standard deviations for DRGs will be computed from all relevant cases in the historical data base, excluding statistical outliers.

WAC 296-23A-0520,

How does the department pay for high outlier cases?, states in part:

> Cases defined as high cost outliers will be reimbursed at the diagnosis-related-group (DRG) payment rate plus one hundred percent of costs in excess of the threshold. Costs are determined by multiplying the allowed charges by the hospital specific percent of allowed charges (POAC) factor.

2013-024 The Health Care Authority's internal controls are insufficient to ensure payment rates for its Healthy Options managed care program are accurate, resulting in over $95,000 in potential overpayments on premium rates paid to the managed care organizations.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster
	93.720 ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775 State Medicaid Fraud Control Units
	93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778 Medical Assistance Program (Medicaid; Title XIX)
	93.778A Medical Assistance Program (Medicaid; Title XIX)-American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles
Questioned Cost Amount:	$47,686

Background

The Health Care Authority 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 Authority, including the cost of the services and demographic, diagnostic and geographic data. Capitation rates are calculated based in part on how much spending managed care organizations report.

The Authority contracts with an actuary to analyze this data to use in developing capitation rates. In general, the rate is higher for plans which include more seriously ill people.

In a report dated August 4, 2010, CMS's Oversight of States' Rate Setting Needs Improvement, 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 rates are appropriate.

In fiscal years 2003 through 2012, we reported concerns regarding the Authority's lack of review of the accuracy of data from providers that are used to determine the rates in this state.

The state paid approximately $1.4 billion to managed care organizations during fiscal year 2013.

Description of Condition

We found the Authority does not verify the accuracy of data from providers that are used to determine the rates, even though it has the knowledge and expertise to do so. It has an actuarially sound process for calculating rates; however, actuarial certification does not ensure the underlying data is reliable. If underlying data used is inaccurate or incomplete, it could result in inaccurate rates.

Cause of Condition

The Authority stated that it planned to take the following action in an effort to resolve the repeat findings on this issue:

- Use encounter data submitted from the Managed Care Organizations (MCOs) for the next rate-setting activities. The MCOs will no longer submit encounter data directly to the Authority's actuary.
- Launch a Managed Care Program Integrity Initiative with the implementation of a new Medicaid payment system and a new Fraud and Abuse Detection System. The purpose of the initiative is to assess the quality and completeness of encounter data provided by MCOs and to conduct analyses that identify potential fraud, waste and abuse. If encounter data problems are identified, the Authority will prepare a report with actionable information for the plans. Subsequent encounter data validation runs will determine the MCOs' progress in remediating the identified issues.

However, the plan was not fully operational during the audit period.

Effect of Condition and Questioned Costs

In fiscal years 2003 through 2011, we reported concerns regarding the Authority's lack of review of the accuracy of data from providers that are used to determine the rates in this state. We did not have quantitative evidence of overpayments as a result of our concerns at the time we released these findings. A performance audit of the Authority's management of the state's two largest MCOs that will be released later this year has provided us with evidence that overpayments from MCOs to providers are affecting the state's Medicaid provider payments.

The analysis included a risk-based, judgmental sample of a limited number of transactions that took place in 2010 and affected state payments to MCOs starting in state fiscal year 2013. The performance audit (PA) identified $91,505 in estimated overpayments made by MCO to providers in 2010 and one underpayment of $15,814, for net estimated overpayments of $75,691.

These estimated overpayments in 2010 resulted in additional costs to the state, because the 2010 expenditures reported by MCOs were used to calculate the premium rates paid by the state to MCOs starting in fiscal year 2013. In order to determine how the estimated overpayments impact premium payments, PA conducted an actuarial analysis that shows that for every $1 in overpayments made by the two audited MCOs to their providers in 2010, the state potentially paid an additional $1.26 in premiums to all MCOs in FY 2013. This is based on an enrollment of 695,000 members.

Based on this rate, the $75,691 of net overpayments to providers in 2010 resulted in $95,371 of premium overpayments to MCOs. We are questioning $47,686, which is the federal portion of the unallowable expenditures.

Recommendation

We recommend the Authority:

- Establish and follow controls to provide reasonable assurance that data used in rate-setting is accurate and complete.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Agency's Response

The Health Care Authority (HCA) does not concur with this finding.

In the Background section, it is noted that this repeat finding questions the accuracy of encounter data and cites the lack of review of data provided to the actuary and used to set rates. No evidence is presented showing that managed care contract rates were inaccurate. While HCA agrees that additional oversight and controls of Managed Care Organizations (MCO) will strengthen the state's ability to adequately manage the MCO contracts, the audit finding does not identify a managed care rate inaccuracy on which to base the questioned costs.

HCA disagrees with the methodologies used to identify questioned costs in this audit finding for three reasons. First, questioned costs were identified in a performance audit which is intended to improve management of the program. No evidence of claims data is presented to support that the payments in question directly impact the managed care rates, as the auditor claims. As a result, HCA is unable to confirm the questioned costs. Second, the audit finding states that items identified as "errors" were "not paid in compliance with standard medical coding practices or were not properly supported with appropriate documentation". This is not necessarily an overpayment; it only shows that documentation should be stronger and practices need to be standardized. Third, the audit finding uses an actuarial analysis to assert that "for every $1 in overpayments made by the two audited MCOs to their providers in 2010, the state potentially paid an additional $1.26 in premiums to all MCOs in FY 2013." While this analysis can be used to identify performance improvements possible in the managed care program, the analysis clearly states there is only a potential for overpayment. No identification of an actual overpayment is made. In addition, the actuarial analysis is not based on the sample of payments in question.

Auditor's Concluding Remarks

We thank the Authority for its response. Without reviewing the accuracy and completeness of data used to set managed care rates, the Authority cannot ensure the rates are appropriate. A performance audit of the Authority's management of the state's two largest MCOs has provided us with quantitative evidence of overpayments as a result of control weakness we identified. We calculated the questioned costs based on the overpayments MCOs made to their providers in 2010 since the 2010 expenditures reported by managed care organizations were used to calculate the premium rates paid by the state to managed care organizations starting in 2013. We reaffirm our finding.

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

42 CFR 456.3, Statewide surveillance and utilization control program, states:

> The Medicaid agency must implement a statewide surveillance and utilization control program that—
>
> (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;
>
> (b) Assesses the quality of those services;
>
> (c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part; and

(d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part.

42 CFR 438.6, Contract requirements, states in part:

(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.

2013-025 The Health Care Authority did not invoice Medicaid drug rebates to drug manufacturers in accordance with the time frame stipulated by state and federal laws.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM	
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles	
Questioned Cost Amount:	None	

Background

Medicaid is a jointly funded state and federal partnership providing health coverage for certain low-income individuals who otherwise might go without medical care. This coverage includes outpatient drugs.

The Medicaid drug program, which began in 1991, is set forth in section 1927 of the Social Security Act. For Federal payment to be available for covered outpatient drugs provided under Medicaid, drug manufacturers are required to enter into a rebate agreement with the Secretary of Health and Human Services and pay quarterly rebates to States. Under these rebate agreements, manufacturers must provide Center for Medicare and Medicaid Services (CMS) with the average manufacturer price (AMP) by national drug code (NDC) for each of their covered drugs. CMS uses the AMP and best price data to calculate the unit rebate amount (URA) for each NDC included in the Medicaid drug rebate program and transmits this information to the States.

States then calculate the total quarterly rebates that participating manufacturers owe by multiplying the URA for a specific drug by the number of units of that drug for which the State reimbursed providers in that quarter. Within 60 days of the end of the quarter, States must invoice the manufacturers for the units reimbursed and indicate the total rebate due for each NDC. The manufacturers process the invoices and pay the rebates to the States within 30 days of receipt of the invoices.

The Authority invoiced manufacturers for more than $163 million in drug rebates for drug units it paid during the audit period.

Description of Condition

During our audit, we reviewed all invoices which were processed during the audit period to determine if the Authority invoiced drug manufacturers within 60 days of the end of each quarter.

The table below summarizes the results.

Quarter Ending Date	Total invoice amount	Average number of days between quarter ending date and invoice date
9/30/2012	$51,175,666.15	117
12/31/2012	$36,686,579.32	149
3/31/2013	$46,757,078.42	89
6/30/2013	$26,072,893.38	123

Cause of Condition

The Authority stated that 60 days is not sufficient to complete invoice process as required by state and federal laws. The first 30 days after the end of quarter are dedicated to the manufacturer for supplying pricing information to CMS. The next 15 days are dedicated to CMS for addressing pricing issues, calculating unit rebate amounts. The State then has only 15 days for invoicing to be completed.

Effect of Condition

Untimely reimbursement requests may result in a hold on limited Medicaid resources that would otherwise be directed to other Medicaid services.

Recommendation

We recommend the Authority invoice Medicaid drug rebates to drug manufacturers in accordance with the time line stipulated by state and federal laws.

Agency's Response

The Authority agrees with this finding.

The Authority strives to ensure that Drug Rebate invoices reflect correct utilization and unit rebate amounts. As such, system modifications and unanticipated data patches have had to be implemented which caused the invoice delays.

The Authority is taking the following steps to improve timely invoicing for Drug Rebates:

- *Re-evaluate and streamline the invoicing workflow established at Provider One implementation;*
- *Review responsibilities and timeline requirements for each element of the invoicing process; and*
- *Drug Rebate system requests/modifications will be elevated to higher priority/visibility.*

Auditor's Concluding Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We 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.

42 U.S.C. 1396r–8. Payment for covered outpatient drugs, states in part:

> (b) Terms of rebate agreement
>
> (1) Periodic rebates
>
> (A) In general: A rebate agreement under this subsection shall require the manufacturer to provide, to each State plan approved under this subchapter, a rebate for a rebate period in an amount specified in subsection (c) of this section for covered outpatient drugs of the manufacturer dispensed after December 31, 1990, for which payment was made under the State plan for such period, including such drugs dispensed to individuals enrolled with a medicaid managed care organization if the organization is responsible for coverage of such drugs. Such rebate shall be paid by the manufacturer not later than 30 days after the date of receipt of the information described in paragraph (2) for the period involved.
>
> (B) Offset against medical assistance: Amounts received by a State under this section (or under an agreement authorized by the Secretary under subsection (a)(1) of this section or an agreement described in subsection (a)(4) of this section) in any quarter shall be considered to be a reduction in the amount expended under the State plan in the quarter for medical assistance for purposes of section 1396b(a)(1) of this title.
>
> (2) State provision of information, states in part:
>
> (A) State responsibility
>
> Each State agency under this title shall report to each manufacturer not later than 60 days after the end of each rebate period and in a form consistent with a standard reporting format established by the Secretary, information on the total number of units of each dosage form and strength and package size of each covered outpatient drug dispensed after December 31, 1990, for which payment was made under the plan during the period, including such information reported by each medicaid managed care organization,'' after ''for which payment was made under the plan during the period, and shall promptly transmit a copy of such report to the Secretary.

Health Care Authority Medicaid Drug Rebate Policy

> C. PREPARING MEDICAID DRUG REBATE INVOICES
>
> 1. No later than 60 days after the end of the calendar quarter, HCA will prepare and transmit an invoice using the CMS-R-144 State Invoice format to each labeler participating in the drug rebate program. HCA will also transmit a copy of form CMS-R-144 to CMS and to the Office of Financial Recovery (OFR).

2013-026 The Health Care Authority's inadequate internal controls over claims from Federally Qualified Health Centers led to more than $226,279.66 in improper payments to providers.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster
	93.720 ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775 State Medicaid Fraud Control Units
	93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778 Medical Assistance Program (Medicaid; Title XIX)
	93.778A Medical Assistance Program (Medicaid; Title XIX)-American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles
Questioned Cost Amount:	$113,139

Background

Medicaid is a jointly funded state and federal partnership providing coverage for certain low-income individuals who otherwise might go without medical care. The state Medicaid program spent more than $7.6 billion during fiscal year 2013. More than $4.5 billion of that relates to activities of the Health Care Authority (Authority), of which more than $4.3 billion was paid directly to providers.

Federally Qualified Health Centers (FQHC) are "safety net" providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Services and programs serving migrants and the homeless. The main purpose of the FQHC program is to enhance the provision of primary care services in underserved urban and rural communities.

With few exceptions, FQHCs are paid based on a client encounter with a provider regardless of the number or type of procedures provided during the encounter. An encounter is a face-to-face visit between a client and a qualified FQHC provider who exercises independent judgment when providing services that qualify for an encounter rate.

Encounters are limited to one per client, per day except in the following circumstances:

- The client needs to be seen on the same day by different practitioners with different specialties; or
- The client needs to be seen multiple times on the same day due to unrelated diagnoses.

During fiscal year 2013, the Authority paid more than $187 million to FQHC providers.

Description of Condition

The Medicaid claim adjudication and payment process is highly automated. The Authority relies heavily on internal controls within ProviderOne, the State of Washington Medicaid Management Information System, to identify and deny claims when charges are unallowable or billed improperly by FQHC providers.

In our prior audit, we reported concerns regarding the Authority's inadequate internal controls over claims from FQHC. We found the internal controls within ProviderOne were not effectively designed to prevent improper claims from being paid.

In response to our finding, the Authority stated that it established an internal workgroup which updates the system and billing guides for FQHCs so the system edits prevent overpayments and improper billings at the point of claim submission. However, new system edits were not implemented during the audit period.

Cause of Condition

ProviderOne system edits designed to prevent improper billings and payments did not work as intended due to system errors. Also, additional system edits the Authority planned to implement were not completed and operational during the audit period.

Effect of Condition and Questioned Costs

Due to the internal control weaknesses described above, we performed tests to determine if the Authority improperly paid FQHC providers. The table below summarizes the results of our testing:

Description	Number of claims	Questioned costs		
		State	Federal	Total
Fee-for-service claims were paid in addition to encounter payments	5,975	75,284.07	75,284.07	150,568.14
Encounter payments were made for encounter ineligible claims	1,208	37,518.42	37,518.42	75,036.84
More than one encounter payment was made for the same client	3	337.34	337.34	674.68
Total	7,186	113,139.83	113,139.83	226,279.66

We are questioning $ 113,139.83, which is the federal portion of the unallowable costs.

During our testing we also noted that some encounter eligible claims were billed and paid at fee-for-services rates. The questioned costs (the net of overpayments and underpayments) cannot presently be determined.

Recommendation

We recommend the Authority:

- Develop adequate internal controls within its ProviderOne system to detect and prevent improper and unallowable claims submitted by FQHC providers.
- Recoup $226,279.66 in overpaid amounts from the FQHC providers.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Agency's Response

The Authority agrees with the finding.

Health Care Authority (HCA) is performing the following activities to address this finding::

- *Complete the update of both the Washington Administrative Code (WAC) and provider billing guide to clearly define allowable encounters; and*
- *Update ProviderOne system logic to align with the WAC and billing guide and ensure that system edits are in place to prevent overpayments and improper billings at the point of claim submission.*

In addition, HCA staff will work with the US Department of Health and Human Services to discuss repayment of questioned costs.

Auditor's Concluding Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We 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.
> (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

OMB Circular A-133 Compliance Supplement for 2012, *Part 3 – Compliance Requirements*, states in part:

> Improper Payments
>
> Under OMB guidance, Public Law (Pub. L.) No. 107-300, the Improper Payments Information Act of 2002, as amended by Pub. L. No. 111-204, the Improper Payments Elimination and Recovery Act, Executive Order 13520 on reducing improper payments, and the June 18, 2010 Presidential memorandum to enhance payment accuracy, Federal agencies are required to take actions to prevent improper payments, review Federal awards for such payments, and, as applicable, reclaim improper payments. Improper payment means:
>
> 1. Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements.
> 2. Incorrect amounts are overpayments or underpayments that are made to eligible recipients (including inappropriate denials of payment or service, any payment that does not account for credit for applicable discounts, payments that are for the incorrect amount, and duplicate payments).
> 3. Any payment that was made to an ineligible recipient or for an ineligible good or service, or payments for goods or services not received (except for such payments where authorized by law).
> 4. Any payment that an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation.

Washington Administrative Code 182-548-1400, Federally qualified health centers – Reimbursement and limitations, states in part:

> (8) The agency limits encounters to one per client, per day except in the following circumstances:
> (a) The visits occur with different health care professionals with different specialties; or
> (b) There are separate visits with unrelated diagnoses.
> (9) FQHC services and supplies incidental to the provider's services are included in the encounter rate payment.

2013-027 The Health Care Authority's inadequate internal controls over claims for dental services led to more than $584,511.96 in overpayments to providers.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster
	93.720 ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775 State Medicaid Fraud Control Units
	93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778 Medical Assistance Program (Medicaid; Title XIX)
	93.778A Medical Assistance Program (Medicaid; Title XIX)-American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles
Questioned Cost Amount:	$292,255.98

Background

Medicaid is a jointly funded state and federal partnership providing coverage for certain low-income individuals who otherwise might go without medical care. The state Medicaid program spent more than $7.6 billion during fiscal year 2013. More than $4.5 billion of that relates to activities of the Health Care Authority (Authority), of which more than $4.3 billion was paid directly to providers.

States are required to provide dental benefits to children covered by Medicaid, but states choose whether to provide dental benefits for adults. Medicaid covers dental services for all child enrollees as part of a comprehensive set of benefits, referred to as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health.

In fiscal year 2013 the Authority paid $247 million for dental services.

Description of Condition

The Medicaid claim adjudication and payment process is highly automated. The Authority relies heavily on internal controls within the ProviderOne payment system, the State of Washington Medicaid Management Information System, to identify and deny claims when charges are unallowable or billed improperly by dental providers. In our audit for fiscal year 2012, we recommended the Authority develop adequate internal controls within its ProviderOne system to detect and prevent improper and unallowable claims submitted by dental providers.

During our current audit we found the internal controls within the system were still not effective to prevent improperly billed claims from being paid.

Cause of Condition

We noted in the previous audit inconsistencies between the Washington Administrative Code and the Authority's Medicaid provider guide for some dental services. The Authority stated that it planned to change the Washington Administrative Code. We also found that some automated controls within the ProviderOne were inadequate. The Authority is aware of the issues and in process of correcting them.

However, during the audit period most issues were not corrected because the Authority did not have adequate time to implement their corrective action plan.

Effect of Condition and Questioned Costs

We selected the following dental services and performed tests to determine whether the payments made to providers were allowable:

Fluoride Treatments for Children

Medicaid covers up to three applications of fluoride in a year for clients six years of age and younger. For clients between seven and 18 years of age, Medicaid covers up to two applications in a year, unless the client is developmentally disabled (DDA). For these clients the program covers up to three applications per client in a year. In fiscal year 2013, claims totaling $10.3 million were paid for these treatments.

The following table summarizes the number of clients who received more than the allowed number of applications and the amounts overpaid to providers for these claims.

Description	Number of Claims	Payments
Service Payments Exceeding Three Times Per DDA Client (7 years and older)	35	$463.75
Service Payments Exceeding Two Times per Non DDA Client (7 years and older)	10,153	$136,252.33
Service Payments Exceeding Three Times Per Client (6 years and younger)	7,177	$136,502.41
Overall Fluoride Testing Totals	17,365	$273,218.49

Dental Cleanings (prophylaxis)

Medicaid covers dental cleanings (prophylaxis) once every six-months for clients eighteen years of age or younger and once every twelve months for clients nineteen years of age and older. If the client is developmentally disabled, Medicaid covers up to three cleanings in a twelve month period, regardless of the client's age. In fiscal year 2013, $13.7 million in claims were paid to providers for these treatments.

We identified 998 claims totaling $32,138.03 paid to providers for cleanings that exceeded the allowed number covered by Medicaid.

Description	Number of Claims	Payments
Service Payments Exceeding Once Every 6 Months For Non-DDA 18-Years-&-Younger Clients	942	$30,058.52
Service Payments Exceeding One Time Per Year For Non-DDA 19-Years-&-Older Clients	31	$1,097.57
Service Payments Exceeding Three Times Per Year For DDA Clients	25	$981.94
Overall Prophylaxis Totals	998	$32,138.03

Oral Evaluation Services

Medicaid covers oral evaluation services, with some restrictions. We reviewed claims for periodic oral evaluations. These claims are covered once every six months and six months must lapse between the client's comprehensive oral evaluation and first periodic oral evaluation. In fiscal year 2013, Medicaid paid providers approximately $11.2 million for these evaluations.

We identified 8,206 claims totaling $254,451.78 where providers were paid for oral evaluation services that exceeded the allowed number covered by Medicaid.

Orthodontic Services

Medicaid covers orthodontic services, with some restrictions. We reviewed claims for orthodontic services. The services are covered once in a lifetime for clients with malocclusion and a qualifying medical condition. In fiscal year 2013, Medicaid paid providers approximately $2.4 million for pre-orthodontic visits.

We identified 7 claims totaling $1,937.25 where providers were paid for pre-orthodontic visits that exceeded the allowed number covered by Medicaid.

Oral Hygiene Instruction

Medicaid covers oral hygiene instruction, with some restrictions. We reviewed claims for oral hygiene instruction only for covered clients who are 8 years of age and younger. Individualized oral hygiene instruction for home care includes tooth brushing techniques, flossing, and use of oral hygiene aids. Oral hygiene instruction is covered no more than once every 6 months, up to 2 times within a 12-month period. In fiscal year 2013, Medicaid paid providers over $312,000 for oral hygiene instruction.

We identified 1,759 claims totaling $22,766.41 where providers paid for oral hygiene instruction that exceeded the allowed number covered by Medicaid.

In total, the Authority made payments of $584,511.96 for services that were not allowable for reimbursement. We are questioning $292,255.98, which is the federal portion[1] of the unallowable payments.

Recommendation

We recommend the Authority:

[1] The federal share is calculated using the state's 2013 FMAP rate of 50 percent.

- Ensure the Medicaid provider guide is consistent with the Code.
- Develop adequate internal controls within its ProviderOne system to detect and prevent improper and unallowable claims submitted by dental providers.
- Recover the $584,511.96 in unallowable claims paid to the dental providers.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Agency's Response

The Authority agrees with this finding.

The Authority is taking the following steps to address the audit finding:

1. *Fluoride treatment for children: The agency agrees that the billing guide, Washington Administrative Code (WAC) and ProviderOne are not aligned. The agency's intent is to allow fluoride with limits based on the client's age and client type, per client, per provider. The agency is correcting the WAC as a result of the previous fiscal year's audit, a process that should be finalized by April 2014.*

2. *Dental Cleanings: The previous fiscal year's audit identified system issues that has been corrected and the agency's office of payment integrity is recouping overpayments.*

3. *Oral Evaluations: The previous fiscal year's audit found that the agency's billing guide and WAC were not aligned with ProviderOne and the agency's intended policy to allow Periodic Oral Evaluations three times per year for clients of the Developmental Disabilities Administration to coincide with cleanings. The agency is updating both the WAC, which should be finalized by April, and billing guides to reflect the agency's policy.*

4. *Orthodontic Services: Although agency rule limits the services to once in a lifetime the rules also permit exceptions to this limit through the Authority's prior authorization process based on Early Periodic Screening, Diagnosis and Treatment (EPSDT) and Exception to Rule. The Agency reviewed the seven claims identified in this audit and found that in each case the provider requested prior authorization and the Authority granted authorization based on the clients' medical necessity.*

5. *Oral Hygiene Instructions: The agency identified a system issue which has been corrected. The agency's Office of Payment Integrity will recoup overpayments.*

Auditor's Concluding Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We 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.
>
> (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

The OMB Circular A-133 Compliance Supplement (June 2012), *Part 3 – Compliance Requirements*, states in part:

Improper Payments

Under OMB guidance, Public Law (Pub. L.) No. 107-300, the Improper Payments Information Act of 2002, as amended by Pub. L. No. 111-204, the Improper Payments Elimination and Recovery Act, Executive Order 13520 on reducing improper payments, and the June 18, 2010 Presidential memorandum to enhance payment accuracy, Federal agencies are required to take actions to prevent improper payments, review Federal awards for such payments, and, as applicable, reclaim improper payments. Improper payment means:

5. Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements.
6. Incorrect amounts are overpayments or underpayments that are made to eligible recipients (including inappropriate denials of payment or service, any payment that does not account for credit for applicable discounts, payments that are for the incorrect amount, and duplicate payments).
7. Any payment that was made to an ineligible recipient or for an ineligible good or service, or payments for goods or services not received (except for such payments where authorized by law).
8. Any payment that an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation.

WAC 182-535-1079 Dental-related services -- General, states in part:

(1) . . . The agency pays for dental-related services and procedures provided to eligible clients when the services and procedures:

(a) Are part of the client's dental benefit package;
(b) Are within the scope of an eligible client's medical care program;
(c) Are medically necessary;
(d) Meet the agency's prior authorization requirements, if any;
(e) Are documented in the client's record in accordance with chapter 182-502 WAC;
(f) Are within accepted dental or medical practice standards;
(g) Are consistent with a diagnosis of dental disease or condition;
(h) Are reasonable in amount and duration of care, treatment, or service; and
(i) Are listed as covered in the agency's rules and published billing instructions and fee schedules.

WAC 182-535-1080 Covered dental-related services-Diagnostic, states in part:

Clients described in WAC182-535-1060 are eligible to receive the dental-related diagnostic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) Clinical oral evaluations. The agency covers:
    (a) Oral health evaluations and assessments.
    (b) Periodic oral evaluations as defined in WAC 182-535-1050, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.
    (c) Limited oral evaluations as defined in WAC 182-535-1050, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client. . . .
    (d) Comprehensive oral evaluations as defined in WAC 182-535-1050, once per client, per provider or clinic, as an initial examination. The agency covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.

(e) Limited visual oral assessments as defined in WAC 182-535-1050, up to two per client, per year, per provider only when the assessment is:
  (i) Not performed in conjunction with other clinical oral evaluation services;
  (ii) Performed by a licensed dentist or dental hygienist to determine the need for sealants or fluoride treatment and/or when triage services are provided in settings other than dental offices or clinics; and
  (iii) Provided by a licensed dentist or licensed dental hygienist.

(2) Radiographs (X rays). The agency:
  (c) Covers an intraoral complete series once in a three-year period only if the agency has not paid for a panoramic radiograph for the same client in the same three-year period. The intraoral complete series includes fourteen through twenty-two periapical and posterior bitewings. The agency limits reimbursement for all radiographs to a total payment of no more than payment for a complete series.
  (e) Covers an occlusal intraoral radiograph once in a two-year period, for clients twenty years of age and younger.
  (g) Covers a maximum of four bitewing radiographs (once per quadrant) once every twelve months.
  (h) Covers panoramic radiographs in conjunction with four bitewings, once in a three-year period, only if the agency has not paid for an intraoral complete series for the same client in the same three-year period.
  (j) Covers cephalometric films once in a two-year period for clients twenty years of age and younger, only on a case-by-case basis and when prior authorized.

WAC 182-535-1082 Covered dental-related services-Prosthodontics, states in part:

Clients described in WAC 182-535-1060 are eligible for the dental-related preventive services listed in this section, subject to coverage limitations and client-age requirements identified for a specific service.

(1) Dental prophylaxis. The agency covers prophylaxis as follows. Prophylaxis:
  (a) Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary or permanent dentition.
  (b) Is limited to once every:
    (i) Six months for clients eighteen years of age and younger; and
    (ii) Twelve months for clients nineteen years of age and older.
  (c) Is reimbursed only when the service is performed:
    (i) At least six months after periodontal scaling and root planing, or periodontal maintenance services, for clients from thirteen to eighteen years of age; and
    (ii) At least twelve months after periodontal scaling and root planing, periodontal maintenance services, for clients nineteen years of age and older.
  (d) Is not reimbursed separately when performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy, or gingivoplasty.
  (e) Is covered for clients of the division of developmental disabilities according to (a), (c), and (d) of this subsection and WAC 182-535-1099.

(2) Topical fluoride treatment. The agency covers:
  (a) Fluoride rinse, foam or gel, including disposable trays, for clients six years of age and younger, up to three times within a twelve-month period.
  (b) Fluoride rinse, foam or gel, including disposable trays, for clients from seven to eighteen years of age, up to two times within a twelve-month period.
  (c) Fluoride rinse, foam or gel, including disposable trays, up to three times within a twelve-month period during orthodontic treatment.

(d) Fluoride rinse, foam or gel, including disposable trays, for clients from nineteen to sixty-four years of age, once within a twelve-month period.
(e) Fluoride rinse, foam or gel, including disposable trays, for clients sixty-five years of age and older who reside in alternate living facilities, up to three times within a twelve-month period.
(f) Additional topical fluoride applications only on a case-by-case basis and when prior authorized.
(g) Topical fluoride treatment for clients of the division of developmental disabilities according to WAC 182-535-1099.

WAC 182-535-1099 Covered dental-related services for clients of the division of developmental disabilities, states in part:

Subject to coverage limitations, restrictions, and client-age requirements identified for a specific service, the agency pays for the dental-related services listed under the categories of services in this section that are provided to clients of the division of developmental disabilities. This chapter also applies to clients of the division of developmental disabilities, regardless of age, unless otherwise stated in this section.

(1) Preventive services.
(a) Dental prophylaxis. The agency covers dental prophylaxis or periodontal maintenance up to three times in a twelve-month period (see subsection (3) of this section for limitations on periodontal scaling and root planing).
(b) Topical fluoride treatment. The agency covers topical fluoride varnish, rinse, foam or gel, up to three times within a twelve-month period.

WAC 182-535-1245 Access to baby and child dentistry (ABCD) program, states in part:

The access to baby and child dentistry (ABCD) program is a program established to increase access to dental services for medicaid-eligible clients ages five and younger. . .

(3) The department pays enhanced fees only to ABCD-certified dentists and other department-approved certified providers for furnishing ABCD program services. ABCD program services include, when appropriate:
(a) Family oral health education. An oral health education visit:
(i) Is limited to one visit per day per family, up to two visits per child in a twelve-month period, per provider or clinic; . . .
(b) Periodic oral evaluation, up to two visits per client, per calendar year, per provider or clinic;

2013-028 The Health Care Authority did not complete the required security reviews of ProviderOne, the new Medicaid Management Information System, risking the loss of Medicaid program assets and jeopardizing Medicaid program integrity.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.720 ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative 93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778A Medical Assistance Program (Medicaid; Title XIX)-American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM
Applicable Compliance Component:	ADP Risk Analysis and System Security Review
Questioned Cost Amount:	None

Background

The Medicaid program is highly dependent on extensive and complex computer systems that include controls for ensuring the proper payment of Medicaid benefits. Federal law requires the state to establish and maintain a program for conducting periodic risk analyses to ensure appropriate, cost effective safeguards are incorporated into new and existing systems. The state is required to perform risk analyses whenever significant system changes occur. On a biennial basis the state is also required to review the Automatic Data Processing (ADP) system security of installations involved in the Medicaid program. At a minimum, the reviews shall include an evaluation of physical and data security operating procedures, and personnel practices.

The ProviderOne system, the State of Washington's Medicaid Management Information System, went live in May 2010. It replaces a 32-year-old payment system for Medicaid, a shared state-federal health program that serves low-income parents, children, seniors and people with disabilities. The new system software, built by Rockville, Md.-based CNSI, handles millions in payments for medical and nursing home care to thousands of health care providers, including doctors and pharmacies.

The state Medicaid program spent more than $7.6 billion during fiscal year 2013, of that more than $4.1 billion was federal dollars.

Description of Condition

The Health Care Authority (HCA) contracted with a vendor, which developed ProviderOne to process state Medicaid payments. For the fiscal year ended June 30, 2013, ProviderOne processed approximately 42 million Medicaid transactions totaling $4.5 billion.

In our audit for fiscal year 2012, we reported the Authority did not complete the ADP risk analysis and system security reviews of the ProviderOne system as required by federal law. The Authority has made improvements by

performing an ADP risk analysis and a system security review of its own processes; however, a significant deficiency continued to exist.

The ProviderOne system is managed by both the Authority and the vendor, CNSI. The Authority owns the hardware and software and CNSI maintains the ProviderOne servers and production database. To protect Medicaid program integrity and data security, the ADP system security review of ProviderOne needs to encompass all systems, operating procedures and personnel practices of the Authority and CNSI.

During our review, we found security reviews were not performed on the ProviderOne servers and production database that CNSI has direct control over.

The Authority stated that it added a requirement to the ProviderOne contract for an independent audit of the system of internal controls at the vendor location in January 2013. An audit of a service organization's internal controls involves a phased approach. The first phase won't be completed until spring of 2014.

Cause of Condition

The Authority and the vendor did not adequately address responsibilities, controls and requirements for monitoring in the contract for the ProviderOne system. The Authority did not have complete knowledge of the extent of their monitoring responsibilities for ProviderOne.

Effect of Condition

The ProviderOne system is vulnerable to unauthorized access and unauthorized or erroneous entries into ProviderOne can be made without Authority knowledge or oversight. Also, the Authority cannot assure that the ProviderOne system is adequately safeguarding program assets and maintaining program integrity to prevent:

- Misuse, loss or misappropriation of public funds
- Inaccurate payments
- Unauthorized software changes to the ProviderOne system
- Unauthorized use or modification of confidential information

Recommendation

We recommend the Authority continue to improve the monitoring and oversight of the ProviderOne system to verify system security reviews of ProviderOne are performed on a regular basis to ensure data security and Medicaid program integrity.

Agency's Response

The Health Care Authority (HCA) disagrees with this finding.

The Authority does not agree that ProviderOne security reviews are lacking or that lack of controls and monitoring in the contract introduce a significant system security review deficiency. While neither expected nor required by the federal government for any Medicaid payment system, to strengthen HCA's ability to monitor vendor controls, the HCA added a requirement for external audit to the ProviderOne vendor contract in January 2013 (Contract 30556-67302 Amendment 34 Section 30). This includes security reviews of servers and production databases and will provide additional assurance that effective controls are in place. Under the new requirement, CNSI is required to undergo a biennial Statement on Standards for Attestation Engagement (SSAE) No.16 Type II or successor audit.

As previously reported, the satisfaction of this SSAE audit occurs in multiple phases including the final completion of the audit in the first quarter of 2014.

The following milestones of this audit were completed on time in 2013 and CNSI has met all contractual obligations:

- *Contractor delivered to HCA SAS70 or SSAE audit report from the Contractor's vendors by March 2013;*
- *Contractor completed and delivered to HCA complete documentation for SSAE Type I and II controls by July and December 2013;*
- *The final phase of this audit is on target to be completed in the first quarter of this year.*

HCA has and continues to ensure that the appropriate safeguards and effective controls are in place to protect Medicaid program integrity and data security.

Auditor's Concluding Remarks

We thank the Authority for its response.

However, security reviews were not performed on the ProviderOne servers and production database that CNSI has direct control over. We reaffirm our finding and will review the status of the Authority'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:
>
> (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 45 CFR 95.621 ADP reviews.

> The Department will conduct periodic onsite surveys and reviews of State and local agency ADP methods and practices to determine the adequacy of such methods and practices and to assure that ADP equipment and services are utilized for the purposes consistent with proper and efficient administration under the Act. Where practical, the Department will develop a mutually acceptable schedule between the Department and State or local agencies prior to conducting such surveys or reviews, which may include but are not limited to:
>
> (a) *Pre-installation readiness.* A pre-installation survey including an onsite evaluation of the physical site and the agency's readiness to productively use the proposed ADP services, equipment or system when installed and operational.
>
> (b) *Post-installation.* A review conducted after installation of ADP equipment or systems to assure that the objectives for which FFP was approved are being accomplished.
>
> (c) *Utilization.* A continuing review of ADP facilities to determine whether or not the ADP equipment or services are being efficiently utilized in support of approved programs or projects.
>
> (d) *Acquisitions not subject to prior approval.* Reviews will be conducted on an audit basis to assure that system and equipment acquisitions costing less than $200,000 or acquisitions exempted from prior approval were made in accordance with Part 92 and the conditions of this subpart and to determine the efficiency, economy and effectiveness of the equipment or service.

(e) *State Agency Maintenance of Service Agreements.* The State agency will maintain a copy of each service agreement in its files for Federal review.

(f) *ADP System Security Requirements and Review Process* —(1) *ADP System Security Requirement* . State agencies are responsible for the security of all ADP projects under development, and operational systems involved in the administration of HHS programs. State agencies shall determine the appropriate ADP security requirements based on recognized industry standards or standards governing security of Federal ADP systems and information processing.

(2) *ADP Security Program.* State ADP Security requirements shall include the following components:

(i) Determination and implementation of appropriate security requirements as specified in paragraph (f)(1) of this section.

(ii) Establishment of a security plan and, as appropriate, policies and procedures to address the following area of ADP security:

(A) Physical security of ADP resources;

(B) Equipment security to protect equipment from theft and unauthorized use;

(C) Software and data security;

(D) Telecommunications security;

(E) Personnel security;

(F) Contingency plans to meet critical processing needs in the event of short or long-term interruption of service;

(G) Emergency preparedness; and,

(H) Designation of an Agency ADP Security Manager.

(iii) Periodic risk analyses. State agencies must establish and maintain a program for conducting periodic risk analyses to ensure that appropriate, cost effective safeguards are incorporated into new and existing systems. State agencies must perform risk analyses whenever significant system changes occur.

(3) *ADP System Security Reviews* . State agencies shall review the ADP system security of installations involved in the administration of HHS programs on a biennial basis. At a minimum, the reviews shall include an evaluation of physical and data security operating procedures, and personnel practices.

(4) Costs incurred in complying with provisions of paragraphs (f)(1)–(3) of this section are considered regular administrative costs which are funded at the regular match rate.

(5) The security requirements of this section apply to all ADP systems used by State and local governments to administer programs covered under 45 CFR part 95, subpart F.

(6) The State agency shall maintain reports of their biennial ADP system security reviews, together with pertinent supporting documentation, for HHS on-site review.

The Office of Financial Management's *State Administrative and Accounting Manual* (SAAM), states in part:
Section 20.10.20 Authority for these policies:

The Budget and Accounting Act is found in Chapter 43.88 RCW. Section 43.88.160 (4) requires that the director of the Office of Financial Management (OFM), as an agent of the governor:

"Develop and maintain a system of internal controls and internal audits comprising methods and procedures to be adopted by each agency that will safeguard its assets, check the accuracy and reliability of its accounting data, promote operational efficiency, and encourage adherence to prescribed managerial policies for accounting and financial controls. The system developed by the director shall include criteria for determining the scope and comprehensiveness of internal controls required by the classes of agencies, depending on the level of resources at risk. Each agency head or authorized designee shall be assigned the

> responsibility and authority for establishing and maintaining internal audits following the standards of internal auditing of the Institute of Internal Auditors . . . ."

Section 20.15.40.e Monitoring, states in part:

> An agency's internal control is most effective when there is a proper monitoring control environment, results are prioritized and communicated, and weaknesses are corrected and followed up on as necessary.

2013-029 The Health Care Authority improperly claimed $73,788.62 in federal reimbursement for unallowable services provided to undocumented aliens and services that were not rendered to deceased Medicaid clients.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster
	93.720 ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775 State Medicaid Fraud Control Units
	93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778 Medical Assistance Program (Medicaid; Title XIX)
	93.778A Medical Assistance Program (Medicaid; Title XIX)-American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM
Applicable Compliance Component:	Activities Allowed or Unallowed
Questioned Cost Amount:	$73,788.62

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 Medicaid program spent more than $7.7 billion during fiscal year 2013, more than $4.1 billion of which was federal dollars.

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.

Under the Alien Emergency Medical program, any visit or service not meeting the criteria of emergency situations is considered unallowable. This includes, but is not limited to:

- Physical, occupational, speech therapy, or audiology services.
- Hospital clinic services.
- Office or clinic-based services rendered by a physician, an ARNP, or any other licensed practitioner.
- Laboratory, radiology, and any other diagnostic testing.
- Home health services.

The state can elect to pay for non-emergency services for nonqualified aliens. The federal government will not share the cost of those services.

Federal regulations state that an overpayment is the amount that a Medicaid agency paid to a provider in excess of the amount allowable for furnished services. Because services cannot be provided after a beneficiary's death, no medical services are allowable after a beneficiary's death. Accordingly, payments for services claimed to have been provided after a Medicaid beneficiary's death are overpayments.

The Health Care Authority (Authority), Washington State's Medicaid agency, receives quarterly death data from the Department of Health. The Authority uses the data to identify a deceased Medicaid client and terminates Medicaid eligibility from Medicaid eligibility file. The Authority also runs an algorithm that identifies Medicaid services paid after a client's date of death and processes a recoupment of the payments made after the client's date of death.

Description of Condition

During our audit, we noted the Authority claimed the following unallowable or unsupported expenditures for federal reimbursement:

Medicaid payments for unallowable services

We found 1,163 non-emergency services provided to 115 nonqualified aliens. The table below summarizes the results of our work:

Description	Number of claims	Payments	Federal Share[1]	State Share
Non-emergency services provided to nonqualified aliens.	1,163	$78,739.82	$39,369.91	$39,369.91

Medicaid payments for unsupported services

We found 236 services provided after a client's death. The table below summarizes the results of our work:

Description	Number of claims	Payments	Federal Share[1]	State Share
Services provided after date of death	236	$68,837.42	$34,418.71	$34,418.71

Cause of Condition

The Authority performs reviews to detect unallowable Medicaid payments for services provided to nonqualified aliens and payments for services provided after a client's death. However, it is still not preventing or catching all unallowable payments.

Effect of Condition and Questioned Costs

When the state provides services to ineligible individuals, or the services are unallowable and/or unsupported, the service cannot be claimed for federal reimbursement. The Authority paid $147,577.24 to providers for services for unallowable activities. We are questioning $73,788.62, the federal portion of the unallowable costs.

We question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support its expenditures.

[1] The federal share is calculated using the state's 2013 FMAP rate of 50 percent.

Recommendation

We recommend the Authority:

- Strengthen internal control procedures to ensure that Medicaid services provided to nonqualified aliens are restricted to emergency services.
- Strengthen internal control procedures for identifying deceased beneficiaries to prevent overpayments.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Agency's Response

The Authority concurs that it made improper reimbursement for Medicaid clients where later research and analysis showed the clients were deceased. The Authority also concurs that it made payments on behalf of non-qualified aliens for non-emergency related services and that improved internal controls are necessary.

The Authority will review all cases and consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Auditor's Concluding Remarks

We thank the Authority for its cooperation and assistance throughout the audit.

Applicable Laws and Regulations

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

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 510, states in part:

(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.

Title 42, Code of Federal Regulations, 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 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 beneficiaries 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.

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.

WAC 182-500-0030, Medical assistance definitions--E, 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:
  (1) Placing the patient's health in serious jeopardy;
  (2) Serious impairment to bodily functions; or
  (3) Serious dysfunction of any bodily organ or part.

WAC 182-507-0115, Alien emergency medical program (AEM), states:
(1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 182-507-0110 is eligible for the alien emergency medical program's scope of covered services described in this section if the person meets (a) and (b) or (c) of this subsection:
  (a) The medicaid agency determines that the primary condition requiring treatment meets the definition of an emergency medical condition as defined in WAC 182-500-0030, 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) Involuntary Treatment Act (ITA) and voluntary inpatient admissions to a hospital psychiatric setting that are authorized by the agency's inpatient mental health designee (see subsection (5) of this section).
(2) If a person meets the criteria in subsection (1) of this section, the agency will cover and pay for all related medically necessary health care services and professional services provided:
  (a) By physicians in their office or in a clinic setting immediately prior to the transfer to the hospital, resulting in a direct admission to the hospital; and
  (b) During the specific emergency room visit, outpatient surgery or inpatient admission. These services include, but are not limited to:
    (i) Medications;
    (ii) Laboratory, X ray, and other diagnostics and the professional interpretations;
    (iii) Medical equipment and supplies;
    (iv) Anesthesia, surgical, and recovery services;
    (v) Physician consultation, treatment, surgery, or evaluation services;
    (vi) Therapy services;
    (vii) Emergency medical transportation; and
    (viii) Nonemergency 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 agency or its designee as described in subsection (3) of this section.

(3) The agency will cover admissions to an LTAC facility or an inpatient PM&R unit if:
   (a) The original admission to the hospital meets the criteria as described in subsection (1) of this section;
   (b) The person is transferred directly to this facility from the hospital; and
   (c) The admission is prior authorized according to LTAC and PM&R program rules (see WAC 182-550-2590 for LTAC and WAC 182-550-2561 for PM&R).

(4) The agency 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 agency or its designee under this program. Exception: Pharmacy services, drugs, devices, and drug-related supplies listed in WAC 182-530-2000, prescribed on the same day and associated with the qualifying visit or service (as described in subsection (1) of this section) will be covered for a one-time fill and retrospectively reimbursed according to pharmacy program rules.

(5) Medical necessity of inpatient psychiatric care in the hospital setting must be determined, and any admission must be authorized by the agency's inpatient mental health designee according to the requirements in WAC 182-550-2600.

(6) There is no precertification or prior authorization for eligibility under this program. Eligibility for the AEM program does not have to be established before an individual begins receiving emergency treatment.

(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. The exception for pharmacy services is also applicable as described in subsection (4) of this section.
   (a) For inpatient care, the certification 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 certification is only for the date of service. If the person is in the hospital overnight, the certification 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 considered not within the scope of service categories as described in WAC 182-501-0060. 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 agency 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 the treatment of the qualifying emergency medical condition;
   (c) Organ transplants, including preevaluations, post operative care, and anti-rejection medication;
   (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 nondurable medical supplies;
(xv) Nonemergency medical transportation;
(xvi) Interpreter services; and
(xvii) Pharmacy services, except as described in subsection (4) of this section.

(9) The services listed in subsection (8) of this section are not within the scope of service categories for this program and therefore the exception to rule process is not available.

(10) Providers must not bill the agency for visits or services that do not meet the qualifying criteria described in this section. The agency will identify and recover payment for claims paid in error.

2013-030 The Health Care Authority did not have adequate controls in place to ensure violations of Medicaid laws and regulations by providers are identified, investigated and referred to the Medicaid Fraud Control Unit, risking the loss of public resources.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster
	93.720 ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775 State Medicaid Fraud Control Units
	93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778 Medical Assistance Program (Medicaid; Title XIX)
	93.778A Medical Assistance Program (Medicaid; Title XIX)-American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM
Applicable Compliance Component:	Medicaid Fraud Control Unit
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 $7.68 billion during fiscal year 2013. More than $4.5 billion of this amount relates to activities of the Health Care Authority, which paid more than $4.3 billion of that directly to providers.

States are required to maintain a Medicaid Fraud Control Unit (MFCU), which investigates and prosecutes fraud by health care providers. The Washington State MFCU is part of the Attorney General's Office. Any suspected criminal violations of Medicaid laws and regulations identified by the state Medicaid program must be referred to MFCU for investigation.

When the Health Care Authority (Authority) receives a complaint of Medicaid fraud or abuse from any source or identifies questionable practices, it must conduct a preliminary investigation to determine whether it has sufficient evidence to warrant a full investigation. This responsibility is designated to the Surveillance and Utilization Review Section (SURS) within the Authority's Office of Program Integrity (OPI). The Authority is required to forward any credible allegations to MFCU and report information regarding its preliminary investigations to the Department of Health and Human Services annually.

Cases requiring a preliminary investigation come from various sources. Staff within the Authority may identify cases based on data mining, submitted claims, or communication with clients. In addition, OPI regularly verifies receipt of services paid with Medicaid clients, and maintains both a fraud line and email address to allow clients and citizens to report any suspected fraud and abuse. Other Authority staff and employees of other State agencies may also identify cases in the course of their daily work, which is also forwarded to OPI. Cases referred to OPI are documented and tracked in staff work plans or the Authority's Case Tracking system for those cases requiring additional review. SURS is responsible for performing a preliminary investigation and referring any cases determined to require a full investigation to MFCU.

Description of Condition:

In order for cases of Medicaid provider fraud to be identified, the Authority's SURS Unit must first review any complaints received. If provider fraud is occurring, it is important for SURS to identify this as quickly as possible.

In our prior audit we reported a finding regarding the Authority's inadequate controls to ensure cases involving violations of Medicaid laws and regulations were identified and referred to MFCU in a timely manner.

On July 1, 2012, the beginning of the fiscal year 2013, SURS had a total of 103 cases open in the Case Tracking system. During fiscal year 2013, the Authority received an additional 394 cases and closed 262 cases. The remaining 235 cases remained open at the end of the fiscal year and required additional review.

We performed an analysis of open cases and found the following:

Total Time in System	Open/Pending Cases	Percentage of Open/Pending Cases
0-30 days	15	6.38%
31-60 days	17	7.23%
61-90 days	10	4.26%
91-120 days	12	5.11%
121-150 days	9	3.83%
151-180 days	22	9.36%
181-365 days	47	20.00%
More than 365 days	103	43.83%
Total	235	100%

The results of this analysis showed that 64% of cases received by the Authority remained in the system beyond 180 days, and 44 percent of cases remained opened beyond 365 days. These findings showed that the Authority does not have internal controls over the process of investigation of possible cases of fraud and is not performing procedures to ensure cases involving alleged violations of Medicaid laws and regulations are identified, investigated and referred to MFCU, if necessary, in a timely manner.

We randomly selected 34 cases out of 394 cases opened during fiscal year 2013 to determine if cases were prioritized (based on the Authority's own policies), appropriately investigated and recorded. We found 37 percent of the cases we reviewed were investigated in a timely manner and had all information pertaining to the investigation. However, 63 percent of cases were not appropriately investigated and/or all relevant and required information pertaining to the case were properly recorded.

The table below summarizes the results of our work:

Description	Number of Cases	Percentage
No exceptions identified	16	37.20%
Missing Information related to the case was not recorded (source, receipt date, etc.)	3	6.98%
Case investigated, but no notes, documents or investigative records could be located	3	6.98%
No Date of Closure Recorded	2	4.65%
Case closed without a disposition	2	4.65%
Cases opened in error	3	6.98%
Cases completed, but not closed	3	6.98%
Cases never investigated or started	11	25.58%
Total	43*	100.00%

*Most cases reviewed had multiple deficiencies

The results of our testing revealed that control weaknesses we identified in our previous audits still existed.

Finally, we found the Authority did not report the number of fraud and abuse complaints that warranted a preliminary investigation to the Department of Health and Human Services. This lack of reporting was also reported in our prior audit.

Cause of the Condition

The Authority did not have any written policies or procedures pertaining to performance of investigations, recording results of investigations, or setting of priorities. This has resulted in each individual investigator setting priorities based on their own individual judgment and a lack of consistency in recording key information pertaining to investigations.

In addition, the Authority did not have adequate monitoring procedures designed to provide oversight of work performed by investigators and ensure cases are reviewed in a timely manner.

The Authority also stated that it had limited resources and staff assigned to review cases and perform investigations.

During our testing we noted the Authority has begun the process of correcting the conditions noted. In fiscal year 2014, the Authority created several positions dedicated to creating policies and procedures for the SURS unit and to provide oversight over the process.

Effect of Condition

By not performing timely investigations, referrals to MFCU may be delayed and Medicaid fraud may go undetected, resulting in a loss of public resources.

The lack of documentation may result in unnecessary work and/or providers not being held responsible for violations of the law.

Recommendation

We recommend the Authority:

- Establish policies and procedures requiring timely and consistent preliminary investigation of all cases of suspected provider fraud.
- Establish policies and procedures requiring consistent and complete recording of all information related to investigations and the resulting conclusions.
- Implement a process for oversight and review of investigative work to ensure all established policies are consistently followed.
- Complete a timely review of all suspected cases of provider fraud to determine if sufficient evidence exists to warrant a full investigation.
- Comply with federal reporting requirements by reporting the number of fraud and abuse complaints to the Department of Health and Human Services.

Agency's Response

The Health Care Authority (HCA) does not concur with this finding.

The agency maintains that adequate controls are in place to ensure that violations of Medicaid laws and regulations are identified and referred to the Medicaid Fraud Control Unit (MFCU) in a timely manner. Referrals received by the Office of Program Integrity (OPI) are initially scrutinized for materiality, severity, and credibility before they are entered into the Case Tracking application; those deemed most substantive are worked immediately. In addition to high priority cases, OPI staff has historically entered non-fraud-related client complaints into the Case Tracking tool, as well as Medical Service Verification (MSV) cases, even though they reflect cases of historically low risk and low value. The number and age of cases tracked are therefore not accurate measures of how the Office of Program Integrity manages referrals or processes allegations of fraud and it is wrong to conclude that HCA does not have control of its caseload and does not refer all appropriate cases to the Medicaid Fraud Control Unit in a timely manner. Processes are in place to prioritize the work of SURS investigators, ensuring that HCA is addressing those cases with the highest potential for fraud, waste and abuse and properly utilizing our resources to focus on cases that yield the highest return on investment.

While disagreeing with the finding, the Authority concurs with several recommendations in the audit. The Office of Program Integrity is currently writing and revising its policies and procedures; increasing supervisory oversight and control of staff activities and documentation; and analyzing the feasibility of enhancement or replacement of its current case tracking system. These operational initiatives will provide additional focus and strengthen OPI's internal processes.

Auditor's Concluding Remarks

We thank the Authority for its response.

We appreciate and acknowledge that the Authority is making many changes to provide oversight and processes in this area. Unfortunately, HCA's current records and tracking system does not support the Authority's assertion of maintaining adequate controls and performing investigations in a timely manner. We acknowledge that this lack of supporting evidence may be due to the system used by the Authority to record, track, and monitor cases, however without adequate support, we are unable to ensure these assertions are accurate.

We reaffirm our finding 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.
>
> (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 455.1 Basic and scope, states:

> 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 beneficiaries.
>
> (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.

Title 42, Code of Federal Regulations, Section 455.13 Methods for identification, investigation, and referral, states:

> The Medicaid agency must have—
>
> (a) Methods and criteria for identifying suspected fraud cases;
>
> (b) Methods for investigating these cases that—
>
> (1) Do not infringe on the legal rights of persons involved; and
>
> (2) Afford due process of law; and
>
> (c) Procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials.

Title 42, Code of Federal Regulations, Section 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, Section 455.15 Full investigation, states:

> 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 §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 beneficiary 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 beneficiary has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

Title 42, Code of Federal Regulations, Section 455.16 Resolution of full investigation states:

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 beneficiary. This resolution may include but is not limited to—
  (1) Sending a warning letter to the provider or beneficiary, 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.

Title 42, Code of Federal Regulations, Section 455.17 Reporting requirements, states:

The agency must report the following fraud or abuse information to the appropriate Department officials at intervals prescribed in instructions.
(a) The number of complaints of fraud and abuse made to the agency that warrant preliminary investigation.
(b) For each case of suspected provider fraud and abuse that warrants a full investigation—
  (1) The provider's name and number;
  (2) The source of the complaint;
  (3) The type of provider;
  (4) The nature of the complaint;
  (5) The approximate range of dollars involved; and
  (6) The legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred.

Title 42, Code of Federal Regulations, Section 455.21 Cooperation with State Medicaid fraud control units, states:

In a State with a Medicaid fraud control unit established and certified under subpart C of this part,
(a) The agency must—
  (1) Refer all cases of suspected provider fraud to the unit;
  (2) If the unit determines that it may be useful in carrying out the unit's responsibilities, promptly comply with a request from the unit for—

(i) Access to, and free copies of, any records or information kept by the agency or its contractors;

(ii) Computerized data stored by the agency or its contractors. These data must be supplied without charge and in the form requested by the unit; and

(iii) Access to any information kept by providers to which the agency is authorized access by section 1902(a)(27) of the Act and § 431.107 of this subchapter. In using this information, the unit must protect the privacy rights of beneficiaries; and

(3) On referral from the unit, initiate any available administrative or judicial action to recover improper payments to a provider.

(b) The agency need not comply with specific requirements under this subpart that are the same as the responsibilities placed on the unit under subpart D of this part.

2013-031 The Health Care Authority did not have adequate controls in place to ensure services billed by providers were rendered to Medicaid beneficiaries, risking the loss of Medicaid resources.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM	
Applicable Compliance Component:	Utilization Control and Program Integrity	
Questioned Cost Amount:	None	

Background:

Federal regulations require state Medicaid agencies to have processes in place to verify with Medicaid clients whether they actually received services billed by providers. This process is intended to improve program integrity and identify potential fraud and abuse in the Medicaid program.

The Health Care Authority (Authority) is responsible for this process, including selecting claims for verification from all eligible claims paid within the last 45 days, sending Medical Services Verification (MSV) surveys to clients and following up when questions regarding the legitimacy of a claim arise. Federal regulations do not require 100 percent verification; a sampling method may be used. Under federal rule, certain types of claims are exempt from this process.

The Authority sends clients a survey asking if they received the listed services. Authority staff review returned surveys and identify responses that require follow up. Regulations require the Authority to follow up for surveys in which clients indicate they did not receive the service and/or paid for the service listed and conduct a preliminary investigation, if necessary, to determine if it has sufficient basis to warrant a full investigation.

If follow-through identifies credible suspicions of fraud or abuse, the Authority is to forward that information to the State Attorney General's Office Medicaid Fraud Control Unit.

The state Medicaid program spent approximately $7.7 billion in fiscal year 2013, of which more than $4.1 billion were paid with federal dollars.

Description of Condition:

In our prior audits, we reported concerns regarding the Authority's procedures for sending out verifications and its lack of follow-up on medical service verifications. During fiscal year 2011, the authority reduced the number of surveys being sent out from 34,662 to 8,401 to enable the Authority to perform more timely and complete follow-ups on returned surveys. During fiscal year 2012, the Authority stated it would modify the computer program to

exclude confidential services from inclusion in the verification process. The Authority also stated it would refine the format of the survey forms to ensure clarity.

In fiscal year 2013, the Authority sent out 5,898 verifications, of which 2,061(35 percent) were returned. Of the verifications returned, 91 contained responses indicating services may not have been provided and/or that the client may have paid for the services. These responses are identified as "negative responses".

We began testing negative responses by identifying all verifications that were not reviewed on the basis of being written in a foreign language. Lack of follow-up on verifications written in foreign languages had been identified as a concern during our previous audits. The Authority had responded to our concern by noting it would not be able to take corrective action to rectify this concern as it did not have the resources to use translators for the verification process. We found that during fiscal year 2013, 10 of the 91 (11 percent) negative responses were not investigated for this reason.

Of the remaining 81 negative responses, we performed detailed testing of 23 randomly selected verifications. The table below summarizes the results of our testing.

MSV Conclusions	Adequate follow-ups performed	Investigation Pending	Claims should not have been included in the survey	Survey forms were not clear	Lack of adequate follow-up	No record of case resolution or results of preliminary investigation
Number of MSVs *	2	2	6	8	10	4
Total	8.70%	8.70%	26.09%	34.78%	43.48%	17.39%

*Nine surveys tested applied to multiple categories.

Our testing found only 2 of the verifications we selected had been reviewed adequately. The remaining 21 cases showed the following:

- Six of 23 surveys were sent for claims that should not have been included in the MSV process. These claims included confidential services, erroneous information on the survey form, and those where Medicaid did not cover any amount of the service.
- Eight of the 23 surveys tested were misinterpreted by the clients as the surveys did not provide all pertinent information. These surveys were addressed to head of household, but the services listed were related to another beneficiary in the survey household. The head of household then responded that services had not been received since the survey form did not specify the beneficiary of the services listed.
- Four surveys were stamped by the Authority as having been received during 2010, but not entered into the system and assigned for follow-up until fiscal year 2013. Once these cases were entered, they were deemed too old to investigate and immediately closed. Authority personnel stated that due to the agency's caseload and the lack of resources, these responses had been set aside and not entered into the system. In addition, 3 additional surveys had been received by the agency six months prior to being input into the system and assigned to an investigator. Once assigned to an investigator, all seven of these cases were deemed too old to work on and immediately closed.
- Four surveys reviewed lacked documentation of investigative work and/or the final disposition of the case.
- Two of the sample surveys were received in August 2012 lacked follow-up and remained in pending status at the time of our audit.

Cause of the Condition

Authority management considers the medical service verification process to have limited value. This has resulted in a lack of oversight to ensure that survey forms are adequately designed, sent on appropriate claims, and adequately investigated.

In addition, the division managing the MSV process did not have written policies over the survey form review processes and did not perform any oversight or review of the work performed. As a result each individual investigator used different interpretations of requirements for investigation and recording results of work performed.

During the audit period the Authority has begun the process of correcting the conditions noted.

Effect of Condition

When a survey form is improperly designed, responses from beneficiaries could be inaccurate causing unnecessary follow-ups and use of limited resources that could be used on more credible cases.

Sending surveys to those with confidential claims puts the privacy of certain clients at risk and is not in compliance with federal laws.

The lack of adequate follow-up on returned surveys and inadequate oversight of the work performed increase the risk that Medicaid fraud may go undetected and take away Medicaid resources that would otherwise be directed to the truly needy citizens of Washington.

Recommendation

We recommend the Authority:

- Implement adequate policies and procedures to ensure verification are sent out, received, recorded, and followed-up on in a consistent manner in accordance with federal regulations.
- Strengthen its oversight to ensure survey forms are properly designed.
- Improve its process to ensure only relevant claims are included for medical service verification.
- Strengthen oversight of MSV survey review processes to ensure a thorough follow-up is performed on all negative responses.

Agency's Response

The Health Care Authority (HCA) does not concur with this finding and asserts that adequate controls are in place to ensure Medicaid services billed by providers were rendered to Medicaid clients.

The agency maintains that it is in compliance with 42 CFR 455.20 that states "the agency must have a method for verifying with beneficiaries whether services billed by providers were received." The Authority does have such a method in place, although planned improvements to that process were not completed during SFY 2013. Although fraud might be detected by issuing random verification forms, experience has proven that limited staff resources are better utilized when the targets for oversight are strategically selected. Using informed allegations, as well as sophisticated analytical tools (behavior modeling, algorithms, comparisons and trends, spike reports, etc.) the Office of Program Integrity has identified millions in overpayments. By contrast, the Medicaid Services Verification (MSV) process has proven to have no value in detecting fraud and the Agency maintains that resources spent on MSV processing actually reduces our ability to focus on program integrity activities that increase controls.

While disagreeing with the Finding, the Authority concurs with several recommendations in the Audit. The change request that refines the service selection process and includes the beneficiary on the form has been approved and is scheduled for implementation in July 2014. In addition, the Office of Program Integrity is currently writing and revising policies and procedures, and increasing supervisory oversight and control of staff activities and documentation. Together, these actions will eliminate the causes of the audit conditions.

Auditor's Concluding Remarks

We thank the Authority for its cooperation and assistance throughout the audit.

The MSV process is very unique as it is one of the processes where the Authority has direct contact with clients to verify paid services. When fraudulent activity occurs, it is typically not a single, large payment that covers all the activities, but numerous small payments that may add up to a large amount. The identification of one fraudulent payment will most likely lead to uncovering many additional fraudulent payments, which highlights the importance of the MSV process.

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.

42 CFR 433.116, FFP for operation of mechanized claims processing and information retrieval systems, states in part:

> FFP for operation of mechanized claims processing and information retrieval systems.
>
> (a) Subject to paragraph (j) of this section, FFP is available at 75 percent of expenditures for operation of a mechanized claims processing and information retrieval system approved by CMS, from the first day of the calendar quarter after the date the system met the conditions of initial approval, as established by CMS (including a retroactive adjustment of FFP if necessary to provide the 75 percent rate beginning on the first day of that calendar quarter). Subject to 45 CFR 95.611(a), the State shall obtain prior written approval from CMS when it plans to acquire ADP equipment or services, when it anticipates the total acquisition costs will exceed thresholds, and meets other conditions of the subpart.
>
> (b) CMS will approve the system operation if the conditions specified in paragraphs (c) through (i) of this section are met.
>
> (c) The conditions of §433.112(b) (1) through (4) and (7) through (9), as periodically modified under §433.112(b)(2), must be met.
>
> (d) The system must have been operating continuously during the period for which FFP is claimed.
>
> (e) The system must provide individual notices, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the plan.
>
> (f) The notice required by paragraph (e) of this section—
>
> (1) Must specify—

(i) The service furnished;
(ii) The name of the provider furnishing the service;
(iii) The date on which the service was furnished; and
(iv) The amount of the payment made under the plan for the service; and

(2) Must not specify confidential services (as defined by the State) and must not be sent if the only service furnished was confidential.

(g) The system must provide both patient and provider profiles for program management and utilization review purposes.

(h) If the State has a Medicaid fraud control unit certified under section 1903(q) of the Act and §455.300 of this chapter, the Medicaid agency must have procedures to assure that information on probable fraud or abuse that is obtained from, or developed by, the system is made available to that unit. (See §455.21 of this chapter for State plan requirements.)

42 CFR 455.1, Basic and scope, states:

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 beneficiaries.

(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.

42 CFR 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.

42 CFR 455.15, Full *investigation*, states:

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 §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 beneficiary 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 beneficiary has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

42 CFR 455.20, Beneficiary verification procedure, states:

(a) The agency must have a method for verifying with beneficiaries 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).

2013-032 The Health Care Authority does not have adequate internal controls to ensure Medicaid drug rebate amounts are accurately reported in CMS 64 report.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster
	93.720 ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775 State Medicaid Fraud Control Units
	93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778 Medical Assistance Program (Medicaid; Title XIX)
	93.778A Medical Assistance Program (Medicaid; Title XIX)-American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report) is a quarterly statement of actual program costs and administrative expenditures for which States are entitled to Federal reimbursement under the authority of Title XIX of the Act (Medicaid). The CMS-64 presents Medicaid expenditures for the quarter being reported and previous fiscal years, as well as collections or refunds received.

States are required to submit the CMS-64 quarterly to the Centers for Medicare & Medicaid Services (CMS) no later than 30 days after the end of the quarter being reported. These submissions provide CMS with the information necessary to issue the quarterly grant awards, monitor current year expenditure levels, compute the Federal financial participation (FFP) for the State's Medicaid Program costs and determine the allowability of State claims for reimbursement.

The Medicaid Drug Rebate Program was established in legislation enacted by Congress in the Omnibus Budget Reconciliation Act of 1990, effective January 1, 1991. The Affordable Care Act (ACA) added Medicaid managed care drug claims to the mandatory Medicaid drug rebate program, following the longstanding rebate provision in fee-for-service (FFS) Medicaid.

In Washington, the Health Care Authority (Authority) is responsible for administering the Drug Rebate Program. The Medicaid program requires states to present a complete, accurate, and full disclosure of all pending drug rebates and collections and to track collections of interest and report these amounts to CMS. States are also required to offset their federal drawdown by the federal share of drug rebates collected.

Medicaid drug rebate activities are reported on CMS-64.9R, "Medicaid Drug Rebate Schedule." The Authority prepares the report using information from Agency Financial Reporting System (AFRS) and ProviderOne, the State's Medicaid Management Information system.

During fiscal year 2013, the state collected drug rebates from manufacturers totaling more than $156 million.

Description of Condition

The Authority did not have adequate procedures to report correct drug rebate balances in the Medicaid Drug Rebate Schedule (CMS64.9R). We reviewed the Medicaid Drug Rebate Schedule and found the Authority did not report drug rebate balances correctly.

The table below summarizes the results of our work:

Period	Total drug rebates reported	Total drug rebates that should have been reported	Drug rebates over (under) reported	
			Amount	Percent of drug rebates over (under) reported
Quarter ending on September 30, 2012	$123,597,690	$78,441,267	$45,156,423	37%
Quarter ending on December 31, 2012	$138,625,996	$87,450,333	$51,175,663	37%
Quarter ending on March 31, 2013	$110,014,858	$73,400,906	$36,613,952	33%
Quarter ending on June 30, 2013	$110,014,858	$119,692,913	$(9,678,055)	(9%)

Cause of Condition

The Authority did not closely monitor reporting procedures to ensure it reports the correct drug rebate activities on the Drug Rebate Schedule. The Authority stated there was a process change and a formatting and formula error was made. The Authority also stated that this formula error had been subsequently corrected.

Effect of Condition

The grantor, the Centers for Medicare & Medicaid Services (CMS), cannot properly monitor the drug rebate program due to the inaccurate information reported on the Medicaid Drug Rebate Schedule.

Recommendation

We recommend the Authority:

- Implement adequate controls to ensure all Medicaid drug rebate activities are accurately reported on the Medicaid Drug Rebate Schedule.
- Work with CMS to fix all past reports to reflect the correct drug rebate balances.

Agency's Response

The Authority agrees with this finding.

Reporting procedures and processes have been reviewed and updated to include adequate controls to prevent inaccurate reporting in the future. The Medicaid Drug Rebate Schedule was completed and reported correctly for the 12/31/2013 quarter.

All previous Medicaid Drug Rebate Schedules have been reviewed and corrected. The Authority is currently working with CMS to report these corrections on the CMS-64.

Auditor's Concluding Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We 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.
>
> (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.

42 CFR 430.30, Grants procedures, states in part:

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

OMB No. 0938-0067- Supporting Statement for Form CMS-64 Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, states in part:

> CMS-64.9R: The form CMS-64.9R has been created to report the aging of pending Drug Rebate collections for Total Computable. This is authorized under Section1927(c)(1) of the Act.

2013-033 The Department of Social and Health Services, Aging and Disability Services Administration, did not respond to nursing home complaints in a timely manner, which could leave Medicaid clients residing in nursing homes vulnerable to serious injury or harm.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM	
Applicable Compliance Component:	Provider Health and Safety Standards	
Questioned Cost Amount:	None	

Background

Medicaid is a jointly funded state and federal partnership providing medical care for low-income individuals, and plays a critical role for people with long-term care needs. Medicaid permits states to furnish long-term care services to Medicaid beneficiaries requiring daily nursing services. Medicaid coverage of Nursing Facility Services is available only for services provided in a nursing home licensed and certified by the state survey agency as a Medicaid Nursing Facility. The state survey agency is also responsible for the investigation of complaints/allegations of abuse, neglect, or misappropriation.

Residential Care Services (RCS), under the Department of Social and Health Services, Aging and Disability Services Administration, is the state survey agency for the state of Washington. Residential Care Services has oversight of the Complaint Resolution Unit (CRU), which is the front line response system for addressing complaints from staff, residents, family members, or the general public.

Nursing home complaints can be submitted to the Complaint Resolution Unit (CRU) by mail, fax, or calling the toll free recorded complaint hotline. The Department uses the FAMLINK case management system to input, prioritize, and track complaints received on the hotline.

The program specialist performs the initial intake and priority assessment of each complaint and clinical triage nurses confirm the prioritization. Complaints that have caused, or are likely to cause, serious injury, harm, impairment, or death to a resident are prioritized as Immediate Jeopardy and are given a higher priority. Complaints can also be prioritized as Non-Immediate Jeopardy-high, Non-Immediate Jeopardy-medium, Non-Immediate Jeopardy-low, or as a Quality Review (QR). A complaint is considered a QR if it is a facility report with no threat to the resident or if appropriate steps have already been taken to safeguard the resident. By classifying the complaint as QR it makes the information accessible to the field but does not require a separate investigation.

Prioritization of complaints is made to ensure the response corresponds to the severity of the allegation. All complaints received are required to be prioritized and referred to the RCS field unit within two working days of receipt of the complaint.

Field Staff then conduct the investigation and follow up within the assigned time frame determined by the severity of the issue. The table below shows the different prioritizations and the anticipated response timeframe:

Prioritization	Anticipated Response
Immediate Jeopardy	Initiate onsite survey within 2 working days of receipt
Non Immediate Jeopardy -High	Initiate onsite survey within 10 working days of prioritization
Non Immediate Jeopardy - Medium	Initiate onsite survey within 20 working days of prioritization
Non Immediate Jeopardy - Low	Initiate onsite survey within 45 working days of prioritization

Prioritization of the complaint, by the Complaint Resolution Unit (CRU), is one of the most important steps of the entire process and sets the expected timeline and tone of response for the remainder of the Unit's complaint response. When complaints are not prioritized timely, the vulnerable residents in nursing homes are at risk for serious injury, harm, impairment or death.

Description of Condition

In fiscal year 2013 the Complaint Resolution Unit received 11,278 complaints. Of these complaints 7,503 were Quality Reviews and the remaining 3,775 were assigned a priority and sent to the RCS field unit to be investigated.

The summary table below shows the number of complaints received and how they were prioritized:

Prioritization	Number of cases
Immediate Jeopardy	183
Non Immediate Jeopardy-High	2,098
Non Immediate Jeopardy-Medium	1,434
Non Immediate Jeopardy-Low	60
Total Cases referred for investigation	3,775
Quality review (QR)	7,503
Total complaints received in fiscal year 2013	11,278

During our testing we found that Residential Care Services does not have adequate controls in place to ensure complaints are responded to in a timely manner. We requested the information for all complaints the Department received requiring an investigation. We then performed tests to determine if the Department responded to nursing home complaints in a timely manner. We identified the following exceptions:

Timeliness of responses to complaint reports

RCW 74.34.063 requires the Department to initiate a response to a complaint report no later than twenty-four hours after receiving a report. Of the 3775 complaints, 202 (5.35 percent) cases exceeded the 24 hour requirement for response.

Timeliness of onsite survey-Immediate Jeopardy

Center for Medicare and Medicaid Services, State Operations Manual, 5070 requires the Department to initiate an onsite survey for immediate jeopardy cases within two working days of receipt. We found that 22 (12 percent) immediate jeopardy cases were not investigated within two working days of receipt.

Timeliness of prioritization and referrals to the RCS field unit

All complaints received are required to be prioritized and referred to the RCS field unit within two working days of receipt of the complaint. The prioritization process sets the expected timeline and tone of the onsite survey. The subsequent referral to the RCS field unit triggers the onsite survey. We found that 1,657 (46 percent) cases were not prioritized or referred to the RCS field unit within two working days of receipt of the complaint.

Timeliness of onsite survey-Non Immediate Jeopardy

Once a complaint is referred to the RCS field unit, surveyors conduct investigations of the complaint within the assigned time frame. During our testing we found 29 (0.81 percent) non immediate jeopardy cases were not surveyed in a timely manner.

The table below summarizes the results of our testing:

Prioritization	Total number of cases	Timeliness Exceptions			
		Responses to complaint reports	Prioritization and referrals to the RCS field unit	Complaint reports to onsite survey-Non Immediate Jeopardy	Complaint reports to onsite survey-Immediate Jeopardy
Immediate Jeopardy	183	7		22	
Non Immediate Jeopardy-High	2,098	113	795		22
Non Immediate Jeopardy-Medium	1,434	79	821		6
Non Immediate Jeopardy-Low	60	3	41		1
Total	3,775	202	1,657	22	29

Cause of Condition

Residential Care Services began utilizing the FAMLINK system for complaint intake and tracking in August 2012. The transition to the FAMLINK system, which included training staff and learning the system, had a larger impact than initially anticipated. The Department stated that data entry into the FAMLINK system took four to five times longer than expected. The Department did not have adequate staffing or procedures in place to absorb the increase in time for intake entry.

Effect of the Condition

When complaints are not investigated timely, vulnerable residents in Nursing homes are at risk for serious injury, harm, impairment or death.

Recommendation

We recommend the Department strengthen internal controls to ensure nursing home complaints are responded to in a timely manner.

Agency's Response

The Department agrees with this finding. We wholeheartedly agree with the need to meet the deadlines of both federal and state requirements for the prioritization of complaints and the initiation of onsite surveys.

In recognition of these issues, and in advance of these findings, the Department took the following actions:

- *The Department temporarily assigned 18 additional staff (field unit managers) to focus on reducing the standing backlog of pending intakes. This was an intensive effort that reduced the backlog by approximately 66% in one week.*

- *The Complaint Response Unit (CRU) utilized LEAN principles to identify workflow issues that contributed to the inability of the unit to process the intakes within the required timeframes.*

- *CRU then implemented workflow changes and additional internal controls to improve timely completion of intakes including:*

    - *All intake workers participated in significant training to improve the quality of their initial and final work product. This relieved a workflow chokepoint by allowing the supervisors to target their quality review and support activities. It also greatly reduced rework of intakes.*
    - *Changing from a general queue of pending intakes to assignment of intakes to individual workers. Each worker is held accountable for timely completion of their assigned intakes and their queue is reviewed twice a day by a supervisor.*
    - *Better utilization of the triage nurses by changing their role from quality review of each intake to that of targeted technical assistance available to workers and supervisors. Targeted technical assistance focused on more complex and difficult complaints. This is possible because of the additional training to the workers and the realignment of supervisors' duties.*

The upstream backlog at CRU and resulting delay in referrals to the field caused the delays in timely onsite surveys by the field investigative units. Now that DSHS has resolved the backlog and improved the workflow, the onsite surveys are being conducted in a timely manner.

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

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.

42 U.S. Code § 1396r(g)(4) Survey and Certification Process, states:

(4) Investigation of complaints and monitoring nursing facility compliance --

Each state shall maintain procedures and adequate staff to

(A) Investigate complaints of violations of requirements by nursing facilities.

(B) monitor, on site, on a regular basis, a nursing facility's compliance with the requirements of subsections (b), (c), and (d) if -

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

> A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering, and preserving evidence, and carrying out appropriate enforcement actions against substandard nursing facilities.

Center for Medicare and Medicaid Services, State Operations Manual, Chapter 5-Complaint Procedures,
5070 - Priority Assignment for Nursing Homes, Deemed and Non-Deemed Providers/Suppliers, and EMTALA states in part:

> An assessment of each intake must be made by an individual who is professionally qualified to evaluate the nature of the problem based upon his/her knowledge and/or experience of current clinical standards of practice and Federal requirements. In situations where a determination is made that immediate jeopardy may be present and ongoing, the SA is required to investigate within two working days of receipt of the information. For all non-immediate jeopardy situations, the complaint/incident is prioritized within two working days of its receipt, unless there are extenuating circumstances that impede the collection of relevant information.

Title 42, code of Federal Regulations, Section 488.335 Action on complaints of resident neglect and abuse, and misappropriation of resident property, states in part:

> (a) Investigation.
> (1) The State must review all allegations of resident neglect and abuse, and misappropriation of resident property and follow procedures specified in § 488.332.
> (2) If there is reason to believe, either through oral or written evidence that an individual used by a facility to provide services to residents could have abused or neglected a resident or misappropriated a resident's property, the State must investigate the allegation.
> (3) The State must have written procedures for the timely review and investigation of allegations of resident abuse and neglect, and misappropriation of resident property.

RCW 74.34.063 Response to report – Timing – Reports to law enforcement agencies -- Notification to licensing authority, states in part:

> (1) - Response to reports - Timing: "The department shall initiate a response to a report, no later than twenty-four hours after knowledge of the report, of suspected abandonment, abuse, financial exploitation, neglect, or self-neglect of a vulnerable adult

The Residential Care Services (RCS) Operational Principles and Procedures for Licensed Long-Term Care Residential Facilities Complaint/Incident Resolution states in part:

> "any Statement of Deficiencies or consultations must be written within ten (10) working days of the last day of data collection, according to principles of documentation and enforcement principles (see pertinent MBs), and only after consultation with the Field Managers."

The Triage Nurse Operations Manual version 1.5 (08/27/2013), Completing the Intake--- CRU Process and Timeline states in part:

> "the CRU goal is to process intakes as quickly as needed and no longer than 2 days from receipt of the complaint. The exception may be when a complaint is not urgent in nature and the complainant cannot be contacted before 2 days have passed. Depending on the nature of the complaint/incident, the intake might be held a few days longer to allow an intake Staff to contact the complainant."

The Triage Nurse Operations Manual version 1.5 (08/27/2013), RCS Complaint Response Time states in part:

> For complaints prioritized as a 10WD (working day) complaint "Complaint and incident investigations shall be initiated within 10 working days of linking the intake to the RCS Field Unit." For complaints prioritized as 20WD (working day) "Complaint and incident investigations shall be initiated within 20

working days of linking the intake to the RCS Field Unit.". For 45WD (working day) - "Complaint and incident investigations shall be initiated within 45 working days of linking the intake to the RCS Field Unit".

2013-034 The Department of Social and Health Services, Aging and Disability Services Administration, did not adequately monitor supported living service providers to ensure all staff with contact to Developmentally Disabled clients have a proper background check and are authorized to have access to vulnerable supported living clients.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM	
Applicable Compliance Component:	Provider Eligibility	
Questioned Cost Amount:	None	

Background

The Department of Social and Health Services (DSHS), Developmental Disabilities Administration (DDA), administers the Home and Community Based Services program for people with developmental disabilities. Supported living is a core service this program offers through staff of contracted supported living providers. The instruction and support staff for these providers assist clients in a variety of daily activities, such as maintaining the home, preparing meals, and shopping to help the client learn, improve, and retain the social and adaptive skills necessary to live in the community and avoid institutionalization. DDA clients receiving supported living services reside in private residents within the community.

DDA contracts with private agencies to provide supported living services. As of June 2013, there were 125 contracted providers serving more than 3,700 clients. All supported living service providers and their employees who are employed directly or by contract and have unsupervised access to supported living clients must successfully complete a background check through DSHS' Background Check Central Unit (BCCU). A state background check is required, at minimum, every three years. If the individual resided outside of Washington State within the past three consecutive years, they must also be screened through a national fingerprint-based background check.

The Secretary of DSHS establishes crimes that automatically disqualify individuals from serving vulnerable clients through a list referred to as "the Secretary's List." Individuals with crimes on the Secretary's List are automatically prohibited from "*licensing, contracting, certification, or from having unsupervised access to children or to individuals with a developmental disability.*" If an individual has a criminal record(s) that does not automatically disqualify the individual, the provider must perform a Character, Competency, and Suitability Review to determine if the individual can have unsupervised access to clients.

During fiscal year 2013, DDA paid more than $303 million to supported living services providers for the care of more than 3,700 clients.

The State Auditor's Office issued a performance audit report dated July 31, 2013 entitled "Improving payment systems and monitoring necessary to prevent errors and improve safety." In this report we noted concerns regarding a number of caregivers who had been hired despite disqualifying background checks.

Description of Condition

We randomly selected 197 supported living clients and reviewed 2,134 caregivers to determine if all staff passed proper background checks necessary to have unsupervised access to the supported living clients. For the caregivers reviewed, we performed tests to ensure the following requirements were met:

- A proper BCCU background check had been performed within the last three years.
- No crimes were listed on the Secretary's List.
- Staff with criminal records that were not listed on the Secretary's passed a character competence and suitability (CCS) review.

The table below showed the results of our testing:

Description of Condition	Number of caregivers
Individuals working with disqualified background results	52
Individuals with no background check completed (1)	2
Individuals with expired background checks	7
Individuals serving the client without a background check during the audit month tested (2)	19

(1) The two individuals provided services to clients in January 2013 and March and April of 2013. Both individuals began the process of obtaining the required background check, but had not completed all required steps at the time of this report.

(2) Background checks were obtained subsequent to our audit testing month for 19 individuals:

Length of time after audit testing month until background check performed	Number of caregivers
0-3 months	6
4-6 months	1
7 -11 months	11
1 year or more	1

Disqualified individuals were permitted to work with clients if they passed a character competence, and suitability (CCS) review. During the audit we found 52 caregivers with disqualifying backgrounds working with clients. We reviewed a sample of CCS reviews, however none of these documents indicated the reason the individual was found suitable to work with vulnerable clients or indicated the review was performed verbally.

Cause of Condition

DSHS's residential care service inspectors perform on-site review of background check results for selected employees of providers. However, the Department's monitoring of providers is limited and infrequent due to the lack of resources.

Effects of Condition

Allowing individuals who do not meet the background check requirements access to vulnerable Medicaid clients could potentially expose the vulnerable Medicaid clients in the supported living program to neglect, harm, and abuse.

In addition, any caregiver who does not meet the background check requirements is not eligible to provide services to Medicaid clients.

Recommendation

We recommend the Department:

- Strengthen monitoring of supported living providers to ensure they perform adequate background checks of all staff who are employed directly or by contract.
- Strengthen monitoring of supported living providers to ensure an individual who fails a background check does not have access to vulnerable Medicaid clients.
- Follow up on the background check results and terminate disqualifying employees' access to clients immediately.

Department's Response

The Department disagrees with the background check citations reported in this audit.

Part of the audit timeframe includes a period (July 2012 through December 2012) when the Department was implementing corrective measures from the FY12 Single Audit. Starting July 2012, the new Department residential services contract was issued with revised policies to include additional background check standards for the SL service providers. As part of the prior corrective action plan and to ensure we kept providers current on Department changes we met with providers across the state between July and December 2013 to inform them of the policy changes and provide training to them regarding the updated background check requirements.

The Department continues to provide this training and information to the SL providers on an ongoing basis. DDA resource managers are also available to the SL agencies to provide consultations, if there are questions regarding background checks.

The Residential Care Services Division is responsible for reviewing background check standards as part of the certification evaluation. Agencies are cited and required to complete a corrective action plan, if there is a finding of non-compliance with the background check rules.

Enterprise Risk Management Office (ERMO) annually reviews twelve SL agencies for compliance with the background check standards. Issues identified by ERMO are sent to DDA. DDA staff ensures all corrective actions are completed by the SL agency.

Response to each of the findings cited in the preliminary report from the SAO is outlined below:

1. *Fifty two individuals working with disqualified background results.*

   The Department reviewed and followed up with the providers on each of these individuals. Providers were able to show non-disqualifying results for forty-nine of those instances. the Department sent this information to the SAO in which 49 of the 52 instances were inaccurate. The three instances where individuals with disqualifying crimes may have worked with clients were immediately remedied. The

SL agency was required to demonstrate that these individuals will have no access to department clients.

2. *Two individuals with no background check completed.*

   SAO gave the Department a list of five individuals with missing background checks. The Department submitted all five cleared background check results to the SAO. The SAO was unable to find these records due to minor differences in how the name was spelled or individuals whose last name changed due to marriage or divorce or other similar situations.

3. *Seven individuals with expired background checks.*

   The Department did not have an opportunity to review and follow up with the SL agency to verify this finding. The Department will ensure that the SL agency have processes in place to complete the renewals in a timely manner.

4. *Nineteen individuals serving the client without a background check during the audit month tested.*

   The Department verified that the agency had current cleared background checks. DDA worked with current information to ensure providers are in compliance with the department's established background check requirements.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit.

We appreciate the extensive corrective measures taken by DDA to train providers across the State. Our results reflect the status of care providers during the audit period. Federal regulations require our office to perform a Single Audit of Medicaid on an annual basis and to follow-up on prior year audit findings. We acknowledge that this timing may not always allow agencies to completely implement required corrective action. In addition, correction of deficiencies and oversights in background check requirements after the audit period does not change the status of individual's eligibility during the period under audit.

We reaffirm our finding and will evaluate 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:
>
> (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 contract or grant agreements related to each of its federal programs.

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines [see also 2 CFR 200.403] 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.

RCW 74.15.030, Powers and duties of secretary, states:

The secretary shall have the power and it shall be the secretary's duty:

(1) In consultation with the children's services advisory committee, and with the advice and assistance of persons representative of the various type agencies to be licensed, to designate categories of facilities for which separate or different requirements shall be developed as may be appropriate whether because of variations in the ages, sex and other characteristics of persons served, variations in the purposes and services offered or size or structure of the agencies to be licensed hereunder, or because of any other factor relevant thereto;

(2) In consultation with the children's services advisory committee, and with the advice and assistance of persons representative of the various type agencies to be licensed, to adopt and publish minimum requirements for licensing applicable to each of the various categories of agencies to be licensed.

The minimum requirements shall be limited to:

(a) The size and suitability of a facility and the plan of operation for carrying out the purpose for which an applicant seeks a license;

(b) Obtaining background information and any out-of-state equivalent, to determine whether the applicant or service provider is disqualified and to determine the character, competence, and suitability of an agency, the agency's employees, volunteers, and other persons associated with an agency;

(c) Conducting background checks for those who will or may have unsupervised access to children, expectant mothers, or individuals with a developmental disability;

(d) Obtaining child protective services information or records maintained in the department case management information system. No unfounded allegation of child abuse or neglect as defined in RCW 26.44.020 may be disclosed to a child-placing agency, private adoption agency, or any other provider licensed under this chapter;

(e) Submitting a fingerprint-based background check through the Washington state patrol under chapter 10.97 RCW and through the federal bureau of investigation for:

(i) Agencies and their staff, volunteers, students, and interns when the agency is seeking license or relicense;

(ii) Foster care and adoption placements; and

(iii) Any adult living in a home where a child may be placed;

(f) If any adult living in the home has not resided in the state of Washington for the preceding five years, the department shall review any child abuse and neglect registries maintained by any state where the adult has resided over the preceding five years;

(g) The cost of fingerprint background check fees will be paid as required in RCW 43.43.837;

(h) National and state background information must be used solely for the purpose of determining eligibility for a license and for determining the character, suitability, and competence of those persons or agencies, excluding parents, not required to be licensed who are authorized to care for children or expectant mothers;

(i) The number of qualified persons required to render the type of care and treatment for which an agency seeks a license;

(j) The safety, cleanliness, and general adequacy of the premises to provide for the comfort, care and well-being of children, expectant mothers or developmentally disabled persons;

(k) The provision of necessary care, including food, clothing, supervision and discipline; physical, mental and social well-being; and educational, recreational and spiritual opportunities for those served;

(l) The financial ability of an agency to comply with minimum requirements established pursuant to chapter 74.15 RCW and RCW 74.13.031; and

(m) The maintenance of records pertaining to the admission, progress, health and discharge of persons served;

(3) To investigate any person, including relatives by blood or marriage except for parents, for character, suitability, and competence in the care and treatment of children, expectant mothers, and developmentally disabled persons prior to authorizing that person to care for children, expectant mothers, and developmentally disabled persons. However, if a child is placed with a relative under RCW 13.34.065 or 13.34.130, and if such relative appears otherwise suitable and competent to provide care and treatment the criminal history background check required by this section need not be completed before placement, but shall be completed as soon as possible after placement;

(4) On reports of alleged child abuse and neglect, to investigate agencies in accordance with chapter 26.44 RCW, including child day-care centers and family day-care homes, to determine whether the alleged abuse or neglect has occurred, and whether child protective services or referral to a law enforcement agency is appropriate;

(5) To issue, revoke, or deny licenses to agencies pursuant to chapter 74.15 RCW and RCW 74.13.031. Licenses shall specify the category of care which an agency is authorized to render and the ages, sex and number of persons to be served;

(6) To prescribe the procedures and the form and contents of reports necessary for the administration of chapter 74.15 RCW and RCW 74.13.031 and to require regular reports from each licensee;

(7) To inspect agencies periodically to determine whether or not there is compliance with chapter 74.15 RCW and RCW 74.13.031 and the requirements adopted hereunder;

(8) To review requirements adopted hereunder at least every two years and to adopt appropriate changes after consultation with affected groups for child day-care requirements and with the children's services advisory committee for requirements for other agencies; and

(9) To consult with public and private agencies in order to help them improve their methods and facilities for the care of children, expectant mothers and developmentally disabled persons.

RCW 74.39A.056 Criminal history checks on long-term care workers, states:

(1) (a) All long-term care workers shall be screened through state and federal background checks in a uniform and timely manner to verify that they do not have a criminal history that would disqualify them from working with vulnerable persons. The department must perform criminal background checks for individual providers and prospective individual providers and make the information available as provided by law.

(b) (i) Except as provided in (b)(ii) of this subsection, for long-term care workers hired after January 7, 2012, the background checks required under this section shall include checking against the federal bureau of investigation fingerprint identification records system and against the national sex offenders registry or their successor programs. The department shall require these long-term care workers to submit fingerprints for the purpose of investigating conviction records through both the Washington state patrol and the federal bureau of investigation. The department shall not pass on the cost of these criminal background checks to the workers or their employers.

(ii) This subsection does not apply to long-term care workers employed by community residential service businesses until January 1, 2016.

(c) The department shall share state and federal background check results with the department of health in accordance with RCW 18.88B.080.

(2) No provider, or its staff, or long-term care worker, or prospective provider or long-term care worker, with a stipulated finding of fact, conclusion of law, an agreed order, or finding of fact, conclusion of law, or final order issued by a disciplining authority or a court of law or entered into a state registry with a final substantiated finding of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in chapter 74.34 RCW shall be employed in the care of and have unsupervised access to vulnerable adults.

(3) The department shall establish, by rule, a state registry which contains identifying information about long-term care workers identified under this chapter who have final substantiated findings of abuse, neglect, financial exploitation, or abandonment of a vulnerable adult as defined in RCW 74.34.020. The rule must include disclosure, disposition of findings, notification, findings of fact, appeal rights,

and fair hearing requirements. The department shall disclose, upon request, final substantiated findings of abuse, neglect, financial exploitation, or abandonment to any person so requesting this information. This information must also be shared with the department of health to advance the purposes of chapter 18.88B RCW.

(4) The department shall adopt rules to implement this section.

RCW 43.43.830, Background checks-Access to children or vulnerable persons-definitions, states in part:

(13)"Unsupervised" means not in the presence of:

(a) Another employee or volunteer from the same business or organization as the applicant; or

(b) Any relative or guardian of any of the children or developmentally disabled persons or vulnerable adults to which the applicant has access during the course of his or her employment or involvement with the business or organization.

With regard to peer counselors, "unsupervised" does not include incidental contact with children under age sixteen at the location at which the peer counseling is taking place. "Incidental contact" means minor or casual contact with a child in an area accessible to and within visual or auditory range of others. It could include passing a child while walking down a hallway but would not include being alone with a child for any period of time in a closed room or office.

(14)"Vulnerable adult" means "vulnerable adult" as defined in chapter 74.34 RCW, except that for the purposes of requesting and receiving background checks pursuant to RCW 43.43.832, it shall also include adults of any age who lack the functional, mental, or physical ability to care for themselves.

WAC 388-06-0110 “Who must have background checks?”, states:

(1) Per RCW 74.15.030, the department requires background checks on all providers who may have unsupervised access to children or individuals with a developmental disability. This includes licensed, certified or contracted providers, their current or prospective employees and prospective adoptive parents as defined in RCW 26.33.020.

(2) [(b)] As described in WAC 388-06-0115, the division of developmental disabilities requires background checks on all contracted providers, individual providers, employees of contracted providers, and any other individual who is qualified by DDD to have unsupervised access to individuals with developmental disabilities.

(3) Long-term care workers as defined in chapter 74.39A RCW hired after January 7, 2012 are subject to national fingerprint-based background checks. For individual providers and home care agency providers refer to WAC 388-71-0500 through 388-71-05909. For adult family homes refer to chapter 388-76 WAC, adult family home minimum licensing requirements. For assisted living facilities refer to chapter 388-78A WAC, assisted living licensing rules.

(4) Per RCW 74.15.030, the department also requires background checks on other individuals who may have unsupervised access to children or to individuals with a developmental disability in department licensed or contracted homes, or facilities which provide care. The department requires background checks on the following people:

(a) A volunteer or intern with regular or unsupervised access to children;

(b) Any person who regularly has unsupervised access to a child or an individual with a developmental disability;

(c) A relative other than a parent who may be caring for a child;

(d) A person who is at least sixteen years old, is residing in a foster home, relatives home, or child care home and is not a foster child.

WAC 388.06.0115, What are the division of developmental disabilities background check requirements, states:

(1) Per RCW 74.39A.056, long-term care workers undergoing a background check for initial hire or initial contract will be screened through a state name and date of birth check and a national fingerprint-based background check; except that long-term care workers in community residential service businesses are

subject to background checks as described in WAC 388-06-0115 (a) and (b). Parents are not exempt from the long-term care background check requirements.

(a) Prior to January 1, 2016 community residential service businesses as defined above will be screened as follows:
  (i) Individuals who have continuously resided in Washington state for the past three consecutive years will be screened through a state name and date of birth background check.
  (ii) Individuals who have lived outside of Washington state within the past three years consecutive will be screened through a state name and date of birth and a national fingerprint-based background check.
(b) Beginning January 1, 2016 community residential service businesses as defined above will be screened as described in WAC 388-06-0115(1).

(2) The division of developmental disabilities requires rechecks for all DDD contracted providers and their employees at least every three years or more frequently if required by program rule. Rechecks will be conducted as follows:
  (a) Individuals who have continuously resided in Washington state for the past three consecutive years will be screened through a state name and date of birth background check.
  (b) Individuals who have lived outside of Washington state within the past three consecutive years will be screened through a state name and date of birth check and a national fingerprint-based background check.

WAC 388-06-0140 "What happens if I don't comply with the background check requirement?", states:

The department will deny, suspend or revoke your license, contract, certification, or authorization to care for children or for individuals with a developmental disability, if you or someone on the premises of your home or facility having unsupervised access does not comply with the department's requirement for a background check.

(1) Individuals are eligible for the one hundred twenty-day provisional hire immediately, except as provided under subsection (2) of this section and WAC 388-06-0540. The signed background check application and fingerprinting process must be completed as required by the applicable DSHS program.
(2) Long-term care workers as defined in chapter 74.39A RCW are eligible for the one hundred twenty-day provisional hire, pending the outcome of the fingerprint-based background check, as long as provisional hiring is allowed by the applicable DSHS program rules and the long-term care worker is not disqualified as a result of the initial name and date of birth background check.

WAC 388-101-3245, Background check-general, states:

(1) Background checks conducted by the department and required in this chapter include but are not limited to Washington state background checks including:
  (a) Department and department of health findings; and
  (b) Criminal background check information from the Washington state patrol and Washington state courts.
(2) Nothing in this chapter should be interpreted as requiring the employment of a person against the better judgment of the service provider.

WAC 388-101-3250, Background checks-Washington state, states:

(1) Service providers must follow the background check requirements described in chapter 388-06 WAC and in this chapter. In the event of an inconsistency, this chapter applies.
(2) The service provider must obtain background checks from the department for all administrators, employees, volunteers, students, and subcontractors who may have unsupervised access to clients.
(3) The service provider must not allow the following persons to have unsupervised access to clients until the service provider receives the department's background check results, verifying that the person does not have any convictions, pending criminal charges, or findings described in WAC 388-101-3090:

(a) Administrators;
(b) Employees;
(c) Volunteers or students; and
(d) Subcontractors.

(4) If the background check results show that the individual has a conviction, pending criminal charge, or finding that is not disqualifying under WAC 388-101-3090, then the service provider must conduct a character, suitability, and competence review as described in WAC 388-06-0190.

(5) The service provider must:
(a) Inform the person of the results of the background check;
(b) Inform the person that they may request a copy in writing of the results of the background check. If requested, a copy of the background check results must be provided within ten working days of the request;
(c) Notify the department and other appropriate licensing or certification agency of any person resigning or terminated as a result of having a conviction record.

(6) The service provider must renew the Washington state background check at least every thirty-six months and keep current background check results for each administrator, employee, volunteer, student, or subcontractor of a service provider.

(7) Licensed boarding homes or adult family homes must adhere to the current regulations in this chapter and in the applicable licensing laws.

(8) Service providers must prevent unsupervised access to clients by any administrator, employee, subcontractor, student, or volunteer who has a disqualifying conviction, pending criminal charge, or finding described in WAC 388-101-3090.

(9) All applicants for certification must have a background check.

2013-035 The Department of Social and Health Services, Developmental Disabilities Administration made overpayments to providers totaling $236,892.73.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.720 ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative 93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778A Medical Assistance Program (Medicaid; Title XIX)-American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles
Questioned Cost Amount:	$118,446.36

Background

Medicaid is the largest source of funding for medical and health related services for people with low income in the United States. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program, and in the state of Washington the Health Care Authority is the single state agency to administer the state's Medicaid program.

The Department of Social and Health Services, Developmental Disabilities Administration (DDA), administers the Home and Community Based Services program for people with developmental disabilities. Staff assist clients in activities of daily living to help the clients with the social and adaptive skills necessary to live in the community and avoid institutionalization.

The Department pays the supported living provider a daily rate for each day of service provided to a client. The total daily rate paid for each client is individualized and adjusted as frequently as necessary, based on changes to the client's support needs and changes to the administrative component of the rate. These rates are entered for payment in the Social Service Payment System (SSPS). The DDA relies on edits in SSPS to prevent paying a provider more than what has been authorized in the system.

The DDA's Case Managers use the Client Authorization Services Input System (CASIS) to authorize payment for supported living services. Based on the rates and number of days that are authorized the system generates a service invoice each month and sends the invoice to the provider for validation. The providers are then responsible for either confirming that the authorized amount is correct or submitting necessary corrections or changes. SSPS relies solely on provider's attestation for services provided during the month to make payments.

Description of Condition

During our audit we found the Department does not have adequate controls in place to prevent multiple authorizations and potential overpayments.

Daily rates for each client are individualized and adjusted as frequently as necessary, based on changes to the client's support needs and changes to the administrative component of the rate. When a client's daily rate changes, a new authorization is entered in the system to ensure the correct amount is paid. If the previous authorization is not removed from the system, the provider will receive invoices for both authorizations. If the provider attests to both, the system will issue a payment for both authorizations. We also found that if a client changes providers, an additional authorization is created for the new provider, again resulting in multiple payments.

Cause of Condition

The Department relied on provider attestations and did not monitor authorization processes thoroughly to ensure it did not pay providers for the same services more than once.

Effect of Condition and Questioned Costs

We reviewed 478 provider payments totaling $920,734.58. The payments we reviewed were for providers that received three or more monthly payments for a particular client. We identified a total of $236,892.73 in overpayments to providers. We are questioning $118,446.36, which is the federal portion of the unallowable costs.

Recommendation

We recommend the Department:

- Monitor authorization processes thoroughly to ensure the same services are not paid more than once.
- Recoup $236,892.73 in overbilled amounts from the providers.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Department's Response

The Department disagrees with this finding.

The Department has a cost settlement reconciliation process that corrects and adjusts supported living payments. The state auditor's review is done by state fiscal year, July 1 through June 30th, while our cost settlement for supported living is conducted annually on a calendar year. This in effect overstated any overpayment; half the year audited had yet to be reconciled by the department. Had the reconciliation for calendar year 2013 occurred within the audit cycle we would have corrected most, if not all, of the overpayments identified.

The way the information is presented leads the reader to believe the Department has an overpayment rate in excess of 25%. This is inaccurate. The error rate is correctly .078%, or less than one percent of the total dollars spent on supported living services. The auditor pulled data on $303,521,862 and selected from that a group of high risk payments totaling $920,734. The $236,892 identified as overpayments should be compared with the total of $303,521,862 rather than a subset of high risk payments. All overpayments identified in the audit have been forwarded to OFR for collection, consistent with DDA practices. .

The Department is confident its settlement process identifies nearly all overpayments; however, we are not satisfied until the overpayments are immaterial. To meet this end the Department's Developmental Disabilities Administration added a staff to the reconciliation process this February and plans to add additional staff before June for cost report reconciliation as a quality assurance measure.

Auditor's Concluding Remarks

We thank the Department for its response. We chose payments for this testing based on the higher likelihood of being an overpayment. The exceptions we identified were the payments the Department made for the same services that had already been paid. We reaffirm our finding.

Applicable Laws and Regulations

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Section 300, states in part:

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

OMB Circular A-87*: Cost Principles for State, Local and Indian Tribal Governments (2 CFR Part 225); Appendix A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:*

2. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
   - f. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
   - g. Be allocable to Federal awards under the provisions of 2 CFR part 225.
   - h. Be authorized or not prohibited under State or local laws or regulations.
   - i. 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 consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
   - k. 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.
   - l. Except as otherwise provided for in 2 CFR part 225, be determined in accordance with generally accepted accounting principles.
   - m. 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.
   - n. Be the net of all applicable credits.
   - o. Be adequately documented.

OMB Circular A-133 Compliance Supplement, *Part 4 (June 2012)- 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 beneficiaries whose coverage is required or allowed under this part.

(b) FFP is available in expenditures for services provided to beneficiaries who were eligible for Medicaid in the month in which the medical care or services were provided except that, for beneficiaries who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the beneficiary'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.

2013-036 The Department of Social and Health Services, Developmental Disabilities Administration did not have adequate controls to ensure Medicaid payments to supported living service providers are allowable and supported, resulting in unallowable payments of $133,128.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster
	93.720 ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775 State Medicaid Fraud Control Units
	93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778 Medical Assistance Program (Medicaid; Title XIX)
	93.778A Medical Assistance Program (Medicaid; Title XIX)-American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles
Questioned Cost Amount:	$66,563.92
Likely Questioned Cost Amount:	$14,514,989

Background

Medicaid is the largest source of funding for medical and health related services for people with low income in the United States. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program, and in the state of Washington the Health Care Authority is the single state agency to administer the state's Medicaid program.

The Department of Social and Health Services, Developmental Disabilities Administration (DDA), administers the Home and Community Based Services program for people with developmental disabilities. Supported living is a core service this program offers through staff of contracted supported living providers. The instruction and support staff assist clients in activities of daily living, such as maintaining the home, preparing meals, and shopping to help the client learn, improve, or retain the social and adaptive skills necessary to live in the community and avoid institutionalization.

The Department pays the supported living provider a daily rate for each day of service provided to a client. The amount and type of instruction and support services a client receives are based on the client's assessed needs and may vary from a few hours per month up to 24 hours per day of one-on-one support. The majority of clients receiving supported living services require daily staff support to maintain their health and safety.

The DDA Case Managers use the Client Authorization Services Input System (CASIS) to authorize payment for supported living services. Based on the rates and number of days that are authorized for each client the system automatically generates a monthly service invoice and sends the invoice to the provider for validation. Providers are then responsible for either confirming that the authorized amount is correct or submitting necessary corrections or changes. SSPS relies solely on provider's attestation for services provided during the month to make payments. Providers are required to maintain adequate payroll records including staff time sheets, work schedules, and payroll vouchers to support payment claims.

In a report dated July 31, 2013, "Improving payment systems and monitoring necessary to prevent errors and improve safety", State Auditor's Office Performance Audit reported concerns regarding the Department's lack of controls to ensure that monthly payments are adequately supported.

During fiscal year 2013, DDA paid more than $302 million to supported living services providers for the care of more than 3,733 clients.

Description of Condition

To be allowable, Medicaid payments made on behalf of developmentally disabled clients must be adequately documented. We found the Department did not have adequate internal controls to ensure supported living providers maintain adequate documentation to support payments claimed for each day of service billed.

Cause of Condition

DDA's processes for monitoring providers' payroll records were limited and infrequent.

Effect of Condition and Questioned Costs

We selected a random sample of 197 monthly payments totaling $1,440,204.28 from a total population of 42,958 monthly payments to verify that payments the Department made for each client month were adequately supported.

Of the 197 payments reviewed, we found 71 payments were supported.

For 30 sample payments we selected we could not determine whether monthly payments were supported because documentation from the providers included records pertaining to a large population of clients and household that did not distinguish services provided to any individual household or client.

For the remaining 96 we found:

Population	Sample size	Exceptions			Projected sample error range*	
		Description	Number of exceptions	Unallowable Payments	Low	High
42,958	197	No payroll records provided	3	$27,425.18	$21,629,262	$36,430,694
		Amounts not supported by payroll records	92	$105,151.02		
		Services not provided	1	$551.64		
		Total	96	$133,127.84		

We identified $133,127.84 in payments that were not fully supported with payroll records. We are questioning $66,563.92, which is the federal portion of the unallowable payments.

We question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support expenditures.

By projecting the results of our sample testing to the entire population of supported living payments, we estimate the amount of unallowable payments to individuals could range from $21,629,262 to $36,430,694.

Recommendation

We recommend the Department:

- Improve internal controls by strengthening its monitoring of providers' payroll records to ensure payments to providers are legitimate and supported.
- Seek recovery of the funds paid to providers who were unable to adequately support claims.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Department's Response

The Department does not concur with the finding.

RCW 71A.12.060 clearly provides the Secretary of the Department of Social and Health Services (DSHS) authority to authorize payments for residents in community residential programs. To date the Secretary has authorized a system that requires payments for all Instruction and Support Services (ISS) hours to be reconciled to the Supported Living Agency (SL Agency) taken as a whole. Through the annual cost report process (described in DDA Policy 6.04), the DSHS Developmental Disabilities Administration (DDA) / Management Services Division (MSD) verifies that the ISS hours reported as provided by a SL Agency match the total hours of service DDA has authorized for all client that the SL Agency serves. If the ISS hours reported in the annual cost report exceed either the total authorized hours for all clients served by the SL Agency, or are not supported by documentation that shows that the reported hours were actually worked, DDA/MSD seeks recovery of any overpayment through the cost report settlement process (see DDA Policy 6.04 (III)). DDA does not require the SL Agencies to provide each client exactly the number of authorized ISS hours over a weekly or monthly period, but DDA does require that, over a year, clients receive all authorized ISS hours. Through this process SL Agencies are audited on a whole SL Agency basis and as a result, any audit that considers only a limited time frame cannot capture the ultimate determination of an SL Agency's actual service delivery, or any corresponding underpayment or overpayment.

SL Agencies are required to complete an annual cost report. The cost report reconciles hours and ISS dollars authorized to hours and ISS dollars provided. A settlement is issued to any SL Agency who fails to meet either standard. The Department relies on provider attestation on the accuracy of the cost report. DSHS' Enterprise Risk Management Office (ERMO) will periodically audit selected providers. Furthermore, as part of the certification evaluation process, DSHS, Aging and Long-term Support Administration, Residential Care Services (RCS) performs a cursory review of hours provided. If concerns are identified in the certification evaluation, MSD/DDA may conduct an audit of the SL Agency. Starting in October 2013, DDA/MSD began conducting audits of selected residential providers. The scope includes agency reconciliation of employee hours provided by households. DDA/MSD will be able to audit 20% of the SL agencies per year.

The approved system allows for more efficient load balancing that saves taxpayer resources (by not requiring staffing for peak demand), and allows better service (by allowing agencies to move resources to where the daily need is). The terms of this policy are further outlined in DSHS DDA Policy 6.04.

The State Auditor's Office (SAO) has implicitly required that an audit of each SL Agency individual provider must reconcile to the ISS hours provided to each individual client. The SAO's proposed system, while easier to audit, would be more costly and would provide inferior service. More importantly, by applying a payment authorization

standard different from what the Secretary has approved by law, the SAO generates an overpayment conclusion because offsetting underpayments generated by SL Agencies. In reaching its overpayment conclusion, the SAO specifically excluded amounts that would otherwise be considered underpayments. Problematically, the SAO's approach would erroneously require Washington State to make payments back to the Federal government without justification.

The SAO audit also states that DDA does not have internal controls to insure SL Agencies maintain adequate documentation to support payments claimed against payroll records. It is accurate to say that historically payment claims are not required by DDA policy to be reconciled to payroll records. However, the standard SL Agency contract issued after July 1, 2013 includes additional standards for cost reporting and maintaining staff payroll records in an auditable form.

Technical concerns

The SAO audit included a number of technical errors. First, the SAO audit reported that 30 sample payments were not reconciled to a client. As explained above, the payments SAO disregarded were, in most cases, underpayments (that is, more ISS hours provided than authorized were delivered to the individual client). The failure to factor in the overprovision of ISS hours into the SAO findings therefore inflates the overpayment amount. Second, the SAO referenced 3 records which were alleged to involve absence of payroll records. Our review found that the SL Agency did not receive the request from the SAO for three of the four samples. As a result, these questioned costs are also not valid. (Note: the SL Agency is willing to send information if it is requested and the SL Agency did submit information from other clients when requested.) Third, for the one sample client where ISS services were not provided, payments were discontinued prior to the sample dates.

Closing Comments

The SAO's scope of audit is counter to DDA's practice of allowing SL Agencies flexibility to manage the support hours. [This is the same flexibility the state provides to itself as it manages State Operated Living Facilities] and it is the strategy best designed to facilitate efficiencies and cost containment for this service delivery system with the greatest quality for clients. Further, technical concerns in the SAO analysis and the failure to off-set underpayments would mistakenly cause Washington State taxpayers to make unjustified payment to the Federal Government.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit.

As part of our audit, we did review the annual cost report process; however we noted the reconciliation does not require any payroll records or documentation supporting the payroll hours claimed by the provider agency. In addition, the report only requires the provider agency to provide the total payroll hours spent by the agency and does not distinguish the type of work the employee has performed. This overall reconciliation process is insufficient to verify whether the provider provided the services for which it was paid.

We contacted all provider agencies by phone in October, 2013 to verify they received the information request and the provider in question stated they had received the correspondence. We also provided regular updates showing the status of records requested to DDA staff and worked closely with DDA to resolve these issues.

We acknowledge the complexity of providing services to DDA clients and the changing needs of each client. However, establishing accountability is not counter to DDA's practice of allowing SL agencies flexibility to manage the support hours. OMB A-87 states that to be allowable under federal awards costs must be adequately documented.

We reaffirm our finding and review this area during our next audit.

Sample Unit

The sampling unit was a monthly payment. A monthly payment consisted of all supported living service payments the Department made to a provider for a specific client on a single month during the period of July 1, 2012 to June 30, 2013.

Estimation Methodology

We used the U.S. Department of Health and Human Services, Office of Inspector General RAT-STATS appraisal program to estimate the amount of unallowable payments the Department made to Supported Living Providers.

***Sampling Results**

The table below shows the value of our universe, sampling frame and questioned costs:

Table 1: Value of universe, sampling frame and questioned costs

Payments In Universe	Value of Universe	Sample Size	Value of Sample	Unallowable Payments	Value of Questioned Costs (federal share)
42,958	$302,601,092	197	$1,440,204.28	$133,127.84	$66,563.92

Projection of Sampling Results

By projecting the results of our statistical sample to the entire Home and Community Based supported living program payments, we estimate the amount of possible unallowable payments to supported living providers could range between the lower limit of our projected results ($21,629,262) and the upper limit ($36,430,694).

Table 2: Projected value of unallowable payments

Precision at the 90-Percent Confidence Level	
	Variables Appraisal
Midpoint	$29,029,978
Lower Limit	$21,629,262
Upper Limit	$36,430,694

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

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part [See also, 2 CFR §200.403]:

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, Appendix A.
    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.

Revised Code of Washington (RCW) 71A.12.060, Payment authorized for residents in community residential programs, states:

> The secretary is authorized to pay for all or a portion of the costs of care, support, and training of residents of a residential habilitation center who are placed in community residential programs under this section and RCW 71A.12.070 and 71A.12.080.

The Department's *Division of Developmental Disabilities' Community Residential Service Contract, Section 11* states in part:

> The Contractor shall maintain records relating to this Contract and the performance of the services described herein. The records include, but are not limited to, accounting procedures and practices, which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this Contract. All records and other materials relevant to this Contract shall be retained for six years after expiration or termination of this Contract.

2013-037 The Department of Social and Health Services, Aging and Long-Term Support Administration, did not adequately monitor adult family home providers to ensure all caregivers and resident managers who are employed directly or by contract have proper background checks.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM	
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 Medicaid program is the major source of public funding for long-term care services. The Medicaid Home and Community Based Services program permits states to furnish long-term care services to Medicaid beneficiaries in community settings, avoiding institutionalization. These services, generally personal care and assistance, are provided in adult family homes by individuals or agencies often chosen by the Medicaid client.

All providers must meet basic qualifications to provide services to Medicaid clients which include background checks, certifications and training. Adult Family Home owners and their employees must complete a Washington State background check and a national finger print-based background check through DSHS' Background Check Central Unit (BCCU).

The Department Social and Health Services, Aging and Long-Term Support Administration, Residential Care Services is responsible for ensuring that all adult family homes and their providers meet and maintain these eligibility requirements to continue providing services to Medicaid clients. All the homes are required a visit every 18 months with a 15 month statewide average to ensure they maintain the homes as required by state laws. These eligibility requirements are intended to ensure program integrity and identify potential fraud and abuse in the Medicaid program. During fiscal year 2013, the Department paid approximately $107 million to more than 1,000 adult family home providers that rendered services to about 5,500 Medicaid clients.

In a report dated July 31, 2013, "Improving payment systems and monitoring necessary to prevent errors and improve safety", the State Auditor's Office Performance Audit reported concerns regarding a number of caregivers who had been hired despite disqualifying background checks.

Description of Condition

State law requires adult family home providers to perform adequate background checks of all caregivers, representatives, and resident managers who are employed to ensure that employees do not have a criminal history that would disqualify them from working with vulnerable persons.

During our audit we performed testing to determine whether adult family home staff who had access to residents were qualified to provide services to Medicaid clients. We identified 456 staff who provided services for Adult Family Homes in fiscal year 2013 without having proper background checks completed according to the BCCU background database. Of the 456 individuals identified, additional inquiries made with the DSHS confirmed that 253 were not eligible to provide services. We summarized our results in this table below:

Description	Number of Ineligible Providers
No match found in the BCCU database.	175
Incomplete background checks (background checks only done at state level).	72
Incomplete background checks (background checks done at state level showed convictions that are on the Secretary's List).	3
Background check was completed but with convictions that are on the Secretary's List.	3

Cause of the Condition

The Department has procedures in place to ensure adult family home providers meet eligibility requirements throughout their enrollment. However, there is a high rate of turn-over in employment at these providers and when performing on-site inspections, the Department only randomly verifies background check completion for one or two employees.

Effect of Condition

A person who does not meet the background check requirement is not eligible to provide services to Medicaid clients, which could potentially expose vulnerable Medicaid clients residing in adult family homes to neglect, harm, and abuse.

Recommendation

We recommend the Department:

- Strengthen monitoring of adult family home providers to ensure they perform adequate background check of all caregivers, representatives and resident managers who are employed directly or by contract.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Department's Response

The Department of Social and Health Services, Aging and Long-Term Support Administration agrees that quality and compliance of adult family home regulations is paramount to ensuring clients are safe and well cared for.

After review of audit findings, the Department has the following response:

When performing on-site inspections, the Department agrees to move from verifying background checks for a sample of employees to checking 100% of employees employed at the adult family home at the time of the on-site inspection.

Checking 100% of employees employed at the time of on-site inspection, however, will not capture employees who worked and subsequently terminated employment in between the average 15-month inspection cycle. Adult family homes have a high employee turnover rate and the Department is not funded to monitor all employees hired in adult family homes across the state. Under RCW 70.128.130(13), the responsibility of determining an adult family home employee's eligibility to have unsupervised access to clients belongs to the adult family home provider. In addition to inspecting 100% of background checks for employees employed at the time of inspection, the Department will also continue to investigate adult family home complaints, including those related to background checks.

Within the auditor's numbers, 266 ineligible providers were identified. Given the short turnaround time, the Department did not have an opportunity to confirm each provider's specific background check situation. There are many reasons why no match is found in the BCCU database, including a name change (e.g. maiden to married) between the time the check was run and the audit was performed or incorrect identifying information, such as an incorrect Social Security Number, was used. When the Department identifies ineligible providers during on-site visits, swift and serious action is taken to ensure clients are safe and providers are compliant. These actions include citation, stop placement, condition, revocation and civil fine, depending on the severity of the finding. All of these findings are available to the public for inspection.

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

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.

OMB Circular A-87, 2 CFR § 225: 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:
   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, Appendix A.
   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.

RCW 70.128.070, License-Inspections-Correction of violations, states:

(1) A license shall remain valid unless voluntarily surrendered, suspended, or revoked in accordance with this chapter.
(2) (a) Homes applying for a license shall be inspected at the time of licensure.
(b) Homes licensed by the department shall be inspected at least every eighteen months, with an annual average of fifteen months. However, an adult family home may be allowed to continue without inspection for two years if the adult family home had no inspection citations for the past three consecutive inspections and has received no written notice of violations resulting from complaint investigations during that same time period.
(c) The department may make an unannounced inspection of a licensed home at any time to assure that the home and provider are in compliance with this chapter and the rules adopted under this chapter.
(3) If the department finds that the home is not in compliance with this chapter, it shall require the home to correct any violations as provided in this chapter.

RCW 74.39A.056, Criminal history checks on long-term care workers, states:

(1) (a) All long-term care workers shall be screened through state and federal background checks in a uniform and timely manner to verify that they do not have a criminal history that would disqualify them from working with vulnerable persons. The department must perform criminal background checks for individual providers and prospective individual providers and make the information available as provided by law.
(b) (i) Except as provided in (b)(ii) of this subsection, for long-term care workers hired after January 7, 2012, the background checks required under this section shall include checking against the federal bureau of investigation fingerprint identification records system and against the national sex offenders registry or their successor programs. The department shall require these long-term care workers to submit fingerprints for the purpose of investigating conviction records through both the Washington state patrol and the federal bureau of investigation. The department shall not pass on the cost of these criminal background checks to the workers or their employers.
(ii) This subsection does not apply to long-term care workers employed by community residential service businesses until January 1, 2016.
(c) The department shall share state and federal background check results with the department of health in accordance with RCW 18.88B.080.
(2) No provider, or its staff, or long-term care worker, or prospective provider or long-term care worker, with a stipulated finding of fact, conclusion of law, an agreed order, or finding of fact, conclusion of law, or final order issued by a disciplining authority or a court of law or entered into a state registry with a final substantiated finding of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in chapter 74.34 RCW shall be employed in the care of and have unsupervised access to vulnerable adults.
(3) The department shall establish, by rule, a state registry which contains identifying information about long-term care workers identified under this chapter who have final substantiated findings of abuse, neglect, financial exploitation, or abandonment of a vulnerable adult as defined in RCW 74.34.020. The rule must include disclosure, disposition of findings, notification, findings of fact, appeal rights, and fair hearing requirements. The department shall disclose, upon request, final substantiated findings of abuse, neglect, financial exploitation, or abandonment to any person so requesting this information. This information must also be shared with the department of health to advance the purposes of chapter 18.88B RCW.
(4) The department shall adopt rules to implement this section.

WAC 388-76-10005, License-Required, states:

(1) Any person or entity must have a license by the department to operate an adult family home.
(2) No person or entity may provide personal care, special care, and room and board for more than one resident without a license.

WAC 388-76-10015, License-Adult family home-compliance required, states:

(1) The licensed adult family home must comply with all the requirements established in chapters 70.128, 70.129, 74.34 RCW, this chapter and other applicable laws and regulations including chapter 74.39A RCW; and
(2) The provider is ultimately responsible for the day-to-day operation of each licensed home.
(3) The provider must promote the health, safety, and well-being of each resident residing in each licensed adult family home.

WAC 388-76-10161, Background checks -- Who is required to have, states:

(1) An adult family home applicant and anyone affiliated with an applicant must have the following background checks before licensure:
(a) A Washington state name and date of birth background check; and
(b) If applying after January 7, 2012, a national fingerprint background check.
(2) The adult family home must ensure that all caregivers, entity representatives, and resident managers who are employed directly or by contract after January 7, 2012, have the following background checks:
(a) A Washington state name and date of birth background check; and
(b) A national fingerprint background check.
(3) All household members over the age of eleven, volunteers, students, and noncaregiving staff who may have unsupervised access to residents must have a Washington state name and date of birth background check. They are not required to have a national fingerprint background check.

WAC 388-76-10175, Background checks—Employment—Conditional hire—Pending results of Washington state name and date of birth background check, states:

An adult family home may conditionally employ a person directly or by contract, pending the result of a Washington state name and date of birth background check, provided the home:

(1) Submits the Washington state name and date of birth background check no later than one business day after conditional employment;
(2) Requires the individual to sign a disclosure statement and the individual denies having been convicted of a disqualifying crime or a disqualifying finding under WAC 388-76-10180;
(3) Does not allow the individual to have unsupervised access to any resident;
(4) Ensures direct supervision, as defined in WAC 388-76-10000, of the individual; and
(5) Ensures the individual is competent and receives the necessary training to perform assigned tasks and meets the staff training requirements under chapter 388-112 WAC.

WAC 388-76-10176, Background checks—Employment—Provisional hire—Pending results of national fingerprint background check, states:

The adult family home may provisionally employ individuals hired after January 7, 2012 and listed in WAC 388-76-10161(2) for one hundred twenty-days and allow those individuals to have unsupervised access to residents when:

(1) The individual is not disqualified based on the results of the Washington state name and date of birth background check; and
(2) The results of the national fingerprint background check are pending.

WAC 388-76-10180, Background checks—Employment—Disqualifying information, states:

The adult family home must not employ anyone, directly or by contract, who is listed in WAC 38 8-76-10161(2) if the individual has any of the convictions, history, or findings, described below:

(1) Has a history of significant noncompliance with federal or state laws or regulations in the provision of care or services to children or vulnerable adults;
(2) Has been convicted of a crime in any federal or state court, and the department determines that the crime is equivalent to a crime under subsections (3), (4), (5), (6), or (7), below;
(3) Has been convicted of a "crime against children or other persons" as defined in RCW 43.43.830, unless the crime is simple assault, assault in the fourth degree, or prostitution and more than three years have passed since conviction;
(4) Has been convicted of "crimes relating to financial exploitation" as defined in RCW 43.43.830, unless the crime is theft in third degree and more than three years have passed since conviction, or unless the crime is forgery or theft in the second degree and more than five years have passed since conviction;
(5) Has been convicted of the manufacture or delivery of drugs or of possession with intent to manufacture or deliver drugs under one of the following laws:
    (a) Violation of the Imitation Controlled Substance Act (VICSA);
    (b) Violation of the Uniform Controlled Substances Act (VUCSA);
    (c) Violation of the Uniform Legend Drug Act (VULDA); or
    (d) Violation of the Uniform Precursor Drug Act (VUPDA).
(6) Has been convicted of sending or bringing into the state depictions of a minor engaged in sexually explicit conduct;
(7) Has been convicted of criminal mistreatment;
(8) Has been found to have abused, neglected, financially exploited, or abandoned a minor or vulnerable adult by court of law or a disciplining authority, including the department of health. Examples of legal proceedings in which such findings could be made include juvenile court proceedings under chapter 13.34 RCW, domestic relations proceeding under Title 26 RCW, and vulnerable adult protection proceedings under chapter 74.34 RCW;
(9) Has a finding of abuse or neglect of a child that is:
    (a) Listed on the department's background check central unit report; or
    (b) Disclosed by the individual, except for findings made before December, 1998.
(10) Has a finding of abuse, neglect, financial exploitation, or abandonment of a vulnerable adult that is:
    (a) Listed on any registry, including the department's registry;
    (b) Listed on the department's background check central unit report; or
    (c) Disclosed by the individual, except for adult protective services findings made before October, 2003.
(11) Pending the results of the background checks, conditional or provisional hiring may be allowed under WAC 388-76-10175 and 388-76-10176.

WAC 388-76-10181, Background checks—Employment—Nondisqualifying information, states:

(1) If any background check results show that an employee or prospective employee has a conviction or finding that is not automatically disqualifying under WAC 388-76-10180, then the adult family home must:
    (a) Determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care; and
    (b) Document in writing the basis for making the decision, and make it available to the department upon request.
(2) Nothing in this section should be interpreted as requiring the employment of any person against the better judgment of the adult family home.

2013-038 The Department of Social and Health Services, Developmental Disabilities Administration did not have adequate internal controls to ensure cost of care adjustments paid to supported living service providers are allowable and supported, resulting in unallowable payments of $604,661.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster
	93.720 ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775 State Medicaid Fraud Control Units
	93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778 Medical Assistance Program (Medicaid; Title XIX)
	93.778A Medical Assistance Program (Medicaid; Title XIX)-American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles
Questioned Cost Amount:	$ 302,330.61

Background

Medicaid is the largest source of funding for medical and health related services for people with low income in the United States. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program, and in the state of Washington the Health Care Authority is the single state agency to administer the state's Medicaid program.

The Department of Social and Health Services, Developmental Disabilities Administration (DDA), administers the Home and Community Based Services program for people with developmental disabilities. Supported living is a core service this program offers through staff of contracted supported living providers. The instruction and support staff for these providers assist clients in a variety of daily activities, such as maintaining the home, preparing meals, and shopping to help the client learn, improve, and retain the social and adaptive skills necessary to live in the community and avoid institutionalization.

DDA uses an evidence-based assessment instrument called the Supports Intensity Scale (SIS) to evaluate a client's support needs. The results of the SIS are used to calculate the number of daily direct support hours, called Instruction and Support Services (ISS) hours. The assessment predicts ISS hours for a client as if the client lives alone. The vast majority of supported living clients, however, live with other clients and many supports can be shared, like nighttime supervision and unstructured protective supervision. Resource Managers (RM) review the results of each assessment and consider additional factors and all possible economies of scale to ensure providers deliver services to clients in the most time- and cost-efficient manner possible.

A cost of care adjustment (COCA) is a reimbursement intended to cover the necessary costs of non-variable staff support and administration to provide services to clients or costs necessary to maintaining a residence when there is a temporary absence of a client. For example, if a client lives with other clients, a COCA may be applied to increase the roommates' rates to account for the loss of certain economies of scale and other fixed administrative costs.

Providers can submit a "Cost of Care Adjustment Request" form (DSHS 06-124) for a cost of care adjustment. COCAs can only be approved for a maximum of three months. COCAs beyond three months must be approved by exception to the policy by a DDA Regional Administrator.

During fiscal year 2013, DDA paid $5,324,417.63 in COCA payments to 83 providers.

Description of Condition

The Department's internal controls over COCAs were not adequate to ensure all COCAs were reasonable, authorized and supported. During the audit, we found many instances where COCA forms were not approved or could not be found. We also noted that many COCA approvals did not include justification for COCA payments to ensure the payments were for the loss of certain economies of scale and other fixed administrative costs that resulted from a temporary absence of a client.

Cause of Condition

DDA did not follow its own policies and procedures for authorization of COCA payments.

Effect of Condition and Questioned Costs

Approval of cost of care adjustments

We tested all 181 COCA payments totaling $1,138,859.52 , which are related to COCA payments submitted for periods over a maximum of three months to determine if the payments were authorized and supported. We reviewed for the following criteria:

- Absence met the definition of temporary.
- COCA forms were prepared and approved.
- Exception to the Rule (ETR) forms were prepared and approved.

The table below summarizes the results of our work:

Exceptions	Number of COCAs*	Related expenditures*	Unallowable expenditures**
Absence not temporary	18	$366,260.00	$545,220.24
Reason for absence not documented	3	$36,868.67	
No COCA forms	15	$379,746.84	
COCA forms were not approved	15	$243,489.91	
No exception to the rule forms submitted for payments for periods over a maximum of three months	27	$406,458.37	

* COCAs and related expenditure exceptions may be in more than one category.

** Unallowable expenditures are not duplicated.

We identified a total of $545,220.24 in unallowable payments that were made to providers. We are questioning $272,610.12, which is the federal portion[1] of the unallowable costs.

[1] The federal share is calculated using the state's 2013 FMAP rate of 50 percent.

COCA payments for overlapping dates

We reviewed 90 COCA payments totaling $231,927.43, which had overlapping dates of absence to determine if COCA payments were approved and not paid more than once for the same absence. We identified a total of $59,440.98 the Department paid to providers for overlapping dates. We are questioning $29,720.49, which is the federal portion[1] of the unallowable costs.

In total, we identified a total of $604,661.22 in unallowable payments the Department made to providers. We are questioning $302,330.61, which is the federal portion[1] of the unallowable payments.

Recommendation

We recommend the Department:

- Follow its policies and procedures to ensure COCA payments to providers are legitimate and supported.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Department's Response

The Department partially concurs with this finding.

The Department does not agree with the audit finding stating "COCA forms were could not be found in 15 instances", resulting in $379,746.84 in unallowable expenditures. DDA staff has provided to SAO all Cost of Care Adjustment (COCA) forms that were requested in the sample.

The Department does agree with the rest of the findings. We have already made changes to our process for authorizing COCA. The changes include issuing guidelines for the resource managers to follow and changing the COCA form to require written justification for all COCA requests.

The Department plans to share the information with all residential services providers. Also, we will train the resource managers to the updated process. The guidelines and updated form will bring accountability, compliance and validity to the authorizations.

The Department's actions will reflect the guidelines and the current version of the DDA policies issued July of 2013.

Auditor's Concluding Remarks

We thank the Department for its response. However, documents provided for the 15 instances were not sufficient to ensure the expenditures were allowable.

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

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part [See also, 2 CFR §200.403]:

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, Appendix A.
   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.

RCW 71A.12.080, Rules, states:

(1) The secretary shall adopt rules concerning the eligibility of residents of residential habilitation centers for placement in community residential programs under this title; determination of ability of such persons or their estates to pay all or a portion of the cost of care, support, and training; the manner and method of licensing or certification and inspection and approval of such community residential programs for placement under this title; and procedures for the payment of costs of care, maintenance, and training in community residential programs. The rules shall include standards for care, maintenance, and training to be met by such community residential programs.
(2) The secretary shall coordinate state activities and resources relating to placement in community residential programs to help efficiently expend state and local resources and, to the extent designated funds are available, create an effective community residential program.

The DDA Policy 6.02, issued July of 2011, states in part:

Definitions

Cost-of-Care Adjustment means a reimbursement adjustment intended to cover the necessary costs of non-variable staff support and administration to provide services to clients when there is a temporary loss of a client served by the agency.

E. Cost of Care Adjustments (COCA)

1. When there is a potential COCA, the division shall consider with the contractor whether a COCA adjustment or rate reassessment for clients sharing the household is most appropriate.
2. Each COCA authorization may be approved for a maximum of three (3) months. COCAs beyond three (3) months may be approved by exception to policy by the Regional Administrator.
3. The COCA must not exceed the total daily rate of the client who temporarily left the program.
4. For adults receiving SL/GH/GTH services:
   a. The COCA applies to existing or new programs.
   b. The COCA may not exceed the cost of care per client when the program is operating at full capacity.
   c. A COCA may be authorized under the following circumstances:
      i. As part of a resident "phase-in" process when a new program is being developed or an existing program is being expanded; and
      ii. In an existing program when a client shares support hours with other clients and moves out, either permanently or temporarily, and there is no other client available to move in immediately or the client's home must be maintained until the client's return.

The DDA Policy 6.18, issued July of 2011, states in part:

B. Calculation of ISS Hours

The original residential service provider may request a cost of care adjustment up to the amount necessary to continue to support the remaining housemates for ninety (90) days. During that time every effort will be made to fill the vacancy. If it is not filled, then cost containment measures must be made.

The Resource Manager will use the rate assessment to recalculate the ISS hours and all other components of the residential rate within 90 days.

2013-039 The Department of Social and Health Services, Developmental Disabilities Administration, did not consistently pay supported living providers at authorized daily rates.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM	
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles	
Questioned Cost Amount:	$ 695	
Likely Questioned Cost Amount:	$151,488	

Background

The Department of Social and Health Services, Developmental Disabilities Administration, administers the Home and Community Based Services program for people with developmental disabilities. Supported living is a core service this program offers through staff of contracted supported living providers. The instruction and support staff assist clients in activities of daily living, such as maintaining their home, preparing meals, and shopping to help the clients learn, improve, or retain the social and adaptive skills necessary to live in the community and avoid institutionalization.

The Department pays the supported living provider a daily rate for each day of service provided to a client. The total daily rate paid for each client is individualized and adjusted as frequently as necessary, based on changes to the client's support needs and changes to the administrative component of the rate. To ensure the accuracy and proper authorization of each rate, the Department established a rate review and approval process. After each rate goes through the review and approval process, the rate is entered for payment in the Social Service Payment System.

The steps below describe the established rate review and approval process and subsequent transfer of the approved rate to the Social Service Payment System:

1. The rate is first reviewed and approved by the Developmental Disabilities Administration Regional Administrator or designee.
2. The rate is reviewed by the Department's Rates Manager.
3. The rate is reviewed by the Division of Developmental Disabilities' Residential Program Manager.
4. The rate is approved for payment by the Division of Developmental Disabilities Director or designee.
5. The approved rate is manually transferred from the approval document into an Excel rate file spreadsheet, where the administrative component of the rate is adjusted, if necessary.
6. The approved rate is manually transferred from the rate file to the Social Service Payment System.

Description of Condition

In our prior audit we reported a finding regarding the Administration's inadequate controls to ensure daily rates paid to supported living providers for Medicaid clients were accurate and properly authorized. To address our recommendation, the Administration implemented an electronic rate approval process and strengthened its monitoring and review processes of transferring approved daily rates to the Social Service Payment System for the proper computation of authorized monthly payments to service providers.

During our testing we selected a random sample of 197 monthly payments from a total population of 42,958 to verify the Administration had adequate controls and paid supported living providers for services at authorized daily rates. We found the Administration had adequate controls in place to ensure daily rates paid to supported living providers for Medicaid clients are accurate and properly authorized.

However, we found 1.5% percent (3 out of 197) of the payments were paid at rates greater than the authorized rates.

Cause of Condition

The Department made improvements in its monitoring and review processes to ensure that all daily rate changes were accurately transferred into the Social Service Payment System for the proper computation of authorized monthly payments to service providers. However, it is still not preventing or detecting all superseded daily rates.

Effect of Condition and Questioned Costs

During our testing, we discovered three instances where The Department utilized inaccurate daily rates for calculating monthly payments to providers, resulting in $1,389 of unallowable payments. We are questioning $695 of this amount, which is the federal portion[1] of the unallowable payments.

By projecting sample results to the entire Home and Community Based supported living program, we estimate the amount of potential unallowable monthly payments made by the Department to supported living providers could be $302,976. We are questioning $151,488 of this amount, which is the federal portion[1] of the unallowable payments.

Federal regulations require us to report known and projected questioned costs when likely questioned costs are greater than $10,000 for each type of compliance requirement. We question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support expenditures.

Recommendation

We recommend the Department:

- Strengthen its data entry processes to the Social Service Payment System to ensure approved rates are used for payments to the provider.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of questioned costs.

Department's Response

The Department concurs with this finding.

Department's review found that there were two overpayments. The two overpayments were processed and sent to the Office of Financial Recovery (OFR). The third client's record indicated no overpayment; this information was provided to the State Auditor's Office (SAO).

DSHS is in the process of changing the current payment system using the Social Service Payment System (SSPS) to ProviderOne (P1). The new payment system will have edits that will only allow non-duplicated approved rates to be paid. This will alleviate payment errors caused by duplicate authorizations.

[1] The federal share is calculated using the state's 2013 FMAP rate of 50 percent.

Developmental Disabilities Administration (DDA) and Management Services Division (MSD) are currently using the electronic rate approval process to ensure approved rates are accurately entered into the provider file. Rates will be sent only from the provider file to P1 for payments.

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.

Sample Design

The sample size consisted of 197 monthly payments from a total population of 42,958 monthly payments the Department made during the period of July 1, 2012 to June 30, 2013.

Estimation Methodology

We used the U.S. Department of Health and Human Services, Office of Inspector General RAT-STATS appraisal program to estimate the amount of unallowable payments made to supported living providers.

***Sampling Results:**

The table below shows the value of our universe, sampling frame and questioned costs:

Payments In Universe	Value of Universe	Sample Size	Value of Sample	Unallowable payments	Questioned Costs (federal share)
42,958	$302,601,092	197	$1,440,204	$1,389	$695

Projection of Sampling Results

Projecting our results to the entire Home and Community Based supported living program, we estimate the amount of unallowable payments to supported living providers could range from $1,389 to $793,098.

Precision at the 90-Percent Confidence Level	
	Variable Appraisal
Midpoint	$302,976
Lower Limit	$1,389
Upper Limit	$793,098

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

OMB Circular A-87: Cost Principles for State, Local and Indian Tribal Governments (2 CFR Part 225); Appendix 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:
   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.

OMB Circular A-133 Compliance Supplement, Part 4 (March 2013) - 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) reviewed by the State consistent with the State's documented procedures and system for determining medical necessity of claims; (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 in part:

(a) Except for the limitations and conditions specified in §435.1007 and §435.1008, 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.)

2013-040 The Department of Social and Health Services, Aging and Long-Term Support Administration, did not perform background checks for some in-home care individual providers in accordance with state law.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.720 ARRA- State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative 93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778A Medical Assistance Program (Medicaid; Title XIX)- American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM
Applicable Compliance Component:	Provider Eligibility
Questioned Cost Amount:	$ 182,305.02

Background

Medicaid is a jointly funded state and federal partnership providing coverage for low-income individuals who otherwise might go without medical care. The Medicaid program is the major source of public funding for long-term care services. The Medicaid Home and Community Based Services program permits states to furnish long-term care services to Medicaid beneficiaries in home and community settings, avoiding institutionalization. These services, generally personal care and assistance, are provided in the client's home by individuals or agencies often chosen by the Medicaid client.

During fiscal year 2013, the Department paid approximately $163 million to more than 19,000 in-home service individual providers for their services.

All individual providers must meet basic qualifications to provide services to Medicaid clients. They must be at least 18 years old, authorized to work in the United States and meet the minimum training requirement.

Individual providers also must successfully complete state and national fingerprint-based background checks.
A state background check needs to be completed every two years. If the provider has lived in Washington State less than three years, the Department is to conduct a national fingerprint-based background check.

In a report dated July 31, 2013, "Improving payment systems and monitoring necessary to prevent errors and improve safety", the State Auditor's Office Performance Audit reported concerns regarding a number of caregivers who had been hired despite disqualifying background checks.

Description of Condition

During the previous audit, we reported the Department did not ensure providers completed background checks before rendering services to Medicaid clients.

We reviewed all 19,062 providers who provided services in fiscal year 2013 to ensure they have cleared a background check as required by state regulation.

We found:

- 32 providers' background checks were not completed in a timely manner.
- 48 providers who have disqualifying crime records provided in-home services to Medicaid clients.

Cause of Condition

The Department has procedures to ensure individual providers meet the background check requirements; however, in some cases, the Department did not confirm that provider background checks were complete before allowing providers to render services to Medicaid clients. The Department stated most late background checks related to typos in its background check monitoring database and untimely communication between the Department and providers. The Department also stated that exceptions related to providers who have disqualifying criminal records resulted from some case managers not following Department policies.

Effect of Condition and Questioned Costs

A provider who does not meet the background check requirement is not eligible to provide services to Medicaid clients. Any payments to ineligible providers are unallowable.

The table below summarizes the results of our work and related expenditures:

Description of Condition	Number of Providers	Questioned Costs	Federal Share	State Share
Background checks were not completed in a timely manner.	32	$155,040.04	$77,520.02	$77,520.02
Providers who had disqualifying crime records provided in-home services to Medicaid clients.	48*	$209,570.00	$104,785.00	$104,785.00
Total	80	$364,610.04	$182,305.02	$182,305.02

*During the audit we identified 48 providers who had disqualifying crime records. The Department terminated 39 providers before verification for background check was requested by our office. Three providers were subsequently terminated after our verification request. The Department is in the process of reviewing the remaining six providers.

The Department paid a total of $364,010.04 to the 80 providers who did not complete a required background check at the time of the services or have disqualifying crime records. We are questioning $182,305.02, which is the federal portion of the unallowable expenditures[1].

We question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support its expenditures.

Recommendation

We recommend the Department:

- Improve its internal controls to ensure all providers have cleared background checks prior to providing services to Medicaid clients.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

[1] The federal share is calculated using the state's 2013 FMAP rate of 50 percent.

Department's Response

The Department concurs with this finding, although the contracts for the majority of disqualified individual providers (39 of 48) were terminated by ALTSA prior to the SAO audit.

Corrective Action Plans were developed and implemented as a result of the FY12 audit, however, the FY13 audit does not capture the results of the corrective actions taken by the Department due to the timeframe of the SAO audit.

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

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.

OMB Circular A-87, 2 CFR § 225: 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:
>
> 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, Appendix A.
>
> 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.

RCW 74.39A.056, Criminal history checks on long-term care workers, states:

> (1) (a) All long-term care workers shall be screened through state and federal background checks in a uniform and timely manner to verify that they do not have a criminal history that would disqualify them from working with vulnerable persons. The department must perform criminal background checks for individual providers and prospective individual providers and make the information available as provided by law.
>
> (b) (i) Except as provided in (b)(ii) of this subsection, for long-term care workers hired after January 7, 2012, the background checks required under this section shall include checking against the federal bureau of investigation fingerprint identification records system and against the national sex offenders registry or their successor programs. The department shall require

these long-term care workers to submit fingerprints for the purpose of investigating conviction records through both the Washington state patrol and the federal bureau of investigation. The department shall not pass on the cost of these criminal background checks to the workers or their employers.

(ii) This subsection does not apply to long-term care workers employed by community residential service businesses until January 1, 2016.

(c) The department shall share state and federal background check results with the department of health in accordance with RCW 18.88B.080.

(2) No provider, or its staff, or long-term care worker, or prospective provider or long-term care worker, with a stipulated finding of fact, conclusion of law, an agreed order, or finding of fact, conclusion of law, or final order issued by a disciplining authority or a court of law or entered into a state registry with a final substantiated finding of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in chapter 74.34 RCW shall be employed in the care of and have unsupervised access to vulnerable adults.

(3) The department shall establish, by rule, a state registry which contains identifying information about long-term care workers identified under this chapter who have final substantiated findings of abuse, neglect, financial exploitation, or abandonment of a vulnerable adult as defined in RCW 74.34.020. The rule must include disclosure, disposition of findings, notification, findings of fact, appeal rights, and fair hearing requirements. The department shall disclose, upon request, final substantiated findings of abuse, neglect, financial exploitation, or abandonment to any person so requesting this information. This information must also be shared with the department of health to advance the purposes of chapter 18.88B RCW.

(4) The department shall adopt rules to implement this section.

WAC 388.71.0510, “How does a person become an individual provider?”, states:

In order to become an individual provider, a person must:

(1) Be eighteen years of age or older;

(2) Provide the social worker/case manager/designee with:

(a) A valid Washington state driver's license or other valid picture identification; and either

(b) A Social Security card; or

(c) Proof of authorization to work in the United States.

(3) Complete the required DSHS form authorizing a background check;

(4) Disclose any disqualifying criminal convictions and pending charges, and also disclose civil adjudication proceedings and negative actions as those terms are defined in WAC 388-71-0512;

(5) Effective January 8, 2012, be screened through Washington state's name and date of birth background check. Preliminary results may require a thumb print for identification purposes.

(6) Effective January 8, 2012, be screened through the Washington state and national fingerprint-based background check, as required by RCW 74.39A.056.

(7) Results of background checks are provided to the department and the employer or potential employer unless otherwise prohibited by law or regulation for the purpose of determining whether the person:

(a) Is disqualified based on a disqualifying criminal conviction, a pending charge for a disqualifying crime, civil adjudication proceeding, or negative action; or

(b) Should or should not be employed as an individual provider based on his or her character, competence, and/or suitability.

(8) Disqualifying crimes, civil adjudication proceedings, and negative actions are listed in WAC 388-71-0540 (4), (5) and (6).

(9) For those providers listed in RCW 43.43.837(1), a second Washington state and national fingerprint-based background check is required if they have lived out of the state of Washington since the first national fingerprint-based background check was completed.

(10) The department may require an individual provider to have a Washington state name and date of birth background check or a Washington state and national fingerprint-based background check, or both, at any time.

(11) Sign a home and community-based service provider contract/agreement to provide personal care services to a person under a medicaid state plan or federal waiver such as COPES or other waiver programs.

Aging and Disability Services Administration Long Term Care Manual Chapter 7A- In-home Provider Requirement states:

How often does a background check need to be completed on a provider?

Every two years, unless you have reasonable cause to believe that the provider has been arrested or convicted of a disqualifying crime. In this circumstance, you need to re-run another background check.

2013-041 The Department of Social and Health Services improperly claimed $691,869.10 in federal reimbursement for the Medicaid program.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1305WA5MAP; 5-1305WA5ADM	
Applicable Compliance Component:	Activities Allowed or Unallowed	
Questioned Cost Amount:	$ 691,869.10	

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 Medicaid program spent more than $7.7 billion during fiscal year 2013, of that more than $4.1 billion was federal dollars.

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 medical emergencies 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.

Under the Alien Emergency Medical program, any visit or service not meeting the criteria of emergency situations is considered unallowable. This includes, but is not limited to:

- Physical, occupational, speech therapy, or audiology services.
- Hospital clinic services.
- Office or clinic-based services rendered by a physician, an ARNP, or any other licensed practitioner.
- Laboratory, radiology, and any other diagnostic testing.
- Personal care services.

- Waiver services.
- Nursing facility services.
- Home health services.

The state can choose to pay for non-emergency services for nonqualified aliens. The federal government will not share the cost of these services.

Federal regulations state that an overpayment is the amount that a Medicaid agency paid to a provider in excess of the amount allowable for furnished services. Because services cannot be provided after a beneficiary's death, no medical services are allowable after a beneficiary's death. Accordingly, payments for services claimed to have been provided after a Medicaid beneficiary's death are overpayments.

The Department 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

During our audit, we noted the Department claimed the following unallowable or unsupported expenditures for federal reimbursement:

Medicaid payments for unallowable services

We found 489 non-emergency services provided to 34 nonqualified aliens. The table below summarizes the results of our work:

Description	Number of claims	Payments	Federal Share[7]	State Share
Non-emergency services provided to nonqualified aliens.	489	$1,310,967.47	$655,483.74	$655,483.73

Medicaid payments for unsupported services

We found 126 services provided after a client's death. The table below summarizes the results of our work:

Description	Number of claims	Payments	Federal Share[1]	State Share
Services provided after date of death	126	$72,770.72	$36,385.36	$36,385.36

Cause of Condition

The Department performs reviews to detect unallowable Medicaid payments for services provided to nonqualified aliens and payments for services provided after a client's death. However, it is still not preventing or detecting all unallowable payments.

[1] The federal share is calculated using the state's 2013 FMAP rate of 50 percent.

Effect of Condition and Questioned Costs

When the state provides services to ineligible individuals, or the services are unallowable and/or unsupported, the service cannot be claimed for federal reimbursement. The Department paid $1,383,738.19 to providers for services for unallowable activities. We are questioning $691,869.10, the federal portion of the unallowable costs.

We question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support its expenditures.

Recommendation

We recommend the Department:

- Strengthen internal control procedures to ensure that Medicaid services provided to nonqualified aliens are restricted to emergency services.
- Strengthen internal control procedures for identifying deceased beneficiaries to prevent overpayments.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Agency's Response

This finding involved three administrations within the Department. Each Administration responded individually.

Aging and Long Term Support Administration (ALTSA)

ALTSA concurs with the findings.

Medicaid payments for unallowable services

The Recipient Aid Code (RAC) for these clients changed in January 2012, but the fiscal office was not notified of this change timely. The account coding in Provider One was updated in October 2013 and all of the questioned costs have been returned to CMS. A RAC changes distribution list has been developed to ensure all parties are notified of changes timely in the future.

Medicaid payments for unsupported services

The Department has now fully implemented monthly reports that identify potentially unsupported payments. Reports are reviewed monthly and remedial actions are taken on any identified invalid payment.

Children's Administration (CA)

CA concurs with the findings.

Of the exceptions, two pertain to CA. Since the findings for FY12 with this population, CA has implemented a new payment type to correct the process that allowed these children to be allocated to a Medicaid funding source.

The federal funds for these clients will be returned and we will communicate the information to the Centers for Medicare and Medicaid Services.

Economic Services Administration (ESA)

ESA concurs with the findings for the four Community Services Division (CSD) cases identified as exceptions. ESA will review these cases and take appropriate action as necessary.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit.

Applicable Laws and Regulations

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Section 300, states in part:

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 510, states in part:

p. 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.

Title 42, Code of Federal Regulations, 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

- 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 beneficiaries 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.

q. 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) 182-500-0030, 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:
> (1) Placing the patient's health in serious jeopardy;
> (2) Serious impairment to bodily functions; or
> (3) Serious dysfunction of any bodily organ or part.

Washington Administrative Code (WAC) 182-507-0115, Alien emergency medical program (AEM).

(1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 182-507-0110 is eligible for the alien emergency medical program's scope of covered services described in this section if the person meets (a) and (b) or (c) of this subsection:
  (a) The medicaid agency determines that the primary condition requiring treatment meets the definition of an emergency medical condition as defined in WAC 182-500-0030, 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) Involuntary Treatment Act (ITA) and voluntary inpatient admissions to a hospital psychiatric setting that are authorized by the agency's inpatient mental health designee (see subsection (5) of this section).
(2) If a person meets the criteria in subsection (1) of this section, the agency will cover and pay for all related medically necessary health care services and professional services provided:
  (a) By physicians in their office or in a clinic setting immediately prior to the transfer to the hospital, resulting in a direct admission to the hospital; and
  (b) During the specific emergency room visit, outpatient surgery or inpatient admission. These services include, but are not limited to:
    (i) Medications;
    (ii) Laboratory, X ray, and other diagnostics and the professional interpretations;
    (iii) Medical equipment and supplies;
    (iv) Anesthesia, surgical, and recovery services;
    (v) Physician consultation, treatment, surgery, or evaluation services;
    (vi) Therapy services;
    (vii) Emergency medical transportation; and
    (viii) Nonemergency 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 agency or its designee as described in subsection (3) of this section.
(3) The agency will cover admissions to an LTAC facility or an inpatient PM&R unit if:
  (a) The original admission to the hospital meets the criteria as described in subsection (1) of this section;
  (b) The person is transferred directly to this facility from the hospital; and
  (c) The admission is prior authorized according to LTAC and PM&R program rules (see WAC 182-550-2590 for LTAC and WAC 182-550-2561 for PM&R).

(4) The agency 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 agency or its designee under this program. Exception: Pharmacy services, drugs, devices, and drug-related supplies listed in WAC 182-530-2000, prescribed on the same day and associated with the qualifying visit or service (as described in subsection (1) of this section) will be covered for a one-time fill and retrospectively reimbursed according to pharmacy program rules.

(5) Medical necessity of inpatient psychiatric care in the hospital setting must be determined, and any admission must be authorized by the agency's inpatient mental health designee according to the requirements in WAC 182-550-2600.

(6) There is no precertification or prior authorization for eligibility under this program. Eligibility for the AEM program does not have to be established before an individual begins receiving emergency treatment.

(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. The exception for pharmacy services is also applicable as described in subsection (4) of this section.

  (a) For inpatient care, the certification 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 certification is only for the date of service. If the person is in the hospital overnight, the certification 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 considered not within the scope of service categories as described in WAC 182-501-0060. 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 agency 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 the treatment of the qualifying emergency medical condition;

  (c) Organ transplants, including preevaluations, post operative care, and anti-rejection medication;

  (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 nondurable medical supplies;
(xv) Nonemergency medical transportation;
(xvi) Interpreter services; and
(xvii) Pharmacy services, except as described in subsection (4) of this section.

(9) The services listed in subsection (8) of this section are not within the scope of service categories for this program and therefore the exception to rule process is not available.

(10) Providers must not bill the agency for visits or services that do not meet the qualifying criteria described in this section. The agency will identify and recover payment for claims paid in error.

2013-042 The Department of Social and Health Services, Aging and Long Term Support Administration, did not ensure that unallowable payroll costs charged to the Money Follows the Person Rebalancing Demonstration were refunded to the federal government in a timely manner.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.791 Money Follows the Person Rebalancing Demonstration
Federal Award Number:	1LICMS300141-01-07
Applicable Compliance Component:	Activities Allowed/Unallowed, Allowable Costs/Cost Principles
Questioned Cost Amount:	$106,273.92

Background

The Washington State Department of Social and Health Services, Aging and Long Term Support Administration, administers the Money Follows the Person Rebalancing Demonstration. This federal grant gives the state funding to address the following four key objectives:

- Increase the use of home and community-based, rather than institutional, long-term care services;
- Eliminate barriers or mechanisms that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice;
- Increase the ability of the State Medicaid program to assure continued provision of home and community based long-term care services to eligible individuals who choose to transition from an institution to a community setting; and
- Ensure that a strategy and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community based long-term care services and to provide for continuous quality improvement in such services.

In fiscal year 2013 the State received approximately $19.5 million in federal funds for the program, approximately 31.5 percent of which were payroll expenses.

Grants may only be used to pay for costs that are allowable and related to the grant's purpose.

Description of Condition

One of the 22 employees who charged 100 percent of their payroll expenditures to the grant during fiscal year 2013 did not actually work on the program. Their wages were incorrectly charged to the grant from December 15, 2011 to March 15, 2013.

Cause of Condition

The Department stated the issue originated as an error in payroll coding when the employee was hired on December 15, 2011. The Department identified the payroll coding error in March 2013. When the Department corrected the payroll coding it did not follow policies and procedures in place to ensure federal funds were refunded as required.

Effect of Condition and Questioned Costs

We identified $106,273.92 in direct payroll and benefits incorrectly charged to the grant that were not refunded to the federal government.

We question costs when we find unallowable costs charged to a federal grant that are not refunded to the federal government in a timely manner.

Recommendation

We recommend that Department follow policies and procedures to ensure that identified unallowable costs be refunded to the federal government in an accurate and timely manner.

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

Agency's Response

The Department agrees with the finding.

When this IT position was hired, it was coded to the RCL grant in error. The error was caught and payroll coding corrected in March 2013. Due to staff shortage, the payroll expenditures were not corrected until January 2014. All funds have been returned to the federal government, all RCL paid staff have been reviewed for accuracy and a process established to monitor all RCL every six months.

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.
>
> 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 fora 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. In reporting questioned costs, the auditor shall include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

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

2013-043 The Military Department does not have adequate internal controls to ensure all subrecipients of Homeland Security Grant Program funds receive audits when required and take timely and appropriate corrective action for any audit findings issued.

Federal Awarding Agency:	U.S. Department of Homeland Security
Pass-Through Entity:	None
CFDA Number and Title:	97.067 Homeland Security Grant Program
Federal Award Number:	2008-SG-T8-0023; 2009-SS-T9-0015; 2010-UA-T0-0023; 2010-SS-T0-0084; EMW-2011-UA-00034; EMW-2011-SS-0030; EMW-2012-SS-00115
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

The Washington Military Department administers the Homeland Security Grant Program. The program is intended to improve and significantly enhance the ability of the Nation to prevent, deter, respond to and recover from, threats and incidents of terrorism and to enhance regional preparedness. The Homeland Security Program provides financial assistance to the states (and through the states to local governments) to support activities such as planning, equipment, training, and exercise to address critical resource gaps identified in the assessments and priorities outlined within each state's Homeland Security Strategy.

The majority of the grant funds are distributed to various municipal governments and non-profit organizations. Federal regulations require the Department to take appropriate measures to ensure all subrecipients of funds that expend more than $500,000 in federal funding receive an audit under U.S. Office of Management and Budget (OMB) Circular A-133. In addition, the Military Department is required to identify any findings reported in these audits affecting the Homeland Security Grant and take steps to ensure these findings are addressed by management of the subrecipient agency within six months.

The Department spent $24.1 million in Homeland Security Grant funds in fiscal year 2013, of which $22.9 million was distributed to other governmental entities and non-profit organizations.

The Department adopted new policies related to subrecipient monitoring in July 2013, after the end of the fiscal year audit. Formal procedures are still in the process of being finalized. The Department paid 49 subrecipient entities during fiscal year 2013.

Description of Condition

The Department requires each subrecipient to sign a contract that includes standard terms and conditions, including the requirement for an audit under U.S. Office of Management and Budget (OMB) Circular A-133 if the subrecipient spends more than $500,000 in federal funding during the year. The contract notifies the subrecipient that it must provide the Department's Finance Division with either a copy of their audit report or a letter explaining why it is exempt from having an audit, within nine months of the subrecipient's fiscal year end.

We reported the Department was not following its internal policy and procedures and lacked effective internal controls to ensure all subrecipients received the required audits in the fiscal year 2012 audit. We also reported the Department did not have a consistent method of determining if a finding affected grant funds it awarded, did not consistently follow-up on findings to ensure corrective action was performed by its subrecipients and did not have a process to ensure its subrecipients submitted audit reports or identified why they did not need an audit.

In our current audit we found the Department did not take any action to correct prior reported deficiencies and did not follow-up with any of its 49 subrecipients to determine if an audit report was required.

Cause of Condition

The Department indicated it did not have sufficient time and resources to complete the process of correcting the deficiencies.

Effect of Condition

Without adequate internal controls and procedures, the Department cannot be certain all of its subrecipients complied with federal grant requirements and therefore, cannot ensure that it has met the monitoring requirement of its federal grantor. Furthermore, the Department cannot be certain that its subrecipients respond to and correct deficiencies found in audits in an appropriate and timely manner.

Recommendation

We recommend the Department continue the process of establishing adequate internal controls and policies and procedures over subrecipient monitoring activities to ensure subrecipients comply with required federal and contract provisions. We further recommend the Department communicate these expectations to program staff and establish procedures to ensure expectations are properly met in a timely manner.

Department's Response

We concur with the findings. The department will review internal controls and policies and procedures and develop a corrective action plan to ensure subrecipients comply with required federal and contract provisions. Staff will be trained on new procedures to ensure expectations are properly met.

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*, states in part:

Section 300

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:

(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 for 2012*, Part 3 – Compliance Requirements states:

Section M. Subrecipient Monitoring:

Compliance Requirements

A pass-through entity is responsible for: …

- Subrecipient Audits – (1) Ensuring that subrecipients expending $500,000 or more in Federal awards during the subrecipient's fiscal year for fiscal years ending after December 31, 2003 as provided in OMB Circular A-133 have met the audit requirements of OMB Circular A-133 and that the required audits are completed within 9 months of the end of the subrecipient's audit period; (2) issuing a management decision on audit findings within 6 months after receipt of the subrecipient's audit report; and (3) ensuring that the subrecipient takes timely and appropriate corrective action on all audit findings. In cases of continued inability or unwillingness of a subrecipient to have the required audits, the pass-through entity shall take appropriate action using sanctions.

2013-044 The Military Department did not have internal controls over earmarking requirements to ensure administrative and management costs were accurately monitored for the Homeland Security grant.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	97.067 Homeland Security Grant Program
Federal Award Number:	2009-SS-T0-0015
Applicable Compliance Component:	Earmarking
Questioned Cost Amount:	None

Background

The Washington Military Department administers the Homeland Security Grant Program. The program is intended to improve and significantly enhance the ability of the Nation to prevent, deter, respond to and recover from, threats and incidents of terrorism and to enhance regional preparedness. The Homeland Security Program provides financial assistance to the states (and through the states to local governments) to support activities such as planning, equipment, training, and exercise to address critical resource gaps identified in the assessments and priorities outlined within each state's Homeland Security Strategy.

The Department spent $24.1 million in Homeland Security Grant funds in fiscal year 2013 of which $22.9 million was distributed to subrecipients.

Federal earmarking requirements specify the amount or percentage of the program's funding that may be used for specified activities, including funds provided to subrecipients. The specific requirements for earmarking are unique to each Federal program and are found in the laws, regulations, and the contract provisions for the individual contract or grant agreements pertaining to the program.

During the 2013 fiscal year audit, the Department closed its 2009 Homeland Security Grant. The Department was allowed to retain three percent of the grant award for costs of management and administration. In addition, subrecipients were also allowed to retain three percent of the total amount awarded for management and administrative costs.

Description of Condition

The Department used data from their accounting system and Excel spreadsheets to track earmarking amounts charged to grants. Earmarking amounts were compiled into monthly reports and reviewed by management to ensure the three percent limitation for management and administrative costs was not exceeded. The Excel spreadsheets were the only tool used by management to monitor earmarking charges on a continuous basis.

We found:

- Data from the accounting system and Excel spreadsheets were not being reconciled.
- Excel spreadsheets used to monitor earmarking charges were not accurate and did not reflect the actual amounts charged.
- Monthly reports used by management to track subrecipient earmaking charges were not being reconciled to accounting records.

The Department's spreadsheets indicated the earmarking allowance had been exceeded. We performed further tests and found that actual earmarking amounts charged by the Department were within allowable limits. Based

on the information in the accounting system, we determined the Department did not exceed the allowable limits and we are not questioning any costs.

Cause of Condition

The Military Department attempted to redesign and reconfigure reports used for monitoring during the 2013 fiscal year. During this reconfiguration, links to other documentation and reports used to obtain information for the reports had broken causing the reports to contain incorrect information. The inaccuracies of these reports were not discovered until our audit.

Effect of Condition

The Military Department relies solely on these compiled reports and spreadsheets to ensure both the Department and its subrecipients are complying with earmarking provisions. Due to the inaccuracy of these reports, the Department was not readily aware of the correct amounts charged to the grant and was not monitoring the actual amounts charged on an ongoing basis as required. This condition creates the risk that the Department or it's subrecipients could exceed contract amounts or earmarking limitation.

Recommendation

We recommend the Department establish a process to ensure earmarking charges are accurately and continually monitored and reviewed as required. Furthermore, we recommend the Department utilize its accounting system in this process to monitor and identify earmarking charges to the extent possible and use the system to verify the accuracy of any reports or secondary tools used as an internal control.

In addition, we recommend the Department establish procedures to verify any reports or internal spreadsheets used as an internal control and for monitoring the grant are accurate and reconcile with underlying reimbursement requests.

Department's Response

During the audit, department management discovered that there were errors in the reports and notified the SAO. Corrective action was taken immediately to address these errors. Internal control procedures will be reviewed and a corrective action plan will be established and implemented.

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.
>
> Section 400(d) - Pass-through entity responsibilities.
>
> A pass-through entity shall perform the following for the Federal awards it makes:

(3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.
(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, *Audits of States, Local Governments, and Non-Profit Organizations*, Compliance Supplement 2013 Part 3 – Compliance Requirements, G. Matching, Level of Effort, Earmarking, states in part:

> The specific requirements for matching, level of effort, and earmarking are unique to each Federal program and are found in the laws, regulations, and the provisions of contract or grant agreements pertaining to the program. For programs listed in this Supplement, these specific requirements are in Part 4 – Agency Program Requirements or Part 5 – Clusters of Programs, as applicable.

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Compliance Supplement 2013, Part 4-Department of Homeland Security, CFDA 97.067 Homeland Security Grant, G. Matching, Level of Effort, Earmarking, states in part:

> Not more than five percent of the FY 2006 and FY 2007 grant funds made available to a State may be used for costs of management and administration (42 USC 3714(c)(2); Title III, Pub. L. No. 108-334; Conference Report 109-241 to the FY 2006 Department of Homeland Security Appropriations Act (Pub. L. No. 109-90)). In FYs 2008 and 2009, not more than three percent of the grant funds may be used for costs of management and administration for SHSP and UASI (6 USC 609(a)(11)). In FY 2010, 2011, and 2012, the amount of HSGP funds (exclusive of OPSG funds, if any (House Report 111-157 to FY 2010 Department of Homeland Security Appropriations Act)) that grantees can allocate towards management and administration costs was increased to five percent (FY 2010 Department of Homeland Security Appropriations Act, Pub. L. No. 111-83, Title III (13)(C) and, FY 2011 Department of Defense and Full-Year Continuing Appropriations Act, Pub. L. No. 112-10). Beginning in FY 2011, five percent of OPSG funds may be used for costs of management and administration (discretionary decision by agency based on feedback from state and local stakeholders).

2013-045 The Military Department did not have adequate internal controls over subrecipient monitoring and did not adequately monitor subrecipients of the Homeland Security Grant Program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	97.067 Homeland Security Grant Program
Federal Award Number:	2008-SG-T8-0023; 2009-SS-T9-0015; 2010-UA-T0-0023; 2010-SS-T0-0084; EMW-2011-US-00034; EMW-2011-SS-0030; EMW-2012-SS-00115
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

The Washington Military Department administers the Homeland Security Grant Program. The program is intended to improve and significantly enhance the ability of the Nation to prevent, deter, respond to and recover from, threats and incidents of terrorism and to enhance regional preparedness. The Homeland Security Program provides financial assistance to the states (and through the states to local governments) to support activities such as planning, equipment, training, and exercise to address critical resource gaps identified in the assessments and priorities outlined within each state's Homeland Security Strategy.

The Department spent $24.1 million in Homeland Security Grant funds in fiscal year 2013, of which $22.9 million was distributed to subrecipients.

Pass-through entities are responsible for monitoring the subrecipients' use of federal awards to ensure they comply with federal law and grant agreements.

In our fiscal year 2012 audit, we reported the Department lacked internal controls over subrecipient monitoring activities and did not adequately comply with federal provisions. We noted the Department's subrecipient monitoring policy mostly relied on informing subgrantees of requirements through contracts internal reviews and audits, site visits, and interaction with subrecipients for monitoring activities. In accordance with these practices, minimal reliance was placed on expense reimbursement packages submitted by subrecipients and the Department required support only for subrecipient equipment purchases. Monitoring of all other activities and documentation for non-equipment purchases was only required if specifically requested by the Department and/or checked on a sample basis during monitoring activity by program staff.

The Department used a perpetual calendar to document and schedule monitoring activity for its subrecipients prior to fiscal year 2013. The Department's policy suggested a minimum of one formal monitoring activity a year, but at least one every two years. The calendar contained dates of all activity including both previous and future visits. Policy required program managers to maintain reports and documentation of any monitoring activity performed.

In our prior audit we found the Department's perpetual monitoring schedule/calendar did not list 17 of the 54 subrecipients selected for testing. These 17 subrecipients were either not listed on the calendar, never had any documented monitoring activity on the calendar, or had no monitoring activity during the two fiscal years prior to the audit. We also found the Department was unable to locate a report or any supporting documentation to show the results of 4 of 7 monitoring visits.

Description of Condition

During fiscal year 2013, the Department began the process of correcting the deficiencies noted in the fiscal year audit, but did not formalize any changes. The Department adopted two new policies related to subrecipient

monitoring in July 2013, after the end of the fiscal year audit. It continues to work on correcting the deficiencies noted; however no corrective action was performed during state fiscal year 2013.

In addition, the Department performed six visits to subrecipients to begin the process of becoming compliant with subrecipient monitoring provisions. Our review found that reports for four of the six visits, which had occurred in April and May of 2013 were not completed and signed until October 2013, after the current audit period. Of the two remaining reports completed during the fiscal year, one showed no evidence that documentation supported reimbursements were reviewed.

Cause of Condition

The Department did not have sufficient time and resources to complete the process of correcting noted deficiencies.

Effect of Condition

Without adequate internal controls the Department cannot verify its subrecipients are in compliance with federal requirements and contract provisions. In addition, the Department cannot verify it is reimbursing subrecipients only for allowable and actual costs.

Recommendation

We recommend the Department continue to establish adequate internal controls and policies and procedures over subrecipient monitoring activities to ensure subrecipients comply with required federal and contract provisions. We also recommend the Department only reimburse subrecipients for actual and allowable costs that are supported by documentation in accordance with federal requirements. We further recommend the Department communicate these expectations to all program staff and establish procedures to ensure expectations are properly met in a timely manner.

Department's Response

The Department does not believe that we have reimbursed subrecipients for other than actual and allowable costs. The department will review internal controls and policies and procedures and develop a corrective action plan to ensure subrecipients comply with required federal and contract provisions. Staff will be trained on new procedures to ensure expectations are properly met.

Auditor's Concluding Remarks

We determined the Department relies solely on unsupported A-19s to reimburse all expenditures except equipment purchases. Without examining supporting documents, at least on a sample basis, the Department cannot have reasonable assurance they are only reimbursing actual and allowable costs.

We thank the Department for their cooperation and assistance.

Applicable Laws and Regulations

OMB Circular A-133 Compliance Supplement Subpart C—Auditees

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.

(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, 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 that performance goals are achieved.

(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-87, *Cost Principles for State, Local, and Indian Tribal Governments* (2 CFR 225(repealed 2/14/2014)), (2 CFR 200.403(g))

Appendix A, Section C.- Basic Guidelines, 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.

U.S. Office of Management and Budget Circular A-133, *Compliance Supplement for 2012*, Part 3, states in part:

Section M. Subrecipient Monitoring:

Compliance Requirements

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.