

**Schedule of Findings and Questioned Costs  
For the Fiscal Year Ended June 30, 2014**

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**Federal Findings and Questioned Costs**

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**2014-001**            **The Department of Agriculture does not have adequate internal controls to ensure compliance with federal suspension and debarment requirements for the Food Distribution cluster.**

**Federal Awarding Agency:** U.S. Department of Agriculture  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 10.565 Commodity Supplemental Food Program  
10.568 Emergency Food Assistance Program (Administrative Costs)  
10.569 Emergency Food Assistance Program (Food Commodities)  
**Federal Award Number:** 13137WAWA3Y8005; 14147WAWA3Y8005;  
13127WAWA9Y8105; 13137WAWA9Y8105;  
1413WAWA9Y8105; 14147WAWA9Y8105  
**Applicable Compliance Component:** Suspension and Debarment  
**Questioned Cost Amount:** None

**Background**

The Washington State Department of Agriculture administers the federal Food Distribution Cluster program. This program provides food donated by the U.S. Department of Agriculture to supplement the diets of eligible clients. The Department of Agriculture contracts with food banks and non-profit agencies that determine eligibility and order and deliver food to the clients. In fiscal year 2014 the Department spent over \$1.9 million in administrative funds and provided over \$10 million in food to food banks and non-profit agencies.

Federal requirements prohibit grant recipients of federal awards from contracting with or making subawards to vendors or subrecipients who have been suspended or debarred from doing business with the federal government. The Department is required to verify that all subrecipients, and vendors receiving \$25,000 or more in federal funds, have not been suspended or debarred.

Grantees can meet this requirement by:

- Checking the federal Excluded Parties List System

- Collecting a certification from the vendor or subrecipient
- Adding a clause or condition to the covered transaction with the vendor or subrecipient

The U.S. Department of Agriculture also requires the Department to ensure its subrecipients include a specific certification in all applicable lower tier subawards or contracts. This certification specifies the suspension and debarment requirements and requires the subrecipient or vendor to certify they will include this certification in any lower tier transactions.

During fiscal year 2014 the Department paid subrecipients approximately \$1.7 million in program funds.

### **Description of Condition**

We found the Department did not verify whether 20 subrecipients and one vendor paid in fiscal year 2014 were suspended or debarred. We were able to verify the subrecipients and vendor that received more than \$25,000 had not been suspended or debarred, therefore, we are not questioning costs for these payments.

The Department also did not include the federally required certification in any of their subawards or the applicable vendor contract.

### **Cause of Condition**

The Department was unaware of suspension and debarment requirements and their responsibilities to ensure subrecipients and vendors were not suspended or debarred.

We consider this internal control weakness to be a material weakness.

### **Effect of Condition**

This material weakness in internal controls increases the risk the Department will enter into contracts with subrecipients or vendors who are suspended or debarred from receiving federal funds. Payments to subrecipients or vendors who are suspended or debarred would be unallowable and the Department may have to repay the funding to the grantor. In addition, failure to comply with grant requirements could result in loss of eligibility for future federal awards.

Additionally, by not including the required certification in agreements with subrecipients and vendors, the Department cannot ensure these entities will follow the required regulations and pass them along to any entities they award subawards or contracts to. This could result in the subgrantee or vendor also being noncompliant with federal regulations.

## **Recommendation**

We recommend the Department establish internal controls adequate to ensure:

- All subrecipients receiving federal funds, and vendors receiving more than \$25,000, have not been suspended or debarred prior to entering into contracts.
- All subawards and applicable vendor contracts include the federally required certification regarding suspension and debarment.
- Staff responsible for contracting with subrecipients and vendors receive training on federal suspension and debarment requirements.

## **Department's Response**

*The Department concurs with the auditor's recommendation to establish internal controls regarding federal suspension and debarment requirements.*

*Effective with the new biennial contract period (July 1, 2015 – June 30, 2017) the federal suspension and debarment language will be added to each contract. In addition, program staff will check the federal Excluded Parties List system prior to the contract execution date. The contractor verification documentation will be maintained in each contract file. Staff will require each contractor to include suspension and debarment language in all lower tier agreements. All Food Assistance program staff will receive training and written instructions on federal suspension and debarment requirements by June 30, 2015.*

*We appreciate the opportunity to work with the auditors to ensure the department meets all state and federal requirements in the administration of the Food Assistance program.*

## **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.

*Government Auditing Standards*, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- .11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

Significant deficiency in internal control over compliance. A deficiency, or a combination of deficiencies, in internal control over compliance that is less severe

than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Title 2, Code of Federal Regulations, states in part:

Section 180.210 – Which nonprocurement transactions are covered transactions?

All nonprocurement transactions, as defined in Sec.180.970, are covered transactions unless listed in the exemptions under Sec.180.215.

Section 180.970 – Nonprocurement transaction.

(a) *Nonprocurement transaction* means any transaction, regardless of type (except procurement contracts), including, but not limited to the following:

(1) Grants.

Section 180.220 – Are any procurement contracts included as covered transactions?

(a) Specifically, a contract for goods or services is a covered transaction if any of the following applies:

(1) The contract is awarded by a participant in a non-procurement transaction that is covered under Sec.180.210, and the amount of the contract is expected to equal or exceed \$25,000.

Title 7, Code of Federal Regulations, states in part:

Section 3017.510 Participants' responsibilities.

(a) *Certification by participants in primary covered transactions.* Each participant shall submit the certification in Appendix A to this Part for it and its principals at the time the participant submits its proposal in connection with a primary covered transaction, except that States need only complete such certification as to their principals. Participants may decide the method and frequency by which they determine the eligibility of their principals. In addition, each participant may, but is not required to, check the Nonprocurement List for its principals (Tel. #). Adverse information on the certification will not necessarily result in denial of participation. However, the certification, and any additional information pertaining to the certification submitted by the participant, shall be considered in the administration of covered transactions.

(b) *Certification by participants in lower tier covered transactions.*

(1) Each participant shall require participants in lower tier covered transactions to include the certification in Appendix B to this part for it and its principals in any proposal submitted in connection with such lower tier covered transactions.

(2) A participant may rely upon the certification of a prospective participant in a lower tier covered transaction that it and its principals are not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction by any Federal agency, unless it knows that the certification is erroneous. Participants may decide the method and frequency by which they determine the eligibility of their principals. In addition, a participant may,

but is not required to, check the Nonprocurement List for its principals and for participants (Tel. #).

Title 7, Code of Federal Regulation,

APPENDIX B TO PART 3017— CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION— LOWERTIER COVERED TRANSACTIONS

Instructions for Certification

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
4. The terms *covered transaction*, *debarred*, *suspended*, *ineligible*, *lower tier covered transaction*, *participant*, *person*, *primary covered transaction*, *principal*, *proposal*, and *voluntarily excluded*, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction,” without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions,

unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

*Certification Regarding Debarment, Suspension, Ineligibility an Voluntary Exclusion—Lower Tier Covered Transactions*

- (1) The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
- (2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

**2014-002**            **The Department of Agriculture does not have adequate internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act for the Food Distribution Cluster are filed correctly.**

**Federal Awarding Agency:** U.S. Department of Agriculture  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 10.565 Commodity Supplemental Food Program  
10.568 Emergency Food Assistance Program  
(Administrative Costs)  
10.569 Emergency Food Assistance Program  
(Food Commodities)  
**Federal Award Number:** 13137WAWA3Y8005; 14147WAWA3Y8005;  
13127WAWA9Y8105; 13137WAWA9Y8105;  
1413WAWA9Y8105; 14147WAWA9Y8105  
**Applicable Compliance Component:** Reporting  
**Questioned Cost Amount:** None

### **Background**

The Washington state Department of Agriculture administers the federal Food Distribution Cluster program. This program provides food donated by the U.S. Department of Agriculture to supplement the diets of eligible clients. The Department of Agriculture contracts with food banks and non-profit agencies that determine eligibility and order and deliver food to the clients. In fiscal year 2014 the Department spent over \$1.9 million in administrative funds and provided over \$10 million in food to food banks and non-profit agencies.

Under the Federal Funding Accountability and Transparency Act (Accountability Act), the Office is required to collect and report information on each subaward or amendment of \$25,000 or more in federal funds in the Federal Funding Accountability and Transparency Act Subaward Reporting System. The reporting must be done by the end of the month following the month in which the subaward 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 fiscal year 2014, the Department made 21 new subawards for the program totaling approximately \$1.3 million that would require reporting.

### **Description of Condition**

The Department did not have adequate internal controls in place to ensure the fiscal year 2014 Accountability Act reports were filed. The Department should have reported 21 subawards totaling approximately \$1.3 million during the audit period but did not report any subawards.

The Department's process was to report the funds expended by each subrecipient once per year. The Department was entering these subawards into the FFATA Subaward Reporting System and then amending the submission at the end of the federal fiscal year to match what the subrecipient had expended for that subaward.

### **Cause of Condition**

The Department did not have policies and procedures to ensure it complied with Accountability Act reporting requirements. The employee assigned to file the required reports was not aware of reporting requirements, specifically that the amount required to be reported was the amount awarded to the subrecipient, not the amount of federal funds they actually received. Management was not sufficiently monitoring to ensure federal regulations were met.

We consider these internal control deficiencies to constitute a material weakness.

### **Effect of Condition**

By not properly submitting the required 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 properly. We further recommend that a secondary review is conducted prior to reports being submitted.

### **Department's Response**

*The Department concurs with the auditor's recommendation to establish policies and procedures to ensure all Accountability Act reports are submitted properly and that a secondary review is conducted prior to reports being submitted.*

*By March 16, 2015, all Federal Funding Accountability and Transparency Act (FFATA) reportable amounts will be entered into the federal reporting system by the Food Assistance program staff. The program will submit all future FFATA reportable amounts within the established FFATA timeframes. By June 30, 2015, applicable Food Assistance program staff will receive training and written reporting procedures including a secondary review prior to reports being submitted.*

*We appreciate the opportunity to work with the auditors to ensure the department meets all state and federal requirements in the administration of the Food Assistance program.*

## **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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

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Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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.

**2014-003**            **The Recreation and Conservation Office does not have adequate internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act for the Pacific Coast Salmon Recovery Program are filed accurately.**

**Federal Awarding Agency:** U.S. Department of Commerce  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 11.438 Pacific Coast Salmon Recovery – Pacific Salmon Treaty Program  
**Federal Award Number:** NA11NMF4380267, NA11NMF4380165, NA11NMF4380159, NA12NMF4380230, NA12NMF4380098, NA13NMF4380251, NA13NMF4380096  
**Applicable Compliance Component:** Reporting  
**Questioned Cost Amount:** None

### **Background**

The Recreation and Conservation Office is the state agency that manages grants that pay for outdoor recreation opportunities, protect the state’s wildlife habitat and farmland and help restore salmon habitat. The Recreation and Conservation Office, through the Recreation and Conservation Funding Board, administers the federal Pacific Coast Salmon Recovery program.

The Office spent approximately \$27.7 million in Pacific Coast Salmon Recovery funds in fiscal year 2014, of which \$19.6 million was distributed to subrecipients.

Under the Federal Funding Accountability and Transparency Act (Accountability Act), the Office is required to collect and report information on each subaward or amendment of \$25,000 or more in federal funds in the Federal Funding Accountability and Transparency Act Subaward Reporting System. The reporting must be done by the end of the month following the month in which the subaward 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.

We reported a finding in our fiscal year 2012 audit for subawards not being reported in the Federal Funding Accountability and Transparency Act Subaward Reporting System. The prior audit finding number was 12-06.

In fiscal year 2014, the Office made 113 new subawards for the program totaling \$20 million that would require reporting.

## **Description of Condition**

We found the Office did not have adequate internal controls in place to ensure the fiscal year 2014 Accountability Act reports were filed. The Office was reporting state agencies in the Federal Funding Accountability and Transparency Subaward Reporting System even though these transfers of funds are not considered subawards and are therefore not reportable. Although these transfers are not reportable, any subaward made by a state agency receiving funds must be reported by the Office. The Office was not reporting the subawards made by other state agencies.

## **Cause of Condition**

Office management did not monitor reporting activity to ensure it complied with the Act. The employee assigned to file the required reports was not aware of reporting requirements. The employee and management were not aware that state agencies should not be reported as subrecipients. They were also not aware that they had to report subawards made by other state agencies they transfer money to.

We consider these control deficiencies to be a material weakness.

## **Effect of Condition**

We randomly selected and tested 16 subawards and determined three awards to state agencies were improperly reported and three other subawards were reported 52 days late. We expanded our testing and determined the Office reported eight agreements, totaling \$3,465,359, with state agencies that should not have been reported.

We also determined the state agencies that received federal funds from the Office made two subawards totaling \$237,146 that should have been reported. The Office did not report these awards.

By not correctly submitting the required 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 update its policies and procedures to ensure Accountability Act reports are submitted accurately.

## **Office's Response**

*RCO agrees with the finding and would like to thank the State Auditor's Office for a thorough review of our agency's Accountability Act reporting.*

*As a result, RCO will no longer report on pass through funds given to other state agencies. Additionally, RCO will ask the state agencies to report what portion of the funds have been*

*passed through to subreipients. Any amount passed from the agencies, to non-state subreipients, will be reported in RCO's Accountability Act reports. This will begin with the next monthly reporting in March 2015.*

### **Auditor's Concluding Remarks**

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

### **Applicable Laws and Regulations**

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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

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met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

**Material noncompliance.** In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

**Material weakness in internal control over compliance.** A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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.fsr.gov> specify.

**2014-004**

**The Military Department did not maintain required documentation for payroll costs charged to the National Guard program.**

**Federal Awarding Agency:** U.S. Department of Defense  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 12.401 National Guard Military Operations and Maintenance (O&M) Projects  
**Federal Award Number:** W91K23-11-2-1000  
**Applicable Compliance Component:** Allowable Costs / Cost Principles  
**Questioned Cost Amount:** \$66,924

**Background**

The Washington state Military Department administers the National Guard Military Operations and Maintenance Projects. This federal cooperative agreement supports the operations and maintenance of Army National Guard (ARNG) and Air National Guard (ANG) facilities and provides authorized service support activities to National Guard units and personnel.

In fiscal year 2014, the Department spent approximately \$19 million in federal funds on the program, approximately 37 percent of which were payroll expenses.

Recipients may use grant money only for costs that are allowable and related to the grant's purpose. Federal regulations specify the documentation that must be kept to support employee compensation charged to federal grants. If an employee works solely on the grant program and all related payroll costs are charged to that grant, the employee must certify this in writing at least semi-annually. Payroll costs of employees who work on multiple programs must be supported by personnel activity reports, such as timesheets. These reports must:

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

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

**Description of Condition**

During all of fiscal year 2014, a manager who billed his time to both state and federal program codes did not prepare required timesheets. Federal regulations, as well as the Department's own policies, required that the employee prepare monthly timesheets.

### **Cause of Condition**

The manager was unaware of the grant requirement to create and maintain documentation to support time and effort even though it is required by both federal regulations and the Department's policies. Additionally, the Department did not adequately monitor the employee's activities to ensure the required documentation was maintained.

### **Effect of Condition and Questioned Costs**

We found \$66,924 in direct payroll and benefit charges to the National Guard Military Operations and Maintenance Projects grants that were not supported in compliance with federal requirements and Department policies.

In accordance with federal audit requirements, 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. The federal grantor could disallow these charges and require the Department to pay back the money.

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 time and effort charged to a federal grant is supported by required documentation. We also recommend that Department management review time sheets and certifications to ensure charges to the grant are adequately supported.

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

### **Department's Response**

*We concur with the SAO finding. We have taken action to inform the manager and the division director that timesheets are required when billing a federal grant. The manager is currently filling out timesheets which are approved by the division director when billing federal grants and will continue to complete timesheets as long as this funding is available.*

### **Auditor's Concluding Remarks**

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

### **Applicable Laws and Regulations**

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

The auditee shall:

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

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.

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

Appendix B, Section 8(h):

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

- (1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a reasonable official(s) of the governmental unit.
- (2) No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.
- (3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semiannually and will be signed by the employee or supervisory official having firsthand knowledge of the work performed by the employee.
- (4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection 8.h.(5) of this appendix unless a statistical sampling system (see subsection 8.h.(6) of this appendix) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:
  - (a) More than one Federal award
  - (b) A Federal award and a non--Federal award
  - (c) An indirect cost activity and a direct cost activity
  - (d) Two or more indirect activities which are allocated using different allocation bases, or
  - (e) An unallowable activity and a direct or indirect cost activity.
- (5) Personnel activity reports or equivalent documentation must meet the following standards:

- (a) They must reflect an after the fact distribution of the actual activity of each employee,
  - (b) They must account for the total activity for which each employee is compensated,
  - (c) They must be prepared at least monthly and must coincide with one or more pay periods, and
  - (d) They must be signed by the employee
  - (e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:
    - (i) The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;
    - (ii) At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and
    - (iii) The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.
- (6) Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort.
- (a) Substitute systems which use sampling methods (primarily for Temporary Assistance to Needy Families (TANF), Medicaid, and other public assistance programs) must meet acceptable statistical sampling standards including:
    - (i) The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results except as provided in subsection 8.h.(6)(c) of this appendix;
    - (ii) The entire time period involved must be covered by the sample; and
    - (iii) The results must be statistically valid and applied to the period being sampled.
  - (b) Allocating charges for the sampled employees' supervisors, clerical and support staffs, based on the results of the sampled employees, will be acceptable.
  - (c) Less than full compliance with the statistical sampling standards noted in subsection 8.h.(6)(a) of this appendix may be accepted by the cognizant agency if it concludes that the amounts to be allocated to Federal awards will be minimal, or if it concludes that the system proposed by the governmental unit will result in lower costs to Federal awards than a system which complies with the standards.

- (7) Salaries and wages of employees used in meeting cost sharing or matching requirements of Federal awards must be supported in the same manner as those claimed as allowable costs under Federal awards.

**2014-005      The Department of Commerce does not have adequate internal controls to ensure HOME Investment Partnerships 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 Partnerships Program  
**Federal Award Number:** M11-SG-53-0100, M12-SG53-0100, M13-SG53-0100  
**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: the HOME General Purpose program and HOME Tenants Based Rental Assistance program. The General Purpose 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 2014, the Department requested more than \$6 million of HOME funds. The program generated approximately \$1,367,000 in program income.

During our fiscal year 2012 and 2013 audits we determined the Department’s HOME program did not have adequate internal controls to ensure that program income was used prior to drawing federal funds. This was reported as finding numbers 2013-004 and 12-08.

As part of our fiscal year 2014 audit, we reviewed the Department’s finding and corrective action plan to determine the status of the prior audit finding. The Department’s action plan was to review the current process to reconcile the bank balance to the Integrated Disbursement and Information System (IDIS). The Department also planned to refine its methodology to ensure 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 and Accounting Department planned to update their procedures manual.

The completion date of the corrective action was listed as September 2014.

### **Description of Condition**

We found the Department's internal controls are still not adequate to ensure all HOME program income is used before requesting additional federal HOME funds. We commend the Department for taking steps to reduce the program income account balance, including more regularly entering information in IDIS. However, it did not fully implement its corrective action plan during fiscal year 2014.

Specifically, we found program income was not drawn prior to requesting federal funds. Federal draws made in fiscal year 2014 totaled \$6,067,757. The Department made an effort to reduce the balance of the program income account by making draws from October 2013 to June 2014 for a total of approximately \$1.5 million, but did not draw program income to zero at any time prior to drawing additional federal funds. The average program income account balance at the time of making a federal draw was approximately \$323,000. The program income account balance on June 30, 2014 was \$225,554.

### **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 IDIS. 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.

We consider these internal control weaknesses to constitute a material weakness.

### **Effect of Condition**

As a result of this condition the Department received excess federal funds of approximately \$226,000 during fiscal year 2014. Without a process to ensure that all available program income receipts are drawn prior to drawing federal funds the Department cannot ensure it is in compliance with federal requirements.

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:

- Draw all available program income receipts prior to drawing federal funds.
- Update 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 current process has been evaluated and new procedures identified. The new process will be accomplished by having the Accounting Office:*

- *Develop and maintain a "check" register showing the deposits made to the HOME Program Income account*
- *Identify the balance in the HOME Program Income account at a minimum of twice a month*
- *Require the approval of the Federal Draw and the HOME Program Income payment be completed by the supervisor that oversees banking authorizations.*
- *Require the approval of the HOME Program Income account bank reconciliation to be conducted by the Accounting Manager*
- *Update the desk manual for HOME program income and federal draws to include the process identified above*

### **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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with

provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, as follows:

.11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

**Deficiency in internal control over compliance.** A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

**Material noncompliance.** In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

**Material weakness in internal control over compliance.** A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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*, 2. Post-award Policies, 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 2014, 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

15 days 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.

**2014-006**      **The Department of Commerce does not have adequate internal controls to ensure subrecipients spending \$500,000 or more in total federal dollars obtain audits as required.**

**Federal Awarding Agency:**      U.S. Department of Housing and Urban Development  
U.S. Department of Justice  
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 Program  
16.575      Crime Victim Assistance  
66.468      Capitalization Grants for Drinking Water State Revolving Funds  
66.483      Disaster Relief Appropriations Act (DRAA) Hurricane Sandy Capitalization Grants for Drinking Water State Revolving Funds  
93.568      Low Income Home Energy Assistance  
93.569      Community Services Block Grant

**Federal Award Number:**      M11-SG-53-0100; M12-SG53-0100; M13-SG53-0100; 2013-VA-GX-0047 ; FS-99083907; FS-99083908; FS-99083909; FS-99083910; FS-99083911; FS-99083912; FS-99083913; 2011G992201; 2011G992204; 2012G992201; 2012G99BX11; 2013G992201; 2014G992201; 2014G995623  
G-12B1WACOSR; G-13B1WACOSR; G-14B1WACOSR

**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 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. 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 has received an audit finding for not ensuring all subrecipients receive their required audits during the three previous audits. These were reported as finding numbers 2013-003, 12-09 and 11-10. During the prior audit, 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.

During fiscal year 2014 the Department paid 234 subrecipients approximately \$148 million from the federal programs included in our review with approximately \$14 million of these funds going to 174 subrecipients who spent less than \$500,000 from the Department.

### **Description of Condition**

We reviewed the Department's process to ensure audit reports are obtained from subrecipients and determined the Department had improved their internal controls sufficiently to ensure subrecipients who spent over \$500,000 in federal funds from the Department receive an audit. However, we also determined the Department is not ensuring that subrecipients who spent less than \$500,000 from the Department obtain a required audit if required. The Department has developed a process to ensure that these subrecipients are contacted to determine whether they required and received an audit but did not begin using this process until after the audit period.

### **Cause of Condition**

While the Department does have a policy in place for ensuring organizations that spent less than \$500,000 in federal funds from them receive an audit, if required, it did not follow this policy during the audit period. We consider this control weakness to be a significant deficiency.

### **Effect of Condition**

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 it has met the monitoring requirements of its federal grantor.

### **Recommendation**

We recommend the Department ensure that its existing audit policy and procedures are clearly communicated, understood, and followed by staff.

### **Department's Response**

*The Department concurs with the finding. The fiscal year 2014 audit recommends the Department ensure that its existing audit policy and procedures are clearly communicated,*

*understood, and followed by staff. The Department is currently drafting new policies and procedures to articulate roles and responsibilities for the processes. After new policies and procedures are finalized, the Department will communicate to all levels of the agency.*

*During fiscal year 2014, the Department began a process of identifying and contacting subrecipients that received less than \$500,000 from the Department and may have received federal funding from other sources. At the time of this audit, the process was not fully implemented. The Department will continue to enhance and implement a process to help ensure the Department identifies and obtains the required audit reports. Specifically, the Internal Auditor will work with program areas to identify a proactive approach to identify subrecipients that received less than \$500,000 from the Department and may have received federal funding from other sources. Once identified, the Internal Auditor and program areas will follow-up with subrecipients to ensure they submit their required audits to the Department. Audits will be filed using the Department's Contract Management System.*

### **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.

#### 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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements

that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

**2014-007**      **The Department of Commerce does not have adequate internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act for the Crime Victim Assistance Program are filed accurately.**

**Federal Awarding Agency:** U.S. Department of Justice  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 16.575 Crime Victim Assistance  
**Federal Award Number:** 2013-VA-GX-0047  
**Applicable Compliance Component:** Reporting  
**Questioned Cost Amount:** None

### **Background**

The Department of Commerce is the lead state agency charged with enhancing and promoting sustainable community and economic vitality in Washington. The Department of Commerce, through the U.S. Department of Justice, administers the federal Crime Victim Assistance program.

The Department spent approximately \$7.7 million in Crime Victim Assistance funds in fiscal year 2014, of which \$7.4 million was distributed to subrecipients.

Under the Federal Funding Accountability and Transparency Act (Accountability Act), the Department is required to collect and report information on each subaward or amendment of \$25,000 or more in federal funds in the Federal Funding Accountability and Transparency Act Subaward Reporting System. The reporting must be done by the end of the month following the month in which the subaward 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 fiscal year 2014, the Department made 77 subawards for the program totaling \$4.8 million that would require reporting. In addition, the Department of Social and Health Services (DSHS) received federal funds from the Department and made 44 subawards totaling approximately \$2.5 million that should have been reported.

### **Description of Condition**

We found the Department did not have adequate internal controls in place to ensure the fiscal year 2014 Accountability Act reports were filed properly. The Department reported \$2,894,958, which was transferred to DSHS as a subaward. The transfers of funds from one state agency to another are not considered a subaward and, therefore, should not have been reported. In addition, we found DSHS made 44 subawards, totaling \$2,464,633, that were not reported as required by the Department.

We randomly selected and reviewed 12 subawards that were reported by the Department and determined that, while the reported subaward data was accurate, all 12 subawards were filed late. Of the 12 subawards, 11 were filed 108 days late, and one was filed 78 days late.

### **Cause of Condition**

The employee assigned to file the required reports was not aware of all reporting requirements. The employee did not know a state agency should not be reported as a subrecipient, or that the Department had to report subawards made by another state agency they transfer money to. There was no independent review or management oversight of the employee's work to verify reports were being filed completely and accurately.

We consider these control deficiencies to be a material weakness.

### **Effect of Condition**

By not correctly submitting the required 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 properly and timely. We further recommend that a secondary review is conducted prior to reports being submitted.

### **Department's Response**

*The Department concurs with the finding. The Department will be drafting a new policy and procedures to ensure all Accountability Act reports are submitted properly and timely.*

*The program has established a new process to include dual controls. Administrative support staff enters the information into the Federal Funding Accountability and Transparency Subaward Reporting System and the program manager reviews and submits the information. In addition, because the programs ability to enter the information in a timely way is dependent on the grant being entered into the system by the federal funder, when the program is unable to enter the information before the deadline the program will document the inability to enter it with screen shots of the system and email correspondence with the federal program manager.*

*The Department will also ensure that subawards through other Washington State Agencies are reported.*

### **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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

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Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either

individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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.

**2014-008**            **The Employment Security Department does not have adequate internal controls to ensure transportation reimbursement payments to Trade Adjustment Assistance program participants are allowable and accurate.**

**Federal Awarding Agency:**            U.S. Department of Labor  
**Pass-Through Entity:**                None  
**CFDA Number and Title:**            17.245    Trade Adjustment Assistance  
**Federal Award Number:**            TA-24376-13-55-A-53  
    TA-22690-12-55-A-53  
    TA-21249-11-55-A-53  
**Applicable Compliance Component:** Activities Allowed or Unallowed  
    Allowable Costs/Cost Principles  
**Questioned Cost Amount:**            \$ 1,544  
**Likely Questioned Cost Amount:**    \$ 159,560

## **Background**

The Employment Security Department administers the Trade Adjustment Assistance grant to assist eligible workers who are unemployed because of international trade. The United States Department of Labor certifies companies where foreign trade was a cause of the worker's job loss or threat of job loss. Once a company is certified, the Employment Security Department is responsible for determining what training and education services and benefits each employee is eligible for, how long they are eligible to receive these benefits and how much they are allowed to receive. The Department may also use federal grant funds to provide reimbursement for transportation costs.

Participants must be preapproved to be reimbursed for travel costs. This preapproval is calculated based on the actual distance the participant must travel and must be documented on a request for transportation/subsistence allowance form. Once they are determined eligible and begin training, the participant must submit a weekly transportation/subsistence allowance form to receive a payment. According to program requirements, the participant must have their instructor sign the form to verify they attended class on the days for which they submitted reimbursement.

The Departmental process is for one employee to maintain a tracking spreadsheet that shows the preapproved daily mileage amount. This tracking spreadsheet is updated regularly and participants are removed when they are no longer eligible. When a participant submits a transportation/subsistence allowance form it is sent to this employee for review. The employee is responsible for comparing the reimbursement request to the tracking spreadsheet to ensure the amount requested was accurate. They also must review to ensure the form was signed by the participant's instructor.

The Department spent approximately \$8.5 million in federal program funds in fiscal year 2014 with approximately \$700,000 paid directly to participants for transportation costs.

### **Description of Condition**

The Department did not have adequate internal controls to ensure transportation reimbursement payments were allowable and for the proper amounts.

We tested 40 payments totaling \$6,106 for transportation reimbursements and found that in 20 instances the Department's internal controls did not function as intended. Specifically:

- Eleven reimbursements did not match the approved amount on the tracking spreadsheet or the participant was not on the spreadsheet.
- Four reimbursements were not supported by transportation/subsistence allowance form and therefore the required instructor's signatures were missing.
- Five reimbursements were missing from the tracking spreadsheet and were not supported by transportation/subsistence allowance forms.

Additionally, 14 of the payments we tested were not adequately supported. We found:

- Seven instances when there was no supporting documentation to verify if payments were accurate and allowable,
- Five payments were calculated incorrectly and not detected.
- Two payments lacked adequate documentation and included incorrect calculations.

### **Cause of Condition**

Management did not adequately monitor or review the work of Department staff and does not have written policies or procedures in place to ensure transportation reimbursements are allowable and calculated accurately.

The Department is not keeping the documentation required to support payments. The Department stated the reason supporting documentation was missing in some cases is they destroyed the Transportation/Subsistence Allowance forms after payments were entered into its payment system instead of retaining them as required by federal regulations and state law. The tracking spreadsheet used to monitor payments is updated regularly, with participants removed when they are no longer eligible. Therefore, no historical records are maintained. Due to the lack of supporting documentation we were unable to determine where in the review process the breakdown in internal controls occurred for each payment.

We consider these internal control weaknesses to be a significant deficiency.

### **Effect of Condition and Question Costs**

Without adequate internal controls in place, the Department risks making unallowable payments with federal funds and cannot ensure reimbursements for transportation to

participants are accurate. The Department paid \$1,544 to participants that was either not allowable or unsupported. Because we used a statistical sampling method to select transactions for testing, we estimate the amount of likely questioned costs to be \$159,560.

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 establish and follow written policies and procedures sufficient to ensure transportation payments to participants are accurate and allowable. We recommend these procedures include the retention of supporting documentation in accordance with state and federal laws and regulations and a secondary review or other form of management oversight.

### **Department's Response**

*The Employment Security Department appreciates the feedback received from the State Auditor's Office and agrees with their recommendations. The following actions will be taken to improve the program and to ensure that transportation payments to participants are accurate and allowable:*

- *Establishing written policies and procedures to address program requirements.*
- *Initiated a separation of duties and verification of documented information. One individual will enter the obligation in the case management system and participant tracing spreadsheet and a second individual will verify information entered is accurate and complete.*
- *All payment supporting documentation will be scanned and documented to meet the Federal and State's record retention guidelines.*
- *One individual will enter the payment information and another individual will verify the payment before delivering payment batch to vendor payment unit.*
- *The department will create new internal control procedures that will be reviewed and monitored by management on an ongoing basis*

### **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.

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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

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OMB Circular A-87 states in part:

General Principals for Determining Allowable Costs

**C. Basic Guidelines**

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

The Washington State Office of Financial Management's State Administrative & Accounting Manual (SAAM), states in part:

Section 20.15.40

There are five interrelated components of an internal control framework: control environment, risk assessment, control activities, information and communication, and monitoring. These components make up the minimum level of internal control an agency needs to have in place and are the basis against which internal control is evaluated.

To implement the framework, management develops the detailed policies, procedures, and practices to fit their agency's operations, and ensures that they are built into and are an integral part of operations. If an agency considers the framework components in its planning efforts and builds them into its daily processes, the agency will be poised to achieve the maximum benefit for the lowest cost.

Section 20.15.40.c

Control activities help ensure risk responses are effectively carried out and include policies and procedures, manual and automated tools, approvals, authorizations, verifications, reconciliations, security over assets, and segregation of duties. These

activities occur across an agency, at all levels and in all functions, and are designed to help prevent or reduce the risk that agency objectives will not be achieved.

## Revised Code of Washington (RCW)

Section 40.14.060: Destruction, disposition of official public records or office files and memoranda – Record Retention Schedules

(1) Any destruction of official public records shall be pursuant to a schedule approved under RCW 40.14.050. Official public records shall not be destroyed unless:

- (a) Except as provided under RCW 40.14.070(2)(b), the records are six or more years old; or
- (c) The originals of official public records less than six years old have been copied or reproduced by any photographic or other process approved by the state archivist which accurately reproduces or forms a durable medium for so reproducing the original.

State Government General Records Retention Schedule (SGGRRS) Version 5.1 (August 2011)

### 3.4 GRANTS MANAGEMENT

The function relating to the administration of grants either issues by the state or received by state agencies. Records include grant applications, grantor and grantee correspondence and official responses, grant contacts, fiscal records, reports, administrative correspondence, grant products, and other related records.

#### DESCRIPTION OF RECORDS

##### Grants Received by State Agencies (GS 23004)

Documentation of grant projects and funds received and expended by state agencies. May include copies of Requests for Proposals (RFPs), applications, notifications of grant awards, fiscal reports and supporting documentation, reports and correspondence related to grant monitoring, audit reports, status reports, compliance reports, grants modifications requests, progress reports and final reports.

#### Retention and Disposition Action

Retain for 6 years after end of grant period then destroy.



information into the participant management system. There was no secondary review of the information that was entered into this system to verify the accuracy of the information and that only eligible participants were entered.

### **Cause of Condition**

The Department did not have written policies and procedures in place to ensure only eligible participants receive services and benefits. Additionally, management did not sufficiently monitor or review the work of Department staff to ensure that it was accurate and complete and did not establish segregation of duties. The Department stated insufficient staffing was the primary reason for the lack of a secondary review.

We consider these control weaknesses to be a significant deficiency.

### **Effect of Condition**

By not monitoring to ensure eligibility determinations are made properly, the Department risks providing services to ineligible participants. This could lead to federal funds being used to pay for benefits and services for ineligible participants and could put the Departments at risk the federal grantor will take actions that could adversely affect the program and/or the program funding.

### **Recommendation**

We recommend the Department establish and follow written policies and procedures sufficient to ensure that only eligible participants receive services and benefits. We recommend these procedures include a secondary review, or other form of managerial oversight, to ensure compliance with federal requirements.

### **Department's Response**

*The Employment Security Department appreciates the feedback received from the State Auditor's Office and agrees with their recommendations. The following actions will be taken to improve the program and to ensure that only eligible participants receive services and benefits:*

- *Establishing written policies and procedures to address program requirements.*
- *Implemented a new process to ensure that only eligible participants receive the benefits*
- *Initiated separation of duties, by establishing one individual to determine the eligibility for benefits using the General Unemployment Insurance Design Effort (GUIDE) system with second individual entering information into the Case Management System.*
- *Increased managerial oversight to ensure program compliance.*
- *The department will create new internal control procedures that will be reviewed and monitored by management on an ongoing basis.*

## 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:

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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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

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#### Section 20.15.40

There are five interrelated components of an internal control framework: control environment, risk assessment, control activities, information and communication, and monitoring. These components make up the minimum level of internal control an agency needs to have in place and are the basis against which internal control is evaluated.

To implement the framework, management develops the detailed policies, procedures, and practices to fit their agency's operations, and ensures that they are built into and are an integral part of operations. If an agency considers the framework components in its planning efforts and builds them into its daily processes, the agency will be poised to achieve the maximum benefit for the lowest cost.

#### Section 20.15.40.c

Control activities help ensure risk responses are effectively carried out and include policies and procedures, manual and automated tools, approvals, authorizations, verifications, reconciliations, security over assets, and segregation of duties. These

activities occur across an agency, at all levels and in all functions, and are designed to help prevent or reduce the risk that agency objectives will not be achieved.

OMB Circular A-133 Compliance Supplement, part 4 information for the Trade Adjustment Assistance Program, states in part:

E. Eligibility

1. Eligibility for Individuals

a. *Department of Labor Certification and Qualifying Separations*

*TAA* – In order to be eligible for training and other reemployment services under the TAA program, an individual must be an adversely affected worker covered under a DOL certification, and have a qualifying separation which occurred (i) on or after the impact date specified in the certification as the beginning of the import caused unemployment or underemployment ,and (ii) before the expiration of the 2-year period beginning on the date on which the Secretary of Labor issued the certification for his or her group or, if earlier, before the termination date, if any, specified in the certification (19 USC 2272; 29 CFR section 90.16).

b. *Training*

Under the Trade Act of 2002, workers must be enrolled in their approved training within 8 weeks of the issuance of the certification or within 16 weeks of their most recent qualifying separation, whichever is later, unless this requirement is waived prior to reaching those deadlines (19 USC 2291(a)(5)(A) and (c)).

Under the Trade Act of 2009 or 2011, workers must be enrolled in their approved training within 26 weeks of the issuance of the certification or their most recent qualifying separation, whichever is later, unless this requirement is waived prior to reaching those deadlines (19 USC 2291(a)(5)(A)(II) and (c)), as amended by Section 1801(a), ARRA, 123 Stat 375 and 376)

c. *Maximum Number of Weeks for Receipt of Approved Training*

Under the Trade Act of 2002, the maximum duration for any approvable training program is 130 weeks, and no individual shall be entitled to more than one training program under a single certification (19 USC 2293(a)).

Under the Trade Act of 2009, the maximum duration for any approvable training program is 156 weeks and no individual shall be entitled to more than one training program under a single certification (19 USC 2293(a), as amended by Section 1823, ARRA, 123 Stat 377 and 378).

Under the Trade Act of 2011, the maximum duration for any approvable training program is 130 weeks and no individual shall be entitled to more than one training program under a single certification (19 USC 2293(a) as amended by Section 213 of Pub. L. No. 112-40).

**2014-010**

**The Department of Transportation does not have adequate internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act for the Highway Planning and Construction grant program are filed accurately.**

<b>Federal Awarding Agency:</b>	U.S. Department of Transportation
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	20.205 Highway Planning and Construction (Federal-Aid Highway Program)
	20.205A Highway Planning and Construction (Federal-Aid Highway Program) – American Recovery and Reinvestment Act (ARRA)
	20.219 Recreational Trails Program
	23.003 Appalachian Development Highway System
<b>Federal Award Number:</b>	Numerous
<b>Applicable Compliance Component:</b>	Reporting
<b>Questioned Cost Amount:</b>	None

## **Background**

The Washington State Department of Transportation administers the Highway Planning and Construction grant program. The program is intended to assist state transportation agencies in the planning and development of an integrated, interconnected transportation system important to commerce and travel by constructing and preserving the National Highway System, including federal-aid highways and other public roads.

The Department of Transportation spent approximately \$840 million in Highway Planning and Construction funds during fiscal year 2014, of which \$264 million was distributed to subrecipients.

Under the Federal Funding Accountability and Transparency Act (Accountability Act), the Department is required to collect and report information on each subaward or amendment of \$25,000 or more in federal funds in the Federal Funding Accountability and Transparency Act Subaward Reporting System. The reporting must be done by the end of the month following the month in which the subaward 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 fiscal year 2014, the Department executed 972 awards to subrecipients. Of those subawards, 488 awards, totaling approximately \$274 million, had obligation amounts which required reporting under the Accountability Act.

## **Description of Condition**

The Department does not have adequate internal controls in place to ensure that Accountability Act reports are filed correctly for subawards or amendments using federal funds, resulting in the Department reporting both state administered contract awards as well as subawards to local agencies when only subawards are required to be reported.

We found the Department improperly reported 455 Federal-aid contracts which should not have been reported under the Accountability Act. In total, approximately \$528 million was over reported by the Department.

## **Cause of Condition**

The Department did not have adequate policies and procedures in place to ensure it complied with Accountability Act reporting requirements.

The over reported awards were the result of staff in a division that does not make subawards not understanding the reporting requirements. Department management stated the contracts issued by this division were determined to be reportable when the Accountability Act was first enacted. The reporting in this division was not subject to an independent review or managerial oversight.

We consider these control deficiencies to constitute a material weakness.

## **Effect of Condition**

By not correctly submitting the required 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. We further recommend that a secondary review is conducted prior to reports being submitted.

## **Department's Response**

*Thank you for the opportunity to respond to the draft finding for the Washington State Department of Transportation (WSDOT), as part of the 2014 Statewide Single Audit (SWSA). The Department values an independent review of its operations including adherence to federal laws and regulations.*

*As indicated in the finding, WSDOT reported 455 Federal-aid contracts which should not have been reported under the Federal Funding Accountability and Transparency Act finding (FFATA). Since being informed of this situation, WSDOT has discontinued the reporting of*

*these Federal-aid contracts not sub-awarded to other local governments or entities. In addition, the WSDOT office responsible to track these Federal-aid contracts, is putting processes in place whereby they will confer with the grantor should questions on proper accountability reporting arise and document their decisions. Given the lack of clarity in reporting requirements when they first took effect, WSDOT chose to report the Federal-aid contracts, presuming reporting would serve the tax payers better than having not reported these contracts.*

*We appreciate the assistance from your staff and look forward to continuing our working relationship based on a high level of professional standards.*

### **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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

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Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

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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.

**2014-011**            **The Department of Health does not have adequate internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act for the Drinking Water State Revolving Fund are filed correctly.**

<b>Federal Awarding Agency:</b>	Environmental Protection Agency
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	66.468    Capitalization Grants for Drinking Water State Revolving Funds
	66.483    Disaster Relief Appropriations Act (DRAA) Hurricane Sandy Capitalization Grants for Drinking Water State Revolving Funds
<b>Federal Award Number:</b>	FS-99083913-0
<b>Applicable Compliance Component:</b>	Reporting
<b>Questioned Cost Amount:</b>	None

## **Background**

Capitalization grants are awarded to states to create and maintain Drinking Water State Revolving Fund programs. States can use the grant funds to establish a revolving loan fund to assist public water systems finance the costs of infrastructure needed to achieve or maintain compliance with Safe Drinking Water Act requirements and protect the public health objectives of the Act. The Drinking Water State Revolving Fund can be used to provide loans and other types of financial assistance for publicly owned community water systems, privately owned community water systems and non-profit/non-community water systems. States may also set aside certain percentages of their capitalization grant or allotment for various activities that promote source water protection and enhance water systems management.

The Department of Health is responsible for collecting loan applications and determining which water districts are eligible to receive funding. They are also responsible for submitting reports required by the federal government. The Department of Commerce manages the contracts once they have been executed to ensure water districts follow grant guidelines. They also send the Department of Health information needed to submit the federally required reports.

The Department of Health spent almost \$55.8 million in federal funds in fiscal year 2014, of which over \$50 million was distributed to subrecipients.

Under the Federal Funding Accountability and Transparency Act, the Department is required to collect and report information on each subaward or amendment of \$25,000 or more in federal funds in the Federal Funding Accountability and Transparency Act Subaward Reporting System. The reporting must be done by the end of the month following the month in which the subaward was made. The intent of the Accountability Act is to hold governments

accountable for spending decisions and to reduce wasteful spending. The Environmental Protection Agency requires the Department to report 69 percent of the final federal grant amount, which is the amount that is actually used to fund Drinking Water contracts. If the subawards during a fiscal year equal more than the federal reportable amount, they are required to report up to the reportable amount and not over.

### **Description of Condition**

The Department of Health did not have adequate internal controls in place to ensure the fiscal year 2014 Accountability Act reports were filed correctly. The Departmental process was for the Department of Commerce to select contracts that should be submitted for the Accountability Act as they are executed. The selected contract information was then sent to Department of Health staff to be entered and submitted. The Department of Health did not verify the accuracy of the information provided by the Department of Commerce before submitting the Accountability Act reports.

### **Cause of Condition**

The Department of Health did not have adequate written policies and procedures in place to ensure reports were filed accurately. The employee responsible for submitting the Accountability Act report was not aware of the total amount of the federal award that was supposed to be reported. Additionally, management did not monitor or review the work of Department staff to ensure reports were filed accurately.

We consider these internal control weaknesses to be a material weakness.

### **Effect of Condition**

The Department of Health should have reported four subawards totaling \$14,834,310 for fiscal year 2014, but only reported \$13,621,220. One of the subawards was under reported by \$1,213,090.

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, including suspending or terminating the award or withholding future awards.

### **Recommendation**

We recommend that the Department establish written policies and procedures over the selection and reporting of subawards. We further recommend that a secondary review be conducted of reports and that the Department verifies the accuracy of the subaward information.

## **Department's Response**

*The Department concurs with the finding.*

*In January 2015, the Department amended the FFATA reporting for grant award #FS99083913, adding \$1,213,090 in sub-awards.*

*The Department has also revised its written FFATA reporting procedures for the Drinking Water State Revolving Fund grants. These revised procedures include a secondary review conducted by the Drinking Water Budget and Performance Accounting Section Manager after receiving the information from the Department of Commerce.*

*Once the secondary review is complete, the reports will be forwarded to the Central Administration Grants Unit for input into the Federal FFATA reporting system. The FFATA input will be reviewed and approved by a Grants Unit Supervisor prior to submittal to the Federal FFATA reporting system.*

## **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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and

material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

Administrative Conditions for Grant #FS-99083913-0 include, in part:

16. Subaward Reporting 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 [www.fsrs.gov](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 [www.fsrs.gov](http://www.fsrs.gov) specify.

**2014-012                    The Workforce Training and Education Coordinating Board did not have adequate internal controls to ensure it meets federal level of effort requirements for the Career and Technical Education Grant.**

**Federal Awarding Agency:** U.S. Department of Education  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 84.048 Career and Technical Education – Basic Grants to States (Perkins IV)  
**Federal Award Number:** V048A130047, V048A120047, V048A110047  
**Applicable Compliance Component:** Level of Effort  
**Questioned Cost Amount:** None

**Background**

The Workforce Training and Education Coordinating Board administers the Career and Technical Education – Basic Grants to States (Perkins IV). The federal grant provides funds for programs that offer courses of study to ensure students are career ready. The Board provides federal funds to high schools and skills centers through the Office of Superintendent of Public Instruction and to colleges through the State Board for Community and Technical Colleges. The Career and Technical Education Grant focuses on the academic achievement of career and technical education students, strengthens the connections between secondary and postsecondary education, and improves state and local accountability.

The Board spent approximately \$19.5 million in Career and Technical Education funds in fiscal year 2014.

The grant states that the Board must meet general and administrative level of effort requirements. To meet the administrative level of effort requirement, a state must provide from non-federal sources an amount that is not less than the amount provided by the state from non-federal sources for the preceding fiscal or program year. The Board is responsible for tracking the administrative level of effort.

**Description of Condition**

The Board did not have adequate internal controls in place to ensure that administrative level of effort requirements were met. During our fieldwork, Board staff did not track administrative level of effort and could not inform us how it was tracked in the past.

**Cause of Condition**

Management stated one staff member was previously responsible for tracking the administrative level of effort for all three agencies to ensure that the total level of effort was met each year. When this staff member left the Board during the audit period, it did not

assign anyone to take over this duty. The Board also did not have written policies and procedures in place to ensure that staff accurately tracked level of effort.

We consider these internal control weaknesses to constitute a significant deficiency.

### **Effect of Condition**

By not properly tracking and documenting that level of effort requirements are being met, the Board cannot be sure it was in compliance with this requirement for the Career and Technical Education grant.

### **Recommendation**

We recommend the Board establish and follow written policies and procedures to ensure the accurate tracking of administrative level of effort for agencies that receive Career and Technical Education funding.

### **Board's Response**

*The Workforce Training and Education Coordinating Board (Workforce Board) in partnership with the State Board for Community and Technical Colleges (SBCTC) and the Office of Superintendent of Public Instruction (OSPI), will identify and analyze options to incorporate maintenance of effort and administrative matching funds review semi-annually during state fiscal year.*

*The Workforce Board has established agency guidelines related to maintenance of effort determination, and will require the collection of maintenance of effort data and certification from its subaward recipients each calendar quarter instead of the historical annual review. In addition to the maintenance of effort, data collection and certification will include the subaward recipients' reporting of the nonfederal matching funds required for grant administration.*

*The Workforce Board recognizes the significance and the priority of internal controls over the analysis and certification of maintenance of effort, and the reporting of matching funds in a timely manner, allowing ample time for any necessary corrective action.*

### **Auditor's Concluding Remarks**

We thank the Board for its cooperation and assistance throughout the audit. We will review the status of the Board'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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In

this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

U.S. Code Title 20 § 2413. State administrative costs.

(a) General rule

Except as provided in subsection (b), for each fiscal year for which an eligible agency receives assistance under this chapter, the eligible agency shall provide, from non-Federal sources for the costs the eligible agency incurs for the administration of programs under this chapter, an amount that is not less than the amount provided by the eligible agency from non-Federal sources for such costs for the preceding fiscal year.

**2014-013**

**The Workforce Training and Education Coordinating Board does not have adequate internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act are filed.**

**Federal Awarding Agency:** U.S. Department of Education  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 84.048 Career and Technical Education – Basic Grants to States (Perkins IV)  
**Federal Award Number:** V048A130047, V048A120047, V048A110047  
**Applicable Compliance Component:** Reporting  
**Questioned Cost Amount:** None

### **Background**

The Workforce Training and Education Coordinating Board administers the Career and Technical Education – Basic Grants to States (Perkins IV). The federal grant provides funds for programs that offer courses of study to ensure students are career ready. The Board provides federal funds to high schools and skills centers through the Office of Superintendent of Public Instruction and to colleges through the State Board for Community and Technical Colleges. The Career and Technical Education Grant focuses on the academic achievement of career and technical education students, strengthens the connections between secondary and postsecondary education, and improves state and local accountability.

The Board spent approximately \$19.5 million in Career and Technical Education funds in fiscal year 2014, of which \$7.5 was distributed to subrecipients.

During fiscal year 2014, \$6,971,439 in new subawards was granted to 90 local school districts by the Office of Superintendent of Public Instruction. The Office was the only agency that made subawards with the federal grant funds during fiscal year 2014.

Under the Federal Funding Accountability and Transparency Act (Accountability Act), the Board is required to collect and report information on each subaward or amendment of \$25,000 or more in federal funds in the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS). The reporting must be done by the end of the month following the month in which the subaward 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 Board did not have adequate internal controls in place to ensure the fiscal year 2014 Accountability Act reports were filed correctly for subawards made using federal funds. The Board did not report 90 subawards totaling \$6,971,439 for fiscal year 2014.

### **Cause of Condition**

Board staff was not aware that subawards and amendments of \$25,000 or more needed to be reported in the Accountability Act reporting system. This requirement is specified in the grant agreement, but the staff that oversee the program had not read the agreement in its entirety.

We consider these internal control weaknesses to constitute a material weakness.

### **Effect of Condition**

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

### **Recommendation**

We recommend the Board establish and follow written policies and procedures to ensure all Accountability Act reports are submitted as required. We further recommend the Board ensure all federal grant award terms and conditions are reviewed to ensure the Board is aware of all federal grant requirements.

### **Board's Response**

*The Workforce Training and Education Coordinating Board (Workforce Board) as the prime awardee, has established processes to record each subaward executed and to determine whether the subaward is reportable in the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS). Beginning in December 2014, the agency, in Partnership with the Office of Superintendent of Public Instruction (OSPI), developed its planned FSRS reporting process to include maintaining a copy of each report filed. The agency will add a quarterly review of all new subawards executed each quarter in order to provide an additional review for FFATA applicability. In addition, the agency will add a secondary review of draft FSRS reports each quarter before submitting the reports to ensure all information has been entered accurately.*

### **Auditor's Concluding Remarks**

We thank the Board for its cooperation and assistance throughout the audit. We will review the status of the Board'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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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.



specific unit or individual and management did not provide sufficient oversight to ensure this requirement was met.

We consider these internal control weaknesses to constitute a material weakness.

### **Effect of Condition**

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 it has met the monitoring requirements of its federal grantor.

### **Recommendation**

We recommend the Department develop and follow policies and procedures to ensure all subrecipients receive required audits.

### **Department's Response**

*The Department of Early Learning (DEL) appreciates the Washington State Auditor's (SAO) work regarding the internal controls over subrecipients A-133 audit compliance. DEL concurs with the auditor's findings.*

*DEL lacked clear communication to program staff on their requirement for tracking A-133 audits and the Finance Division did not have a process in place to ensure that program staff was meeting their obligations*

*DEL has begun the process of updating policies and procedures for identifying grantees who may meet the threshold for A-133 audit requirements. To address the finding DEL is working on adding additional functionality in the Integrated Contact Information System (ICIS) to assist in tracking of subrecipients of federal funds who require an A-133 audit. In addition, DEL will also contact grantees who are under the threshold, but may receive federal funds from other sources. DEL will establish communication of audit report due dates to contractors and track the information. All communications will be tracked by Program Staff and the Federal Grants Manager in the Finance Division.*

*DEL will provide training to all grants program staff and finance staff on the policies and procedures for subrecipient A-133 audit compliance. Any new requirements will be properly communicated with applicable agency staff. The Federal Grants Manager is responsible for the A-133 audit compliance and will provide a quarterly report to the Internal Control Officer updating the status of A-133 audit compliance and tracking, staff training, and any policy and procedure changes.*

### **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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal

control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

**Deficiency in internal control over compliance.** A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

**Material noncompliance.** In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

**Material weakness in internal control over compliance.** A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

**Significant deficiency in internal control over compliance.** A deficiency, or a combination of deficiencies, in internal control over compliance that is less severe

than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

**2014-015**

**The Department of Early Learning does not have adequate internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act are filed accurately for the Race to the Top-Early Learning Challenge and Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting programs.**

**Federal Awarding Agencies:** U.S. Department of Education  
U.S. Department of Health and Human Services

**Pass-Through Entity:** None

**CFDA Numbers and Titles:** 84.412 Race to the Top-Early Learning Challenge  
93.505 Affordable Care Act - Maternal, Infant, and Early Childhood Home Visiting Program Formula, Expansion, and Development Grants to States

**Federal Award Numbers:** D89MC23536; X02MC23096; S412A120035

**Applicable Compliance Component:** Reporting

**Questioned Cost Amount:** None

## **Background**

The Washington state Department of Early Learning administers the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program and the Race to the Top-Early Learning Challenge (RTT) program. The MIECHV program supports and strengthens cooperation and coordination and promotes linkages among various programs that serve pregnant women, expectant fathers, young children, and families in tribal communities and result in high-quality, comprehensive early childhood systems in every community. The Race to the Top- Early Learning Challenge grant aids to improve and develop early learning programs for children.

The Department spent approximately \$7.5 million in MIECHV funds in fiscal year 2014 and made one subaward for approximately \$8.7 million. The Department spent approximately \$12.8 million in RTT-Early Learning Challenge funds in fiscal year 2014 and made 15 subawards totaling approximately \$13 million.

Under the Federal Funding Accountability and Transparency Act (Accountability Act), the Department is required to collect and report information on each subaward or amendment of \$25,000 or more in federal funds in the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS). The reporting must be done by the end of the month following the month in which the subaward 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 found the Department did not have adequate internal controls in place to ensure the fiscal year 2014 Accountability Act reports were filed correctly for subawards made using MIECHV and RTT program funds.

The Department reported four contracts totaling \$447,200 that should not have been reported because they were not subawards.

For the RTT program, the Department was unable to demonstrate it reported any of the 15 subrecipient awards, totaling \$13,020,593 during fiscal year 2014. The information in the FSR system showed all reports were filed after the audit period and the Department was unable to provide documentation showing the reports were filed prior to June 30, 2014.

## **Cause of Condition**

The Department did not have policies and procedures to ensure it complied with 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 or management oversight of the employee's work to verify reports were being filed completely and accurately.

We consider these control deficiencies to constitute a material weakness.

## **Effect of Condition**

By not correctly submitting the required 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. We further recommend that a secondary review is conducted prior to reports being submitted.

## **Department's Response**

*The Department of Early Learning (DEL) appreciates the Washington State Auditor's (SAO) work regarding the internal controls over the agency's Federal Funding Accountability and Transparency Reporting. DEL concurs with the MIECHV portion of the auditor's findings regarding these reports.*

*The RTT grant was issued by the Department of Education under the incorrect DUNs number for the State of Washington. This was reported to the Department of Education and the RTT grant was revised and available to DEL for reporting in February 2013.*

*The employee responsible acted upon a good faith effort and reported the RTT program in the FSRS system starting February 25, 2013. The employee used the revise/reopen report function in the system and provided the information as a running total for the program year. For FY14 the employee used the copy report function in FSRS to create a new report. The employee then continued to revise the report as needed based on the understanding of the reporting requirements for FFATA. The FSRS system shows that the report was revised/reopened for FY14 on September 5<sup>th</sup>, December 17<sup>th</sup>, January 6<sup>th</sup>, February 12<sup>th</sup>, and May 23<sup>rd</sup>. The employee did not print copies of the reports because FSRS showed when the reports were updated.*

*Upon notification of the improper reporting per SAO, DEL established a detailed procedure to assist employees with FFATA reporting. DEL has also assigned an additional employee to FFATA reporting and implemented a review process by the Comptroller before any reports are released in the system to ensure information is reported accurately. Starting in January 2015 DEL updated the FFATA reporting process to include maintaining Integrated Contact Information System (ICIS) reports of contracts and a pdf copy of the FFATA report filed for each grant.*

### **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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or

regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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.

**2014-016**

**The Department of Health does not have adequate internal controls to ensure it meets federal level of effort requirements for the Public Health Emergency Preparedness and National Bioterrorism Hospital Preparedness Programs.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.069 Public Health Emergency Preparedness 93.889 National Bioterrorism Hospital Preparedness Program
<b>Federal Award Number:</b>	5U90TP000559
<b>Applicable Compliance Component:</b>	Level of Effort
<b>Questioned Cost Amount:</b>	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 \$11.8 million in Public Health Emergency Preparedness funds and \$7.1 million in Hospital Preparedness Program funds in fiscal year 2014.

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 Hospital Preparedness grant.

The recipient of grant funds acknowledges acceptance of the award terms and conditions when it draws funds through the grant payment system. If the recipient does not agree with the terms of the award, they are required to notify the Grants Management Officer.

We reported findings in our fiscal year 2011, 2012 and 2013 audits that noted the Department did not have adequate internal controls to ensure it complied with level of effort requirements for either grant program. These were previously reported as finding numbers 11-20, 12-21, and 2013-012.

## **Description of Condition**

The Department implemented new internal controls at the beginning of the audit period to ensure its level of effort requirements were met. The Department's process was for a staff member to run a quarterly report to track the specific costs used to meet the level of effort requirements. The amounts were then entered into a log and compared to the amount needed to meet federal requirements. The staff member responsible for monitoring the program's level of effort left the program in March, 2014. No other staff member continued the monitoring process for the remainder of the fiscal year.

We also determined the Department knew it would be noncompliant with the level of effort requirements for the National Bioterrorism Hospital Preparedness program before the staff member left the position, but did not inform the grantor as required by the grant terms and conditions.

## **Cause of Condition**

Although the Department implemented internal controls to monitor its level of effort, management did not ensure the process continued when the staff member left the program. The Department did not have written policies and procedures in place to ensure staff accurately tracked its level of effort. There were also no procedures that provided guidance to staff about how to proceed if they would not meet the level of effort requirement.

We consider these internal control weaknesses to constitute a material weakness.

## **Effect of Condition**

We determined that, while the Department met the level of effort requirements for the Public Health Emergency Preparedness program, it was \$114,902 under the requirement for the National Bioterrorism Hospital Preparedness Program. Additionally, by not contacting the federal grantor and informing them that the Department would not meet its level of effort requirement for the year, the Department was not in compliance with its grant agreement.

The grant agreement allows the grantor to take action for noncompliance that can include temporarily withholding funds, wholly or partly suspending or terminating the award and withholding further awards from the program

## **Recommendation**

We recommend the Department establish and follow written policies and procedures to ensure the accurate tracking, documenting and reporting of administrative level of effort. We also recommend the Department inform their grantor when it becomes aware it will be noncompliant with grant requirements

## Department's Response

*We concur with the finding.*

*The Department will establish and follow written policies and procedures for tracking, documenting, and reporting the level of effort.*

*The Department will also consult with its federal grantor to determine the best method for how and when to provide notification in the event that the required level of effort will not be met.*

*Once the Department has received guidance on this matter, it will also be included in the policies and procedures.*

## Auditor's Concluding Remarks

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

## Applicable Laws and Regulations

U.S. Office of Management and Budget (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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

The Cooperative Agreement number 5U90TP000559 Terms and Conditions states, in Note 27:

**ADDITIONAL REQUIREMENTS:** Successful applicants must comply with the administrative requirements outlined in 45 Code of Federal Regulations (CFR) Part 92, as appropriate....

**2. ACCEPTANCE OF THE TERMS OF AN AWARD:**

By drawing or otherwise obtaining funds from the grant payment system, the recipient acknowledges acceptance of the terms and conditions of the award and is obligated to perform in accordance with the requirements of the award. If the recipient cannot accept the terms, the recipient should notify the Grants Management Officer.

The Department of Health and Human Services Grants Policy Statement states in part:

II: Terms and Conditions of Award - Effect and Order of Precedence

Any waiver or deviations from these terms and conditions must be requested and approved in writing by the Grant Management Officer. OPDIV determination of applicable terms and conditions of award or a GMO's denial of a request to change the terms and conditions is discretionary and not subject to appeal.

A recipient indicates acceptance of an award and its associated terms and conditions by requesting and accepting funds from PMS or the designated HHS payment office for that award. If a recipient cannot accept an award, including the legal obligation to perform in accordance with its provisions, it should notify the GMO immediately upon receipt of the NoA. If resolution cannot be reached, the GMO will void the grant. Once an award is accepted by a recipient, the contents of the NoA are binding on the recipient and the OPDIV unless and until modified by a revised NoA signed by the GMO.

45 Code of Federal Regulations Part 92

Subpart C--Post-award Requirements

Reports, Record Retention, and Enforcement

Sec. 92.43 Enforcement.

- a. Remedies for noncompliance. If a grantee or subgrantee materially fails to comply with any term of an award, whether stated in a Federal statute or regulation, an assurance, in a State plan or application, a notice of award, or elsewhere, the awarding agency may take one or more of the following actions, as appropriate in the circumstances:
  1. Temporarily withhold cash payments pending correction of the deficiency by the grantee or subgrantee or more severe enforcement action by the awarding agency,
  2. Disallow (that is, deny both use of funds and matching credit for) all or part of the cost of the activity or action not in compliance,
  3. Wholly or partly suspend or terminate the current award for the grantee's or subgrantee's program,
  4. Withhold further awards for the program, or
  5. Take other remedies that may be legally available.

**2014-017**            **The Department of Health does not have adequate 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:** U3REP090228, 2U90TP017010, 1U90TP000559,  
5U90TP000559  
**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 \$11.8 million in Public Health Emergency Preparedness funds and \$7.1 million in Hospital Preparedness Program funds in fiscal year 2014.

Under the Federal Funding Accountability and Transparency Act (Accountability Act), the Department is required to collect and report information on each subaward or amendment of \$25,000 or more in federal funds in the Federal Funding Accountability and Transparency Act Subaward 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.

We reported a finding in our fiscal year 2013 audit for subawards not being reported in the Federal Funding Accountability and Transparency Subaward Reporting System. This was reported as finding number 2013-013.

## **Description of Condition**

We found the Department did not have adequate internal controls in place to ensure the fiscal year 2014 Accountability Act reports were filed correctly.

We reviewed 11 subawards, totaling \$5,016,623, and determined four, totaling \$2,747,770, were not reported during the audit period. Additionally, one subaward for \$65,250 was over reported by \$591,000.

## **Cause of Condition**

Although the Department has procedures in place for collecting contractor information that will be submitted on the Accountability Act Report, they do not have written policies or procedures for how to enter and submit the report accurately. The process in place was not adequate to ensure reports were filed accurately. Specifically, the four missing subawards and one improperly reported subaward were not detected by the staff submitting the reports even though the supporting documentation contained the proper information. Additionally, management did not adequately monitor or review work of Department staff to ensure it was accurate and complete.

We consider these internal control weaknesses to constitute a material weakness.

## **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 written policies and procedures to ensure all Accountability Act reports are submitted as required. We further recommend that a secondary review is conducted prior to reports being submitted.

## **Department's Response**

*Four subawards were not reported by the Department of Health (DOH) because the federal award did not appear in the FFATA Subgrant Reporting System (FSRS). The federal awards have now been added to the FSRS by the federal awarding agency and the FFATA information submitted in FSRS.*

*This condition existed during the FY13 Single Audit. The State Auditor's Office recommended that the Department send the federal awarding agency an email notifying them when the federal award fails to appear in the FSRS. The Department implemented this recommendation effective January 2014. This effective date is subsequent to the date these four sub-awards were executed.*

*In regards to the one subaward over reported by \$591,000: This was a data input error. An extra digit was inadvertently added to the sub-award amount. This error was not identified prior to the report being submitted in FSRS.*

*It is currently the practice of the Department for the Grants Unit Supervisor to review and approve FFATA data prior to being submitted in FSRS.*

*The Department will update its written procedures for submitting Accountability Act reports, adding additional detail. The procedures will include the review and approval of FFATA data by the Grants Unit Supervisor prior to being submitted in FSRS and the necessary steps for ensuring all FFATA data is submitted in a timely manner.*

### **Auditor's Concluding Remarks**

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

### **Applicable Laws and Regulations**

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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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

- I. Reporting Sub-awards and Executive Compensation.
  - a. Reporting of first-tier sub-awards.
    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 sub-award 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 sub-award 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.

**2014-018**            **The Department of Social and Health Services does not have adequate internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act for the Substance Abuse and Mental Health Services Projects of Regional Significance programs are filed accurately.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.243 Substance Abuse and Mental Health Services Projects of Regional and National Significance  
**Federal Award Number:** 1U79SP020155-01; 1H79SM060196-01; 5H79SM060196-02; 5H79SM060196-03; 5H79SM060196-04; 1U79TI024265-01; 5U79TI024265-02; 1U79TI023477-01; 5U79TI023477-02; 5U79TI023477-03  
**Applicable Compliance Component:** Reporting  
**Questioned Cost Amount:** None

### **Background**

The Department of Social and Health Services, Division of Behavioral Health and Recovery, administers the Substance Abuse and Mental Health Services Projects of Regional and National Significance program. This federal grant program is designed to address priority substance abuse treatment, prevention and mental health needs of regional and national significance. The Department spent approximately \$4.9 million of grant funds during fiscal year 2014.

Under the Federal Funding Accountability and Transparency Act (Accountability Act), the Department is required to collect and report information on each subaward or amendment of \$25,000 or more in federal funds in the Federal Funding Accountability and Transparency Act Subaward Reporting System. The reporting must be done by the end of the month following the month in which the subaward 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.

During fiscal year 2014 the Department made 39 subawards, totaling \$5,901,671 that were reportable under Accountability Act reporting requirements.

### **Description of Condition**

We found the Department did not have adequate internal controls in place to ensure the fiscal year 2014 Accountability Act reports were filed properly. During fiscal year 2014 the Department awarded 39 subgrants, totaling \$5,901,671 that should have been reported in

accordance with Accountability Act requirements. None of these 39 subgrants were reported. The Department did report four subawards totaling \$115,000, but we determined these were actually contracts and interagency agreements and should not have been reported.

We consider these internal control weaknesses to be a material weakness.

### **Cause of Condition**

The Department did not have adequate written policies and procedures in place to ensure reports were filed accurately. We determined there was no one assigned to submit Accountability Act reports and management was not monitoring to ensure reports were filed.

### **Effect of Condition**

By not correctly submitting the required 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 written policies and procedures over the reporting of subawards. We further recommend that management ensure the reports are filed and are accurate and complete.

### **Department's Response**

*The Department concurs with this finding.*

*The Department's Budget and Finance Director for BHSIA will develop policy, procedures and internal controls to collect and report information on each subaward or amendment of \$25,000 or more in federal funds in the Federal Funding Accountability and Transparency Act Subaward Reporting System.*

*The Department's Budget and Finance Director for BHSIA will develop and maintain a tracking methodology and validation procedure to ensure reports are timely and properly filed in accordance with the Federal Funding Accountability and Transparency Act (Accountability Act) of 2006.*

### **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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 Communicating Deficiencies in Internal Control, Fraud, Noncompliance with Provisions of Laws, Regulations, Contracts, and Grant Agreements, and Abuse states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively. ...

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

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Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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.

**2014-019**

**The Department of Social and Health Services does not have adequate internal controls in place to ensure subrecipients of the Block Grants for Prevention and Treatment of Substance Abuse and Substance Abuse and Mental Health Services Projects of Regional Significance programs receive required audits.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.243 Substance Abuse and Mental Health Services Projects of Regional and National Significance  
93.959 Block Grants for Prevention and Treatment of Substance Abuse

**Federal Award Number:** 2B08TI010056-12; 2B08TI010056-13;  
2B08TI010056-14; 1U79SP020155-01;  
1H79SM060196-01; 5H79SM060196-02;  
5H79SM060196-03; 5H79SM060196-04;  
1U79TI024265-01; 5U79TI024265-02;  
1U79TI023477-01; 5U79TI023477-02;  
5U79TI023477-03

**Applicable Compliance Component:** Subrecipient Monitoring  
**Questioned Cost Amount:** None

## **Background**

The Department of Social and Health Services, Division of Behavioral Health and Recovery, administers the Block Grants for Prevention and Treatment of Substance Abuse. The Department subawards most of the funds to counties, tribes, nonprofit organizations and other state agencies to develop prevention programs and provide treatment and support services. The Department spent almost \$32 million of grant funds during fiscal year 2014. Of this amount, over \$10 million was passed through to 58 subrecipients.

The Department also administers the Substance Abuse and Mental Health Services Projects of Regional Significance. This federal grant program is designed to address priority substance abuse treatment, prevention and mental health needs of regional and national significance. The Department spent approximately \$4.9 million of grant funds during fiscal year 2014. Of this amount, approximately \$1.9 million was passed through to 37 counties, school districts and nonprofit organizations as subrecipients.

Federal regulations require the Department to monitor the grant-funded activities of subrecipients. This includes ensuring organizations that spend \$500,000 or more in federal grant money during a fiscal year receive an audit of expenditures and related internal controls, in accordance with the federal Office of Management and Budget Circular A-133. The

Department is also required to follow up on any findings a subrecipient receives that may affect the federal program. These requirements ensure grant money is used for authorized purposes and within 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.

### **Description of Condition**

The Department does not have adequate internal controls in place to verify:

- Its subrecipients received required audits
- Findings are followed-up on
- Funds received are being reported for audit purposes

During the audit period the Department received audit reports from counties electronically and used a tracking spreadsheet to monitor the results of the audits. We found the Department verified only seven of the 33 counties (21 percent) received a required audit. We found no evidence that the Department verified whether the 25 tribal subrecipients, 4 school districts or 3 nonprofit organizations obtained a required audit.

One of the subrecipients received an audit finding affecting the Block Grants for Prevention and Treatment of Substance Abuse program, but the Department did not follow up as required by federal regulations.

### **Cause of Condition**

The Department had a process in place to track the audits of the counties, but only did so until November of 2013. The employee who performed the duty left their position and no one at the Department continued the process.

The tribal audit reports were not tracked during the audit period because the program staff thought the Department's Office of Indian Policy was receiving and tracking whether required audits were performed. This was not the case and the Office of Indian Policy staff stated it was the responsibility of the program staff to receive and track the audits.

Department management is responsible for establishing internal controls within the program. During the audit period, management had not established adequate internal controls by monitoring to ensure federal requirements were met. We consider this internal control deficiency to be a material weakness.

### **Effect of Condition**

By not verifying its subrecipients obtained required A-133 audits, the Department cannot ensure it complied with federal regulations. Additionally, by not following up on subrecipient findings related to the program, the Department cannot ensure the identified audit issue(s) are resolved.

We determined that while all 33 counties and 25 tribes had A-133 audit reports issued, seven of the tribes did not report having received federal Block Grant funds. Because the Department did not review the A-133 audit reports, they were not aware that their subrecipients were not reporting the Block Grant funding they received. When a subrecipient does not report receiving federal program funds their audit will not include this program and they will therefore not be compliant with federal regulations.

We also determined one county received a finding related to the Block Grant funds received from the Department but the Department did not perform finding follow up as required. Without this finding follow up the Department cannot be sure the subrecipient has corrected the identified problem.

### **Recommendation**

We recommend the Department develop policies and procedures and improve its monitoring of subrecipients by:

- Verifying all required audits occurred.
- Following up on all subrecipient audit findings related to the program.
- Ensuring subrecipients report the federal funds that are received from the Department.

### **Department's Response**

*The Department concurs with this finding.*

*The Department will conduct a review of existing contract's terms to ensure the audits of expenditures and internal controls, per OMB circular A-133, are required in contract language conducted by organizations that spend \$500,000 or more in federal grant money during a fiscal year, including counties, tribes, non-profit organizations and other state agencies.*

*The Department will designate the appropriate staff to be responsible for the development and enforcement of a tracking system of the sub-recipient's required audits and internal controls. As a minimum the system will track:*

- *Name of the subrecipient (i.e., counties, local government, and tribes)*
- *Date(s) of A-133 audit and review of internal controls*
- *Period covered by the audit*
- *Finding(s)*

*The Department will conduct follow-up telephone interviews or on-site visits as appropriate when findings are reported to ensure corrective action plans are followed.*

*The Department's efforts will be coordinated with our Office of Indian Policy to ensure tribal subrecipients properly report the federal funds received from the Department of Social and Health Services.*

## **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.

- (d) Pass-through entity responsibilities. A pass-through entity shall perform the following for the Federal awards it makes:
  - (8) 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.
  - (9) 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.
  - (10) 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.
  - (11) 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.
  - (12) 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.
  - (13) Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.

- (14) 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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

U.S. Office of Management and Budget Circular A-133, *Compliance Supplement 2014*, 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.

**2014-020**

**The Department of Social and Health Services did not have adequate internal controls over, and was not compliant with, its required collection of Data Universal Numbering System (DUNS) numbers from subrecipients under the Block Grants for Prevention and Treatment of Substance Abuse and Substance Abuse and Mental Health Services Projects of Regional Significance programs.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.243 Substance Abuse and Mental Health Services Projects of Regional and National Significance  
93.959 Block Grants for Prevention and Treatment of Substance Abuse

**Federal Award Number:** 2B08TI010056-12; 2B08TI010056-13;  
2B08TI010056-14; 1U79SP020155-01;  
1H79SM060196-01; 5H79SM060196-02;  
5H79SM060196-03; 5H79SM060196-04;  
1U79TI024265-01; 5U79TI024265-02;  
1U79TI023477-01; 5U79TI023477-02;  
5U79TI023477-03

**Applicable Compliance Component:** Subrecipient Monitoring  
**Questioned Cost Amount:** None

**Background**

The Department of Social and Health Services, Division of Behavioral Health and Recovery, administers the Block Grants for Prevention and Treatment of Substance Abuse. The Department subawards most of the funds to counties, tribes, nonprofit organizations and other state agencies to develop prevention programs and provide treatment and support services. The Department spent almost \$32 million in Block Grants for Prevention and Treatment of Substance Abuse federal funds during State Fiscal Year 2014. Of this amount, over \$10 million was passed through to 58 subrecipients.

The Department also administers the Substance Abuse and Mental Health Services Projects of Regional Significance. This federal grant program is designed to address priority substance abuse treatment, prevention and mental health needs of regional and national significance. The Department spent approximately \$4.9 million of grant funds during fiscal year 2014. Of this amount, approximately \$1.9 million was passed through to 37 counties, school districts and nonprofit organizations as subrecipients.

Federal law requires state agencies to obtain a Data Universal Numbering System (DUNS) number from a subrecipient before making a sub-award. DUNS numbers are used to identify

organizations that are receiving funding under grants and cooperative agreements and to provide consistent name and address data for electronic grant application systems.

### **Description of Condition**

Of the Department's 58 Block Grant subrecipients, we determined 31 had contracts that began after July 1, 2013. Block Grant funds awarded for these contracts totaled \$1,728,927. The Department did not collect DUNS numbers from any of these subrecipients.

We determined that the Department's Substance Abuse and Mental Health Services Projects of Regional Significance program gave 42 subawards, to 37 subrecipients, that began after July 1, 2013. These contracts totaled approximately \$5.9 million. The Department did not establish internal controls to ensure DUNS numbers were collected. We randomly selected nine subawards for testing and found the Department did not collect a DUNS number for three of them.

### **Cause of Condition**

Department management was not aware of the requirement to collect DUNS numbers prior to making subawards. Because of this no policies, procedures or other internal controls were in place to ensure the federal requirement was met. We consider this control deficiency to be a material weakness.

### **Effect of Condition**

By not obtaining DUNS numbers from every subrecipient prior to awarding federal funds, the Department cannot ensure public transparency for the money it provides.

### **Recommendation**

We recommend the Department:

- Create policies, procedures and other internal controls sufficient to ensure it obtains DUNS numbers from its subrecipients.
- Provide the necessary training for all employees who are responsible for the collection and documentation of DUNS numbers.
- Monitor the collection of this information to ensure compliance with the requirement.

### **Department's Response**

*The Department concurs with this finding.*

*The Department will develop policy, procedures and internal controls to obtain DUNS numbers from sub-recipients prior to making sub-awards in accordance with 2 CFR, Appendix A to Part 25.*

*The Department will reach-out to our Central Contracting Office in order to request a change to be made on the Department's contractor information database that will allow the system to store DUNS numbers for all registered contractors and sub-recipients. Until such change is done, DUNS numbers will be recorded in the Special Terms and Conditions section of all applicable contracts. The Department will develop the appropriate training and checklists to ensure all employees responsible for collecting and documenting DUNS numbers are aware and comply with 2 CFR, Appendix A to Part 25 requirements.*

*The Department's Budget and Finance Director for BHSIA will develop and maintain policies and procedures to monitor the collection of DUNS numbers and will conduct random checks to ensure compliance.*

### **Auditor's Concluding Remarks**

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

### **Applicable Laws and Regulations**

U.S. Office of Management and Budget (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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

## 2 CFR Appendix A to Part 25 – Award Term

### B. Requirement for Data Universal Numbering System (DUNS) Numbers

If you are authorized to make subawards under this award, you:

1. Must notify potential subrecipients that no entity (see definition in paragraph C of this award term) may receive a subaward from you unless the entity has provided its DUNS number to you.
2. May not make a subaward to an entity unless the entity has provided its DUNS number to you.

**2014-021            The Department of Social and Health Services does not have adequate internal controls to ensure only eligible refugees receive Refugee Cash Assistance.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.566    Refugee and Entrant Assistance – State-Administered Programs  
**Federal Award Number:** 1301WARCMA, 1401WARCMA  
**Applicable Compliance Component:** Eligibility  
**Questioned Cost Amount:** \$15,290  
**Likely Questioned Cost Amount**    \$187,235

**Background**

The Department of Social and Health Services, through their Office of Refugee and Immigrant Assistance, administers the Refugee and Entrant Assistance program. One of the benefits of the program, which is available to qualified applicants, is Refugee Cash Assistance (RCA).

To be eligible to receive cash assistance, applicants must meet all the following requirements:

- Enter the United States with an eligible immigration status
- Provide documents verifying their immigration status and date of arrival into the U.S
- Provide the name of the voluntary agency which resettled the refugee
- Meet income and resource requirements
- Meet work and training requirements
- Be ineligible for other Temporary Assistance for Needy Families (TANF) or Supplemental Social Security Income

The Department is responsible for determining eligibility for all applicants. Department staff at a Community Service Office (CSO) enter the applicant’s information into an automated eligibility system that assists in determining what federal programs the applicant is eligible for, including Refugee Cash Assistance (RCA). As a condition for receipt of RCA, a refugee must, unless they meet very limited exemptions, register and participate in employment services. The Department contracts with employment providers to ensure that employability services are available. Case notes are required to be entered in the Department’s case management system indicating whether the client adequately met the work and training requirements. Failure to participate in the work and training activities results in the client being ineligible to receive cash assistance.

The Department spent approximately \$11.6 million in federal program funds in fiscal year 2014 with approximately \$1.4 million paid as cash assistance to 1,328 clients.

## **Description of Condition**

We found the Department did not have adequate internal controls to ensure only eligible refugees received cash assistance and to ensure that refugees receiving RCA met the requirements to register and participate in employment services. We reviewed records for 57 randomly selected clients and found:

- Four applicants were improperly approved for benefits because they were eligible to receive TANF. These clients received improper payments totaling \$ 2,420.
- Case files for ten applicants lacked required documentation to evidence that clients registered and participated in employment services. These applicants received improper payments totaling \$12,870.

## **Cause of Condition**

Staff was not adequately monitored to ensure written procedures were followed and information was input accurately in the automated eligibility system. If the information had been input properly, the four clients would have been deemed eligible for TANF prior to being authorized as eligible for refugee cash assistance.

During the audit period, the Department lacked the formal process for staff to consistently track RCA recipients to ensure their registration and participation with employment and training providers. Management did not sufficiently monitor staff to ensure they were verifying client participation in work and training activities.

We consider these internal control weaknesses to be a material weakness.

## **Effect of Condition and Questioned Costs**

Without having adequate internal controls in place, the Department is at a higher risk for approving cash assistance benefits for ineligible clients. This can result in making improper payments with federal funds. We used a statistical sampling method to select clients for review. We estimate the amount of likely questioned costs to be \$187,235.

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 a payment.

## **Recommendation**

We recommend the Department establish adequate internal controls to ensure only eligible clients receive refugee cash assistance. We also recommend this include establishing procedures for tracking work and training activities for eligible clients.

## **Department's Response**

*The Department concurs with the overall findings of the State Auditor's Office.*

*The Department agrees that during the audit period, refugees were improperly enrolled in Refugee Cash Assistance (RCA) when they were eligible for and should have been enrolled in TANF. RCA is available for refugees who are ineligible for TANF or other federal benefits for up to eight months after the date of arrival.*

*The Department employs the following controls to ensure that only eligible clients are enrolled in the RCA program:*

- *When processing client eligibility, Community Service Division (CSD) staff first determines eligibility for TANF. Refugees who are age 65 or older can be authorized for RCA immediately, but are also referred to receive assistance with applying for Social Security Administration benefits (SSI). If ineligible for TANF or SSI, refugees will receive eight months of RCA.*
- *Supervisors audit staff work monthly. These audits consist of full case reviews of probationary staff for which 100% of their case work is audited, as well as ongoing, periodic full case reviews of permanent (non-probationary) staff.*

*The Department will implement additional controls to further ensure RCA program integrity. For instance, the ESA Management Accountability and Performance Statistics Office (EMAPS) will create and deliver a monthly report to the Office of Refugee and Immigrant Assistance (ORIA). This report will show all new RCA cases, which the ORIA staff will review (to ensure eligibility was accurately determined), and take appropriate action, if any.*

*Also, CSD will ensure all staff determining eligibility for the RCA program takes an annual, mandatory training on internal controls and proper enrollment in the RCA program.*

*The Department also agrees it lacked the ability to ensure that refugees receiving RCA registered and participated in employability services. It is important to note that, unlike the four applicants identified in the report as improperly approved for RCA because they were eligible to receive TANF, the ten applicants identified as lacking documentation were ineligible for TANF, and eligible for and properly enrolled in RCA. The Department considers these cases potentially ineligible because of a lack of documentation. ORIA is already implementing improved processes that will track work and training activities for clients receiving RCA.*

## **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 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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

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Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

45 CFR section 400.53(a) states in part:

400.53 General eligibility requirements.

(a) Eligibility for refugee cash assistance is limited to those who—

- (1) Are new arrivals who have resided in the U.S. less than the RCA eligibility period determined by the ORR Director in accordance with § 400.211;
- (2) Are ineligible for TANF, SSI, OAA, AB, APTD, and AABD programs;

45 CFR section 400.75(a) states:

400.75 Registration for employment services, participation in employability service programs and targeted assistance programs, going to job interviews, and acceptance of appropriate offers of employment.

(a) As a condition for receipt of refugee cash assistance, a refugee who is not exempt under § 400.76 of this subpart must, except for good cause shown—

- (1) Register with an “appropriate agency providing employment services,” as defined in § 400.71, and within 30 days of receipt of aid participate in the employment services provided by such agency, as defined in § 400.154(a) of this part.
- (2) Go to a job interview which is arranged by the State agency or its designee.
- (3) Accept at any time, from any source, an offer of employment, as determined to be appropriate by the State agency or its designee.

- (4) Participate in any employability service program which provides job or language training in the area in which the refugee resides, which is funded under section 412(c) of the Act, and which is determined to be available and appropriate for that refugee; or if such a program funded under section 412(c) is not available or appropriate in the area in which the refugee resides, any other available and appropriate program in such area.
- (5) Participate in any targeted assistance program in the area in which the refugee resides, which is funded under section 412(c) of the Act, and which is determined to be available and appropriate for that refugee.
- (6) (i) Accept an offer of employment which is determined to be appropriate by the local resettlement agency which was responsible for the initial resettlement of the refugee or by the appropriate State or local employment service;
- (ii) Go to a job interview which is arranged through such agency or service; and
- (iii) Participate in a social service or targeted assistance program which such agency or service determines to be available or appropriate.

Washington Administrative Code 388.466.0150 states:

- (1) What are refugee employment and training services?  
Refugee employment and training services provided to eligible refugees may include information and referral, employment oriented case management, job development, job placement, job retention, wage progression, skills training, on-the-job training, counseling and orientation, English as a second language, and vocational English training.
- (2) Am I required to participate in refugee employment and training services?  
If you are receiving refugee cash assistance (RCA) you are required to participate in refugee employment and training services, unless you are exempt.
- (3) How do I know if I am exempt from mandatory employment and training requirements?  
(a) You may be exempt from participation in employment and training requirements if:
  - (i) You are needed in the home to personally provide care for your child under three months of age (see WAC [388-310-0300](#));
  - (ii) You are sixty years of age or older.
- (b) You cannot be exempt from work and training requirements solely because of an inability to communicate in English.
- (4) If I am required to participate, what do I have to do?  
You are required to:
  - (a) Register with your employment service provider;
  - (b) Accept and participate in all employment opportunities, training or referrals, determined appropriate by the department.
- (5) What happens if I do not follow these requirements?  
If you refuse without good reason to cooperate with the requirements, you are subject to the following penalties:

- (a) If you are applying for refugee cash assistance, you will be ineligible for thirty days from the date of your refusal to accept work or training opportunity; or
  - (b) If you are already receiving refugee cash assistance, your cash benefits will be subject to financial penalties.
  - (c) The department will notify your voluntary agency (VOLAG) if financial penalties take place.
- (6) What are the penalties to my grant?  
The penalties to your grant are:
- (a) If the assistance unit includes other individuals as well as yourself, the cash grant is reduced by the sanctioned refugee's amount for three months after the first occurrence. For the second occurrence the financial penalty continues for the remainder of the sanctioned refugee's eight-month eligibility period.
  - (b) If you are the only person in the assistance unit your cash grant is terminated for three months after the first occurrence. For the second occurrence, your grant is terminated for the remainder of your eight-month eligibility period.
- (7) How can I avoid the penalties?  
You can avoid the penalties, if you accept employment or training before the last day of the month in which your cash grant is closed.
- (8) What is considered a good reason for not being able to follow the requirements?  
You have a good reason for not following the requirements if it was not possible for you to stay on the job or to follow through on a required activity due to an event outside of your control. See WAC [388-310-1600\(3\)](#) for examples.

**2014-022                    The Department of Social and Health Services improperly charged grant expenditures prior to the start of the Refugee and Entrant Assistance grant's period of availability.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.566    Refugee and Entrant Assistance – State-Administered Programs  
**Federal Award Number:** 1401WARCMA  
**Applicable Compliance Component:** Period of Availability  
**Questioned Cost Amount:** \$54,377

**Background**

The Department of Social and Health Services, through their Office of Refugee and Immigrant Assistance, administers the Refugee and Entrant Assistance Program. The goal of the Refugee and Entrant Assistance program is to assist in the resettlement of qualified applicants in Washington and to promote self-sufficiency as quickly as possible. This is accomplished by providing social and employment services, as well as financial and medical assistance.

The Department is responsible for administering the funding for refugee services and ensuring grant money is used for costs that are allowable and related to the grant's purpose. Each federal grant specifies a period during which programs costs may be obligated. For the Refugee and Entrant Assistance program the grant period of availability is the same as the federal fiscal year. Payments for costs obligated prior to the starting date of a grant are not allowed without approval by the grantor.

The Department spent approximately \$9.1 million in federal program funds in fiscal year 2014.

**Description of Condition**

The Department's fiscal year 2014 grant period began on October 1, 2013. We found a total of \$54,377 in expenditures that were obligated in September of 2013, but were charged to the fiscal year 2014 grant. The Department did not have authorization from the grantor to charge these pre-award costs to the grant.

**Cause of Condition**

Department management stated their understanding is that an obligation is not incurred until payment for services is made. Based on this understanding the Department thought it was allowable to charge these costs to the new grant even though they occurred prior to the grant start date.

## **Effect of Condition and Questioned Costs**

The Department improperly charged grant expenditures of \$54,377 prior to the start of the grant's period of availability. We are questioning \$54,377 of improperly charged grant 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 an expenditure.

## **Recommendation**

We recommend the Department only charge an expenditure to a federal grant if it is obligated during the period the grant allows and consult with its grantor to determine what, if any, of the questioned costs should be repaid.

## **Department's Response**

*The Department does not concur with SAO finding related to the Refugee and Entrant Assistance Grant period of availability.*

*The SAO is using accrual based accounting for this audit finding but all of our Federal Grants use cash accounting basis.*

*The auditor is stating that the Department obligated costs prior to the start date of the grant but the Department disagrees with the SAO interpretation of obligating funds. Per the rules associated with using a cash basis of accounting, an obligation does not occur until payment is actually made.*

***2 CFR 200.309 Period of Performance***, A non-Federal entity may charge to the Federal award only allowable costs incurred during the period of performance (except as described in §200.461 Publication and printing costs) and any costs incurred before the Federal awarding agency or pass-through entity made the Federal award that were authorized by the Federal awarding agency or pass-through entity.

*Per this definition above, the Department has met its obligation as to Period of Performance as costs are not actually "incurred" until an actual expenditure is made by the Department. Below are applicable citing's which the Department has used to provide backup documentation for this statement.*

***2 CFR 200.34 Expenditures***, when using a cash basis of accounting, states that expenditures are defined as the sum of the following:

- (1) Cash disbursements for direct charges for property and services;*
- (2) The amount of indirect expense charged;*
- (3) The value of third-party in-kind contributions applied; and*
- (4) The amount of cash advance payments and payments made to subrecipients.*

**Title 45: Public Welfare, Subtitle A: Department of Health and Human Services, Sub Chapter A: General Administration, Part 95: General Administration-Grant Programs states the following: 95.13** - In which quarter we consider an expenditure made. (a) We consider a State agency's expenditure for assistance payments under title I, IV-A, IV-E, X, XIV, or XVI (AABD) to have been made in the quarter in which a payment was made to the assistance recipient, his or her protective payee, or a vendor payee, even if the payment was for a month in a previous quarter. (b) We consider a State agency's expenditure for services under title I, IV-A, IV-B, IV-D, IV-E, X, XIV, XVI (AABD), XIX, or XXI to have been made in the quarter in which any State agency made a payment to the service provider.

**45 CFR Part 92.3 Definitions**, Outlays (expenditures) mean charges made to the project or program. They may be reported on a **cash or accrual basis**. For reports prepared on a **cash basis, outlays are the sum of actual cash disbursement for direct charges for goods and services**, the amount of indirect expense incurred, the value of in-kind contributions applied, and the amount of cash advances and payments made to contractors and sub grantees.

The Department performs draws of Federal Revenue for actual expenditures, meaning a disbursement or liquidation (cash out the door), not for any established accruals. Any Federal Revenue drawn in for an accrual would be considered Advance Payments by the Federal Government as no money has actually gone out the door as expenditure for the Department. The Federal Government has strict guidelines about the timeframes between Advance Payment of Federal Revenue and actual expenditures being incurred which are defined below.

**2 CFR 200.3 Advance Payment**, Advance payment means a payment that a Federal awarding agency or pass-through entity makes by any appropriate payment mechanism, including a predetermined payment schedule, before the non-Federal entity disburses the funds for program purposes.

**2 CFR 200.305 Payment**, Advance payments to a non-Federal entity must be limited to the minimum amounts needed and be timed to be in accordance with the actual, immediate cash requirements of the non-Federal entity in carrying out the purpose of the approved program or project. The timing and amount of advance payments must be as close as is administratively feasible to the actual disbursements by the non-Federal entity for direct program or project costs and the proportionate share of any allowable indirect costs.

### **Auditor's Concluding Remarks**

We consulted with both the federal granting agency and our single audit contact for the Office of Inspector General, U.S. Health and Human Services regarding this matter. Both contacts agreed that our interpretation of the federal requirements is correct.

We reaffirm our finding and will review this area during our next audit. We recommend the Department consult with the federal granting agency to resolve this matter.

### **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:

- (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.

Refugee Cash and Medical Assistance Program Grant # 1401WARCMA, Terms and Conditions Addendum: Additional Financial Requirements, states in part:

7. Funding (Project) Period / Obligation Deadline. The funding (project) period for these awards is synonymous with the obligation period. (See 45 CFR 400.210(a)(1) and (b)(1).)

Special Requirement - Cash & Medical Assistance Program. In the event that the Federal funding for the current fiscal year includes “reauthorized funds” from a previous fiscal year, the reauthorized funds must be obligated before newly awarded funds.

- Cash and Medical Assistance Program. One year obligation period: from the first day of the Federal Fiscal Year for which these funds were awarded through the last day of the same Federal Fiscal Year. (i.e., October 1, Federal Fiscal Year 1 through September 30, Federal Fiscal Year 1.)
- Cash and Medical Assistance – Unaccompanied Minor Costs. Two Year obligation period: from the first day of the Federal Fiscal Year for which these funds were awarded through the last day of the following Federal Fiscal Year. (i.e., October 1, Federal Fiscal Year 1 through September 30, Federal Fiscal Year 2.)

Any Federal funds not obligated by the end of the obligation period will be recouped by this Department.

8. Liquidation Deadline. All obligated Federal funds awarded under this grant must be liquidated by the following deadlines. (See 45 CFR 400.210(a)(1) and (b)(2).)

- Cash and Medical Assistance Program (Incl. Unaccompanied Minor Costs). By the last day of the Federal Fiscal Year following the year for which these funds were awarded (i.e., September 30, Federal Fiscal Year 2)

Any awarded Federal funds (including reauthorized funds under Cash & Medical Assistance grants) not liquidated by the end of the liquidation period will be recouped by this Department.

Title 45, Code of Federal Regulations, Section 400.210 – Time Limits for Obligating and Expending Funds and for Filing State Claims, states in part:

Federal funding is available for a State's expenditures for assistance and services to eligible refugees for which the following time limits are met:

(a) CMA grants, as described at § 400.11(a)(1) of this part:

- (1) Except for services for unaccompanied minors, a State must use its CMA grants for costs attributable to the Federal fiscal year (FFY) in which the Department awards the grants. With respect to CMA funds used for services for unaccompanied minors, the State may use its CMA funds for services provided during the Federal fiscal year following the FFY in which the Department awards the funds.
- (2) A State's final financial report on expenditures of CMA grants, including CMA expenditures for services for unaccompanied minors, must be received no later than one year after the end of the FFY in which the Department awarded the grant. At that time, the Department will deobligate any unexpended funds, including any unliquidated obligations.

U.S. Office of Management and Budget Circular A-133, Compliance Supplement 2014, Part 3 – Compliance Requirements, states in part:

#### H. PERIOD OF AVAILABILITY OF FEDERAL FUNDS

##### Compliance Requirements

Federal awards may specify a time period during which the non-Federal entity may use the Federal funds. Where a funding period is specified, a non-Federal entity may charge to the award only costs resulting from obligations incurred during the funding period and any pre-award costs authorized by the Federal awarding agency. Also, if authorized by the Federal program, unobligated balances may be carried over and charged for obligations of a subsequent funding period. Obligations means the amounts of orders placed, contracts and subgrants awarded, goods and services received, and similar transactions during a given period that will require payment by the non-Federal entity during the same or a future period (A-102 Common Rule, § \_\_\_\_.23; OMB Circular A-110 (2 CFR section 215.28)).

U.S. Office of Management and Budget (OMB) Circular A-133, Compliance Supplement 2014, Part 4 – information for the Refugee and Entrant Assistance program, states in part:

#### H. Period of Availability of Federal Funds

##### 1. CMA Funds

A State must obligate its CMA funds awarded for costs attributable to RCA, RMA, and administration during the Federal fiscal year (FFY) in which the grant was awarded. Funds awarded for URM assistance remain available for obligation in the FFY following the FFY in which the grant was awarded. However, all CMA funds, including funds awarded for URM services, must be expended by the end of the FFY following the FFY in which the grant was awarded (45 CFR section 400.210(a)).

2. Refugee Social Services Funds

A State must obligate its Social Services funds within 1 year after the end of the FFY in which the grant was awarded, and must expend these funds within 2 years after the end of the FFY in which the grant was awarded (45 CFR 400.210(b)).

**2014-023**

**The Department of Early Learning does not have adequate internal controls over payments to child care providers for the Child Care and Development Fund program.**

**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; G1401WACCDF  
**Applicable Compliance Component:** Activities Allowed or Unallowed  
**Questioned Cost Amount:** None

**Background**

The Department of Early Learning (DEL) administers the federal Child Care and Development grant to assist eligible working families in paying for child care. The Department of Social and Health Services (DSHS) determines client eligibility and pays child care providers under an agreement with DEL. DEL is responsible for reconciling child care payments to providers with attendance records. In fiscal year 2014, approximately \$238 million was paid to child care centers and providers.

Since fiscal year 2005, we have reported the Departments do not adequately monitor payments to child care providers. During fiscal years 2010 and 2011 we found DSHS did not adequately perform reconciliations between attendance records and child care payments. In fiscal year 2012 DEL took over this process, but only reconciled one month of child care payments to attendance records. In fiscal year 2013 we found no reconciliations were performed for months within state fiscal year 2013. The most recent audit finding numbers were 2013-016, 12-28, 11-23, 10-31, 9-12 and 8-13.

Additionally, in October 2012, our office issued a report, “Audit of State Payments to Child Care Providers<sup>1</sup>,” 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.

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<sup>1</sup> Audit report number 1008493

## **Description of Condition**

In response to the finding issued in fiscal year 2013, DEL stated it would address the identified weaknesses by having dedicated staff perform payment reconciliations for fiscal years 2013 and 2014. DEL also stated it would seek timely reimbursement for overpayments.

We reviewed tracking sheets for reconciliations performed during state fiscal year 2014 and found that, as of June 30, 2014, the only month during the audit period for which a reconciliation was completed was July 2013 although August and September of 2013 were partially completed. DEL had also continued to reconcile payments from fiscal year 2013.

During the audit we also confirmed that, while implementing additional internal controls was being considered, DEL did not implement any other internal controls to address the previous findings.

## **Cause of Condition**

During the audit period DEL chose to focus their staff primarily on payments made during the previous fiscal year instead of performing timely reconciliations of the current fiscal year.

We consider this control deficiency to be a material weakness.

## **Effect of Condition**

Because DEL has not fully completed its reconciliations to source documentation it remains at risk for not identifying overpayments to providers in a timely manner. By not performing the reconciliations timely, DEL reduces the likelihood of collecting overpayments.

Our current audit was for the purpose of determining compliance with federal laws and grant 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. However, the Department’s own internal reconciliations show they identified approximately \$400,000 in overpayments, which was 13 percent of the total payments reviewed during fiscal year 2014.

## **Recommendation**

We recommend the Department continue to improve its procedures for reconciling provider attendance records to payments. Specifically, performing a more timely review of payments to increase the likelihood that any overpayments identified can be collected.

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

## **Department's Response**

*The Department of Early Learning (DEL) appreciates the Washington State Auditor's work regarding the Statewide Single Audit. The Department respectively disagrees with this finding. As of 2/1/2015, the Department will have completed the majority of planned audits for audit months earlier than November 2014. However, per the collective bargaining agreement and Washington Administrative Code, providers are allowed to submit invoices up to twelve months after services are rendered. If the Department were to review only very recent records, the population of records to review would be incomplete and providers could submit invoices for time periods that wouldn't be subject to audit, which would create a significant risk factor that could increase fraud. Also, the statute of limitations is three years for establishing an overpayment and the Department's reviews have historically been made within this timeframe.*

*During Fiscal Year 2014, the Department reviewed 9,349 child attendance records detecting 4,633 errors and writing \$849,129 in overpayments submitted to DSHS. Leading causes of overpayments are claiming absent days when the child was not scheduled and authorized to attend, billing the maximum authorized amount regardless of the actual number of eligible billing days in the month, billing for time periods that weren't authorized, and not having a parental signature or time in/out on the attendance log.*

*In the most recent required Child Care Development Fund (CCDF) Program State Improper Payment Report submitted 7/22/14, the Department reported that in 276 cases sampled, 9 cases (3.3% of the total) had an improper payment error (overpayment or underpayment). The national improper payment error rate for this same time period was 5.7%, so DEL is well below this national average. The federal government requires a corrective action plans for state's exceeding 10%.*

*The Department continues to take steps to improve the integrity of payments in the program and will be implementing a new process of selecting records for review based upon payment date rather than service date. This will allow the Department to review records within four months of payment and include all providers in the sample population.*

## **Auditor's Concluding Remarks**

We thank the Department for its response.

The Department states in its response that it was more current with its post payment audits as of February 2015. The audit period ended on June 30, 2014 and, at that time, the Department was performing audits on payments that were at least 9 months old.

The Department states staff reviewed 9,349 child attendance records and identified 4,633 errors resulting in \$849,129 in overpayments. In our finding we refer to \$400,000 in overpayments because that was the information provided to us during fieldwork. After receiving the Department's response to the finding we requested supporting data for the \$849,129 in overpayments. Department staff reviewed \$4,079,931 in total payments and

determined that approximately 21% were overpayments. The number reviewed by the Department represented 0.2% of total payments to providers.

Our previous audits and the Department's own internal audits have identified a significant improper payment rate for this program. We continue to recommend that the Department strengthen its internal controls over payments to child care providers to not only detect, but prevent overpayments.

We reaffirm our finding and will review this area during our next audit.

### **Applicable Laws and Regulations**

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

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so

that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

**Material noncompliance.** In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

**Material weakness in internal control over compliance.** A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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

Appendix A, General Principles for Determining Allowable Costs, 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.

2014-024

**The Department of Early Learning does not have adequate controls to ensure it draws Child Care and Development Fund program federal funds in accordance with the Cash Management Improvement Act.**

**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; G1401WACCDF  
**Applicable Compliance Component:** Cash Management  
**Questioned Cost Amount:** None

### **Background**

Each year the State of Washington enters into a Cash Management Improvement Act (CMIA) agreement with the United States Treasury Department in which it agrees to draw federal funds on certain schedules. The primary purpose of the CMIA agreement is to ensure greater efficiency, effectiveness and equity in the exchange of funds between the federal government and the state. The agreement specifies the funding technique to be used by the Department of Early Learning when requesting federal funds. For the Child Care and Development Block Grant, the agreement states that the Department shall draw funds twice a month on the day prior to payday. For the Child Care Mandatory and Matching Funds of the Child Care and Development Fund the agreement requires draws to be made monthly no later than the 25<sup>th</sup> of each month. This funding technique is interest neutral.

During our audit period, the Department drew more than \$39 million in federal funds for the block grant and \$78 million for the mandatory and matching funds.

### **Description of Condition**

During our review, we determined the Department does not have adequate internal controls to ensure it draws federal funds in accordance with the CMIA agreement. When the Department draws federal funds, it properly ensures draw amounts are requested on a reimbursement basis. The Department did not, however, monitor the federal drawdown frequency to ensure it was in accordance with the CMIA agreement.

We determined:

Child Care and Development Block Grant fund – scheduled to make 24 draws

- Five draws were skipped and made with the next draw
- Four draws were drawn after the scheduled draw date – between four and 29 days late

## Child Care Mandatory and Matching Funds of the Child Care and Development Fund – 12 scheduled draws

- Three extra draws were made between scheduled draw dates which were between 14 and 19 days early
- Six draws between three and 23 days late

We also determined that when the Department prepares a draw it bases the amount to be drawn on the amount of expenditures that have accrued through the day before the draw instead of through the scheduled draw date. This means each late draw contains expenditures that occurred after the scheduled draw date. These expenditures should not be drawn until the next scheduled date and are therefore being drawn early.

### **Cause of Condition**

Management oversight was not sufficient to ensure draws were being filed in accordance with the CMIA agreement. The employee responsible for processing draws was aware of the cash management requirements and stated draws were not always filed timely due to a lack of staffing. We consider these control deficiencies to be material weaknesses.

### **Effect of Condition**

As a result of this condition the state was noncompliant with the CMIA agreement. This allows the federal government to take numerous actions such as denying the reimbursement of all or part of the state's interest calculation costs claim or initiating an audit to determine the amount of interest owed to the federal government.

Additionally, delaying legitimate federal drawdown requests results in state funds being advanced longer than necessary.

### **Recommendation**

We recommend the Department develop and follow policies and procedures sufficient to ensure draws of federal program funds are in accordance with the cash management agreement. We also recommend these policies include management oversight of this process.

### **Department's Response**

*The Department of Early Learning (DEL) appreciates the Washington State Auditor's work regarding the Statewide Single Audit and agree with this finding. DEL is actively documenting cash draw reporting procedures, establishing internal policies and controls, and providing cross training to ensure draws of federal funds are in accordance with the CMIA agreement. These policies and procedures include internal controls over proper draws, accuracy of the data, and dual reviews of all draws before submission.*

## **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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not

operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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

page 15:

93.575 Child Care and Development Block Grant

Recipient: 357 --- Department of Early Learning --- DEL

% of Funds Agency Receives: 100.00

Component: Administrative costs, direct program/benefit costs

Technique: Modified Direct Program Costs- Admin, Payroll, Payments to Providers (ACH Drawdown on Payroll Cycle)

Average Day of Clearance: 0 Days

93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund

Recipient: 357 --- Department of Early Learning --- DEL

% of Funds Agency Receives: 100.00

Component: Administrative and direct program costs

Technique: Modified Direct Program and Administrative Costs- Monthly

Average Day of Clearance: 0 Days

page 7:

Modified Direct Program Costs -Admin, Payroll, Payments to Providers (ACH Drawdown on Payroll Cycle)

The State shall request funds for all direct administrative costs and/or payroll costs, and/or payments made to providers and to support providers. The request shall be made in accordance with the appropriate Federal agency cut-off time specified in EXHIBIT I. The amount of the funds requested shall be based on the amount of expenditures recorded for direct administrative costs and/or payroll costs and/or payments made to providers or to support providers since the last request for funds. The State payroll cycle is payday twice a month. Draws made day before payday are for deposit on payday. The draw request will be made in accordance with cut-off time in Exhibit I. The amount of the funds requested shall be based on the amount of expenditures recorded for direct administrative costs and/or payroll costs and/or payments made to providers or to support providers since the last request for funds. This funding technique is interest neutral.

Modified Direct Program and Administrative Costs – Monthly

The state draws funds at the close of fiscal month for direct program and indirect administrative costs. The draw request will be made in accordance with the cut-off time in Exhibit I. The funds drawn will be the accumulation of costs since the last draw. This funding technique is interest neutral.

Code of Federal Regulations 31 CFR §205.11 “What requirements apply to funding techniques?” states in part,

- (a) A State and a Federal Program Agency must minimize the time elapsing between the transfer of funds from the United States Treasury and the State's payout of funds for Federal assistance program purposes, whether the transfer occurs before or after the payout of funds.

**2014-025**

**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 and Development Fund program are filed accurately.**

**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; G1401WACCDF  
**Applicable Compliance Component:** Reporting  
**Questioned Cost Amount:** None

### **Background**

The Washington state Department of Early Learning administers the Child Care and 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 approximately \$215 million in Child Care Development funds in fiscal year 2014, of which \$7.5 million was distributed to subrecipients.

Under the Federal Funding Accountability and Transparency Act (Accountability Act), the Department is required to collect and report information on each subaward of \$25,000 or more in federal funds in the Federal Funding Accountability and Transparency Act Subaward Reporting System. The reporting must be done by the end of the month following the month in which the subaward was made. For this grant program there are two different federal funding sources, both of which require reporting of subawards. The federal audit guidance for Accountability Act reporting provides for a good faith exemption from reporting if the Departments attempts to report, but cannot due to reporting system problems outside of their control.

We reported a finding in our fiscal year 2013 audit for subawards not being reported in the Federal Funding Accountability and Transparency Subaward Reporting System. The prior audit finding number was 2013-015.

## **Description of Condition**

During our current audit, we found the Department did not have internal controls in place to ensure the fiscal year 2014 Accountability Act reports were filed correctly for awards made using one of the federal funding sources.

The Department reported two subawards for the program, totaling \$180,348,000, as being awarded to the Department of Social and Health Services. The employee responsible for Accountability Act reporting was not aware that another state agency is not considered a subrecipient. The State as a whole receives the grant funds and the actions between state agencies are considered interagency transfers, not payments to subrecipients. The employee had an understanding that all funds awarded out of mandatory or matching funds needed to be reported through the Federal Funding Accountability and Transparency Act Subaward Reporting System. Federal guidance clearly states that the reporting requirements only apply to the reporting of funds awarded to subrecipients.

The finding that was issued in our fiscal year 2013 audit was related to not reporting subawards made using the other federal funding source. During our current audit, we identified 16 subawards from this funding source that exceeded \$25,000 and were not reported. We reviewed communications between the Department of Early Learning and the U.S. Department of Health and Human Services stating that these subawards could not be filed during the audit period due to a problem with the reporting system for that particular federal funding source. We have determined that a good faith effort was made to comply with the submission process regarding these 16 subawards.

## **Cause of Condition**

The Department did not have policies and procedures to ensure it complied with 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 or management oversight of the employee's work to verify reports were being filed completely and accurately.

We consider these control deficiencies to constitute a material weakness.

## **Effect of Condition**

By not correctly submitting the required 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. We further recommend that a secondary review is conducted prior to reports being submitted.

## **Department's Response**

*The Department of Early Learning (DEL) appreciates the Washington State Auditor's (SAO) work regarding the Statewide Single Audit. The Department believes we demonstrated a "good faith" effort to comply with sub award reporting under Federal Funding Accountability and Transparency Act, as evidenced by documentation. We followed direction provided in OMB Circular A-133 Section B.210, stating that a sub-recipient/subcontractor relationship exists when a portion of the scope of work is transferred to another entity. The majority of the Child Care and Development Fund (CCFD) grant funding received by DEL funds the Working Connections Child Care (WCCC) program. Under the WCCC program, based on general policies established by the Department, Department of Social and Health Service (DSHS) staff independently make daily determinations of who is eligible to receive the federal financial assistance, have responsibility for day-to-day programmatic decision making, are responsible for adherence to some applicable federal program compliance requirements, and use the awarded federal funds to carry out a program of the organization as compared to providing goods or services.*

*The findings of this audit concluded that additional guidelines provided in OMB Circular A-133 indicate that transfers of federal awards to another component of the same awardee do not constitute a sub recipient or vendor relationship. Since this condition was raised by SAO, DEL is no longer reporting DSHS as a sub recipient. In light of this finding, our granting Federal agency also agrees that DEL should no longer report DSHS as a sub recipient.*

*The Department continues to strengthen internal controls with federal reporting. The Department has recently appointed an Internal Control Officer (ICO) who is now reviewing federal reports prior to release. DEL is also updating policies and procedures to improve internal control and oversight throughout the agency.*

## **Auditor's Concluding Remarks**

OMB Circular A-133 Section B.210, referenced by the Department in its response, provides criteria for determining whether an auditee is a subrecipient or a vendor. The auditee for this grant program is the State of Washington. The Department of Early Learning and the Department of Social and Health Services are both components of the same auditee and therefore one cannot be a subrecipient of the other.

We reaffirm our finding and will review this area during our next audit. We thank the Department for its commitment to improving internal controls over financial reporting.

## 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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either

individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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.

2014-026

**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; G1401WACCDF  
**Applicable Compliance Component:** Eligibility  
**Questioned Cost Amount:** None

### **Background**

The Department of Early Learning (DEL) administers the federal Child Care and Development grant to assist eligible working families in paying for child care. 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 fiscal year 2014, child care providers were paid approximately \$238 million.

In order for a family to be eligible for child care assistance children must be:

- Under age 13 (with some exceptions)
- Reside with a family whose income does not exceed 85 percent of state, territorial or tribal median income for a family of the same size; and
- Reside with a parent, or parents, who work or attend a job-training or education program; or are in need of, or are receiving, protective services.

If an ineligible client receives assistance, the payment made to the child care provider is not considered allowable under the program.

### **Description of Condition**

The Department has not established adequate internal controls to ensure it correctly determines and documents client eligibility prior to payments being made to child care providers.

We found:

- 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 who establish authorizations for child care can also alter payment information.
- DSHS conducts monthly audits, but reviews only 1.6 percent of open authorizations for child care. This does not provide adequate coverage to address the internal control weaknesses to prevent improper payments.

We reported similar issues during the fiscal year 2012 and 2013 audits as finding numbers 2013-017 and 12-30.

### **Cause of Condition**

DEL and DSHS are aware of weaknesses in controls over eligibility determination, but have not taken adequate action to address them. We consider this control deficiency to be a material weakness.

### **Effect of Condition**

By not having adequate internal controls in place, the state is at a higher risk of paying providers for child care services when clients are ineligible.

### **Recommendation**

We recommend DSHS and DEL work together to improve internal controls to ensure:

- Authorizations for child care are reviewed and adequately supported.
- Duties are segregated between staff that determine eligibility and authorize payments.

We also recommend that DSHS and DEL improve the current review process to cover a larger population of authorized payments and ensure eligibility is properly determined prior to payments being made.

### **Department's Response**

*The Department of Social and Health Services appreciates, acknowledges and supports the State Auditor's Office's (SAO) mission, which is to hold state and local governments accountable for the use of public resources.*

*The Department of Social and Health Services does not concur with the State Auditor's Office's (SAO) description of the condition identified in this audit, specifically, that "The Department has not established adequate internal controls to ensure it correctly determines and documents client eligibility prior to payments being made to child care providers."*

*The SAO reviewed 44 child care cases and confirmed the Department accurately determined eligibility in each case. The SAO performed a similar review in support of the previous year's*

audit (State Fiscal Year 2013) and again, determined the Department accurately determined eligibility in each case.

These results do not support the SAO's opinion that a material weakness exists in the Department's internal controls.

**SAO Description of Weakness** - 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 this description. Current childcare program policy, as established and maintained by the Department of Early Learning, does not require that separate workers authorize approval for benefits and payment.

DSHS employs the following controls to ensure child care subsidy payment authorizations are made correctly:

- 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.

Also, the federal fiscal year 2013 Improper Payments Information Act (IPIA) audit required by the Federal Office of Child Care and conducted by the Department of Early Learning (DEL) found that less than one percent of the total amount of payments for the sampled cases were made in error.

**SAO Description of Weakness** - 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 description. Washington Administrative Code, established and maintained by the Department of Early Learning, requires workers to request verification if not provided by the consumer. Eligibility workers must verify a consumer's activity and income prior to making eligibility determinations. Childcare program training 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 Description of Weakness** - Caseworkers who establish authorizations for child care can also alter payment information.

*The Department of Social and Health Services partially concurs with this description. While it is true that caseworkers have access to alter payment information, it is important to note that current childcare program policy, as established and maintained by the Department of Early Learning, authorizes approval for benefits and authorization for payment by the same worker. The Department has consistent monitoring protocols to maintain payment integrity including:*

- *An Integrity Report (identifying cases 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 Description of Weakness** - *DSHS conducts monthly audits, but reviews only 1.6 percent of open authorizations for child care. This does not provide adequate coverage to address the internal control weaknesses to prevent improper payments.*

*The Department of Social and Health Services concurs with the description that DSHS conducts monthly audits, but reviews only 1.6 percent of open authorizations for child care. DSHS does not concur with the description that this does not provide adequate coverage to address the internal control weaknesses to prevent improper payments. 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 is 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.*
- *Reviews provider payment authorizations and validates billing records when potential payment discrepancies are identified.*

*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 reviews potential overpayments and requests and attendance records to reconcile 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 SFY14, the Provider Team reviewed over 12,000 cases for possible overpayment. Of the cases reviewed, the provider team wrote over 7,300 overpayments.*

*In addition to DSHS audits, DEL performs audits focusing on provider billing.*

### **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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

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Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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.

**2014-027**            **The Department of Social and Health Services does not have adequate internal controls over, and was not compliant with, foster care payment rate setting and application requirements for the Foster Care program.**

**Federal Awarding Agency:**            U.S. Department of Health and Human Services  
**Pass-Through Entity:**                None  
**CFDA Number and Title:**            93.658    Foster Care – Title IV-E  
**Federal Award Number:**            1301WA1401; 1401WA1401  
**Applicable Compliance Component:** Special Tests and Provisions  
**Questioned Cost Amount:**            None

### **Background**

The Title IV-E Foster Care program helps states provide safe and stable out-of-home care for children under the jurisdiction of the state child welfare agency until the children are returned home safely, placed with adoptive families or placed in other planned arrangements for permanency. The program provides funds to states to assist with the costs of foster care maintenance for eligible children, administrative costs to manage the program and training for state agency staff, foster parents and certain private agency staff. Funds may not be used for costs of social services, such as those that provide counseling or treatment to improve or remedy personal problems, behaviors, or home conditions for a child, the child's family, or the child's foster family.

In Washington State, the Department of Social and Health Services Children's Administration is responsible for the oversight and administration of the Foster Care program. State Foster Care agencies establish basic payment rates for maintenance payments to foster parents, child care institutions or directly to children. As a result, the Department is required to submit a Title IV-E plan to the grantor that must include a periodic review of the payment rates at reasonable, specific and time-limited periods. The Department is also responsible for reviewing Foster Care basic maintenance payment rates for continued appropriateness in accordance with its submitted plan and must establish payment rates that provide only for costs necessary for the proper and efficient administration of the Foster Care program.

During fiscal year 2014 the Department spent approximately \$96 million in federal grant funds with more than \$24 million being paid to eligible foster care recipients and their guardians.

### **Description of Condition**

During our audit, we attempted to perform testing to determine if basic maintenance rates established by the Department were reviewed for their continued appropriateness and if the review was conducted in accordance with the Department's approved plan. We found the Department had not submitted the required information regarding the periodic review of

payment rates in its Title IV-E plan. We also found the Department had been paying the same maintenance payment rates to eligible foster care recipients since 2009 and had not performed a review of basic maintenance payment rates for at least five years.

### **Cause of Condition**

Because the Department's plan was approved by the grantor the Department felt it was sufficient to ensure the Department met all federal program requirements.

Prior to 2009, the Department had been following the statewide regularized approach to examining foster care maintenance rates through the Governor's Vendor Rate Committee. This committee examined many rates paid by the state and made recommendations for periodic adjustments. The committee was repealed in statute in 2009 and the Department has not implemented a replacement review process to ensure its compliance with federal requirements. In 2010, the Department was subject to litigation pertaining to basic maintenance payment rates. Management stated this was a factor in why they did not create a process to replace the maintenance rate review previously done by the Governor's Vendor Rate Committee.

We consider this control deficiency to be a material weakness.

### **Effect of Condition**

Performing periodic reviews of current basic maintenance payment rates for their continued appropriateness is a federal requirement. Not reviewing the payments for appropriateness may result in the Department under-paying foster care providers. Additionally, the grant terms and conditions state failure to comply may result in the loss of Federal funds and may be considered grounds for the suspension or termination of the grant.

### **Recommendation**

We recommend the Department perform a review of its maintenance payment rates, as required by federal regulations. We also recommend the Department establish a process for evaluating basic maintenance payment rates for its continued appropriateness, specifying the methodology and periodicity of required review. We further recommend this process be established in written policies or procedures and the Department ensure this process is included in its Title IV-E plan as required.

### **Department's Response**

*The Department does not concur with this finding.*

*The test on the regular rate reviews and sufficiency required by the federal Office of Management and Budget (OMB) took place under guidance from the Administration for Children and Families (ACF) and is a new test on rate and efficiency as a part of the State Wide Single Audit (SWSA). As stated above, for years CA has described our approach to*

*rates and compliance in its IV-E state plan, which has been approved every year by ACF. The mandate from ACF to review rates for sufficiency is very vague and additional guidance regarding what constitutes compliance is lacking. As a result, this audit represents the first time CA has received feedback that its approach is not compliant with ACF regulations.*

*CA's position, again approved by the federal government in the state IV-E plan has been that our rate structure (maintenance and ad hoc payments provided to foster parents) represents a child specific strategy that flexes with the needs of the children. Furthermore, the development of the Levels 2-4 system in 2001 set out a process, adopted in the administrative code, for identifying the amount of time spent meeting individual children's needs for care and supervision. Combined, these steps work in tandem to create sufficient rates for each foster child. Therefore the required review of the rate is met every time the Department sets a rate for a child and provides additional ad hoc services.*

*In addition to having never been tested on this requirement in previous audits and our subsequent unawareness we were out of compliance, statewide processes and economic conditions would have hampered CA's ability to conduct regularized reviews of the foster care maintenance rate. In addition to the disbanding and repeal of the Governor's Vendor Rate Committee, Washington State entered a deep economic recession beginning in 2009. Along with that recession came explicit budget instructions to not request increases and, in fact, most agencies were asked to submit options for budget reductions. Then in 2011, the Foster Parent Association of Washington (FPAWS) brought a lawsuit against the state alleging the administration was not meeting its obligation under Title IV-E to cover costs for Title IV-E categories of allowable costs incurred by foster parents on behalf of IV-E eligible foster children. That lawsuit essentially froze foster care maintenance rates as the department could not examine these rates while the question was before the court. These three factors, repeal of the Governor's Vendor Rate committee, deep economic recession, and the FPAWS suit created a perfect storm during the years 2009 to present day, essentially eliminating what little authority CA had for the consideration of rates.*

*Again, without clear definitions from ACF regarding what constitutes a "review for appropriateness", it is difficult to think about how the state could reasonably demonstrate compliance with this requirement. Also, CA ultimately does not control the rates paid to foster parents because this service goes through a complex budgeting process known as forecasting. CA would have to request additional funding to raise rates and those requests are far from guaranteed. Compliance is made even less clear in this environment. Would compliance with the ACF requirement be achieved from CA merely reviewing the rate and submitting a budget request? What if that budget request was not funded? Would CA then be out of compliance with this requirement even though that lack of compliance was actually caused by an outside entity (the State Legislature)?*

*CA does not concede that anything more than what the agency has undertaken has been required by ACF. However, CA has a potential resolution that may address the concern specifically identified by this review because it has negotiated a proposed settlement of the FPAWS case. Under the negotiated settlement, CA undertook an economic analysis of rates and negotiated new foster care rates and an accompanying methodology that gives structure*

*to an updating process. Due to lack of clarity, the federal requirement is unclear whether or not this settlement would represent compliance from ACF's perspective. However it does contain one potential mechanism for a "review" of foster care rates. According to the settlement, CA would re-review the rates in four years. CA has submitted a budget request to fund the settlement and is awaiting action by the State Legislature during this legislative session. If funding is not provided, CA will be returning to court to resume the lawsuit and maintenance of the foster care rates at current levels would resume until conclusion of the suit.*

### **Auditor's Concluding Remarks**

We thank the Department for its response and its cooperation throughout the audit. Federal regulations (cited below) clearly state the Department is required to have a written plan that provides for rate reviews to ensure the adequacy of foster care maintenance payments at reasonable, specific, time-limited periods. While we understand this may be difficult to implement, the Department did not have such a plan in place and had not reviewed basic maintenance payments for at least five years.

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.
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- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

Grant Award; GENERAL TERMS AND CONDITIONS; MANDATORY FORMULA, BLOCK and ENTITLEMENT GRANT PROGRAMS

Except as noted otherwise, these Terms and Conditions apply to all mandatory grant programs administered by the Administration for Children and Families (see Appendix

A). Please also review the separate program-specific Addendum to these Terms and Conditions applicable to each program.

By acceptance of the individual awards, each grantee agrees to comply with these requirements. Failure to comply may result in the loss of Federal funds and may be considered grounds for the suspension or termination of the grant.

45 CFR section 1356.21 (m) – Requirements Applicable to Title IV-E states, in part:

*Review of payments and licensing standards.* - In meeting the requirements of section 471(a)(11) of the Act, the title IV-E agency must review at reasonable, specific, time-limited periods to be established by the agency:

(1) The amount of the payments made for foster care maintenance and adoption assistance to assure their continued appropriateness.

42 USC 671(a)(11) - State Plan for foster care and adoption assistance – Requisite features of State Plan states, in part:

In order for a State to be eligible for payments under this part, it shall have a plan approved by the Secretary which –

(11) Provides for periodic review of the standards referred to in the preceding paragraph and amounts paid as foster care maintenance payments and adoption assistance to assure their continuing appropriateness;

OMB Circular A-133 Compliance Supplement – Department of Health and Human Services  
CFDA 93.658 – Foster Care – Title IV-E

(N) Special Tests and Provisions – Payment Rate Setting and Application, states:

**Compliance Requirement** – Title IV-E agencies establish payment rates for maintenance payments (e.g., payments to foster parents, child care institutions or directly to youth). Payment rates may also be established for Title IV-E administrative expenditures (e.g., payments to child placement agencies or other contractors, which may be either subrecipients or vendors) and for other services. Payment rates must provide for proper allocation of costs between Foster Care maintenance payments, administrative expenditures, and other services in conformance with the cost principles. The Title IV-E agency’s plan approved by ACF must provide for periodic review of payment rates for Foster Care maintenance payments at reasonable, specific, time-limited periods established by the Title IV-E agency to assure the rate’s continuing appropriateness for the administration of the Title IV-E program (42 USC 671(a)(11); 45 CFR section 1356.21(m)(1); 45 CFR section 1356.60(a)(1) and (c)).

2014-028

**The Department of Health did not ensure Medicaid hospital and home health agency surveys were performed in accordance with the frequency required by state and federal laws.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.775 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Special Tests and Provisions – Provider Health and Safety Standards  
**Questioned Cost Amount:** None

### **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures. The state Medicaid program spent approximately \$9.3 billion during fiscal year 2014, more than \$5.5 billion of which was federal dollars.

Almost \$1.7 million, state and federal combined, in Medicaid spending relates to the Department of Health.

Washington State has 101 active hospitals that fall into one of three categories:

- Acute care/general
- Chemical dependency
- Psychiatric

State regulations require the Department of Health, or an accreditation agency, to survey all acute care/general hospitals on average at least every 18 months. Surveys for psychiatric and chemical dependency hospitals must be performed on 12 month intervals. The survey focuses on the hospital’s administration and patient services, as well as compliance with federal health, safety and quality standards designed to ensure patients receive safe and quality care services.

The state has 62 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. Federal and state laws require the Department of Health, or accreditation agencies such as the Community Health Accreditation Program or the Joint Commission on Accreditation of Healthcare Organizations, to survey all home health agencies at least every 36.9 months to maintain Medicare certification and accept Medicaid clients.

Federal laws 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.

In the past three years we have reported in audit findings that the Department has not completed required surveys in accordance with the frequency required by federal and state laws. Prior finding numbers 2013-019, 12-33 and 11-25.

### **Description of Condition**

#### *Hospitals*

In fiscal year 2014, the Department of Health did not ensure hospital surveys were performed in accordance with the frequency stipulated by federal and state laws. Of the state’s 95 acute/general hospitals, 43 (45 percent) were not surveyed within the required 18 month average frequency rate. The surveys that exceeded this average ranged from 19.7 to 31.5 months. Five of these hospitals had their survey conducted by an accrediting organization, but the Department was still responsible to ensure the surveys were conducted timely.

Of the state’s six chemical dependency and psychiatric hospitals, five (83 percent) did not meet the required 12 month survey interval. The time period between surveys ranged from 2.8 years to 5 years.

The table below summarizes the results of our testing.

<b>Type of facility</b>	<b>Department of Health</b>	<b>Accreditation organization</b>	<b>Total surveys required</b>	<b>Number of untimely surveys</b>	<b>Percent past required frequency</b>
Acute Care / General	58	37	95	43	45%
Psychiatric and Chemical Dependency	6	0	6	5	83%
<b>Totals</b>	<b>64</b>	<b>37</b>	<b>101</b>	<b>48</b>	<b>48%</b>

## *Home Health Agencies*

During fiscal year 2014, the Department of Health did not ensure surveys of home health agencies were performed within 36.9 months as required by state and federal laws. Of the state's 62 Medicare certified home health agencies two did not receive the required survey within the 36.9 month interval. The time period between surveys ranged from 41.2 to 41.3 months. Although these two surveys were the responsibility of an accreditation organization, the Department was still responsible to ensure the surveys were conducted timely.

### **Cause of Condition**

The number of hospital surveys performed increased from the prior year by approximately 24 percent. Since the regulation bases the timeliness on an average of 18 months between surveys, deficiencies from prior years continued to impact the measurement of hospital surveys in fiscal year 2014.

We consider the internal control deficiencies to be a material weakness.

### **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 required by federal and state laws.

### **Department's Response**

*The Department concurs with the results of the State Auditor's findings for both Hospitals and Home Health Agencies (HHA), for failure to ensure surveys were performed in accordance with state and federal laws.*

#### *Contributing Factors:*

*As the contracted agency for the Center for Medicare and Medicaid Services (CMS), an increase in our workload over the last couple of fiscal years has identified the fact that the Hospital Survey Inspection Program is understaffed. Federal Patient Safety Initiative surveys, assigned CMS surveys following complaint investigations, and validation surveys have impeded the state's ability to get its regularly scheduled workload complete. In addition, there has been significant increase in the workload for End Stage Renal Dialysis (ESRD) facilities, work performed by the same team.*

### *Corrective Actions in Progress:*

*Lean - In an effort to meet federal requirements, the Department went through a hospital survey Lean process to help improve administrative processing and develop surveyor worksheets designed to create a more focused survey approach and concentrate on Infection Control, Quality Assurance and Performance Improvement and Care Continuity (transitions in care).*

*Scheduling - Both the hospital and home health agency programs implemented improved scheduling practices that assured each facility type adhered to their respective survey timelines.*

*Staffing - The workload for ESRDs was such that the department determined the need to create a survey team specific for this facility type. Two nurse surveyors and a public health advisor were hired to focus on the ESRD work and remove the impact that this workload had on the hospital survey schedule. This allowed the Hospital team to work exclusively with Hospitals.*

*The Department will also be hiring a manager to work specifically with the HHA surveyors to maintain current progress and push toward 100% compliance. Both the Hospital and HHA survey manager will work with accrediting organization to ensure continued coordination to ensure surveys are completed within prescribed timelines.*

### *Results So Far:*

*All efforts described above are ongoing and have led to improvements in compliance over last fiscal year as described in your results. The Facilities Survey and Inspection Executive Director will ensure these activities continue.*

*The HHA program has demonstrated significant improvement with a reported compliance rate of 97%. Improved scheduling and new management oversight will ensure compliance rate is maintained or improved within this program. We estimate full compliance by June 30, 2015.*

*Psychiatric hospitals are required to maintain a 12 month survey interval. Therefore, it will take 24 months to generate the similar data to demonstrate compliance. The estimated completion date: December 31, 2016.*

*In December 2014, the Hospital Program reached a point where all hospital surveys that had been previously overdue, had now been surveyed. Because the hospital program requires an 18 month "average" frequency rate, it will take at least two survey cycles (or 36 months) from this point to generate the data necessary to demonstrate compliance. The estimated completion date is December 31, 2017.*

## 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.

*Government Auditing Standards*, December 2011 Revision, paragraph 4.23 Communicating Deficiencies in Internal Control, Fraud, Noncompliance with Provisions of Laws, Regulations, Contracts, and Grant Agreements, and Abuse states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, as follows:

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met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

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Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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 thereunder.

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;

(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.

Private Psychiatric Hospitals WAC 246-322-020 state in part:

(1) A person shall have a current license issued by the department before operating or advertising a private psychiatric hospital.

(3) The licensee shall apply for license renewal annually at least thirty days before the expiration (a) A completed application on forms provided by the department;

RCW 71.12.480 Examination of operation of establishment and premises before granting license

The department of health shall not grant any such license until it has made an examination of all phases of the operation of the establishment necessary to determine compliance with rules adopted under this chapter including the premises proposed to be licensed and is satisfied that the premises are substantially as described, and are otherwise fit and suitable for the purposes for which they are designed to be used, and that such license should be granted.

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.
- (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.

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.

2014-029

**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:** 93.775 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Eligibility  
Activities Allowed/Unallowed  
Allowable Costs/Cost Principles  
**Questioned Cost Amount:** \$66,503

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$9.3 billion during fiscal year 2014, more than \$5.9 billion of which was spent by the Health Care Authority.

Federal regulations require the Authority to obtain a Social Security number from each individual, including children, applying for Medicaid. The Authority is required to verify the number with the Social Security Administration to ensure it was issued to the individual and to verify if the person has been issued any other number. The Authority must assist an applicant with applying for a number if they do not have 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 Washington HealthPlanFinder, a new online application system, federally verifies the validity of a Social Security number at the time of application for Medicaid benefits. Authority staff verify a client provided a Social Security number using the Federal Health Data Services Hub for unverified Social Security numbers. When an application is submitted without a Social Security number or the Social Security number is not federally verified, Authority staff contact the applicant and follows up to obtain a valid Social Security number.

The Social Security Administration provides the state with access to the State On-Line Query, a computer system that enables the Authority to verify the validity of a Social Security number at the time of the Medicaid application.

### **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 identified 183 individuals who did not have a valid Social Security number. Providers were paid \$133,006 for services rendered to these clients in fiscal year 2014.

### **Cause of Condition**

When the HealthPlanFinder started accepting online applications in October 1, 2013, the system approved cases without a Social Security number due to a system malfunction. The system problem was resolved, but the Authority did not have sufficient staff or resources to manually review all cases that were approved without a Social Security number.

The Authority has continuously made improvements in its training and monitoring, and maintains adequate Social Security number verification procedures.

### **Effect of Condition and Questioned Costs**

When the Authority provides services to ineligible individuals, or the services are unallowable and/or unsupported, the services cannot be claimed for federal reimbursement.

We are questioning \$66,503, which is the federal share of the unallowable payments. The federal share is calculated using the state's 2014 FMAP rate of 50 percent. 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 183 clients for whom the Authority could not provide evidence of a correct Social Security number 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 U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

## **Authority's Response**

*The State Auditor's Office correctly states that federal statute requires individuals requesting Medicaid to furnish a social security number. However, 42 CFR 435.910 (f) states, "The agency must not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by SSA." Eligibility staff use this guidance to make determinations when an individual cannot produce an SSN at the time of application. The majority of SSNs are verified electronically.*

*During the implementation of the Affordable Care Act beginning October 2013, staff were overwhelmed by significant caseload growth associated with Medicaid Expansion. A large volume of these cases required manual action, including manual eligibility determination when there was either no SSN or the SSN was incorrect. At that time, a small number of determinations were not flagged for follow-up, and some cases were missed. Staff now follow a process that aligns with CMS guidance and also ensures follow-up on questionable circumstances. Due to this process, the pending SSN report that eligibility staff work is significantly smaller than pre-ACA levels.*

*The Authority has followed up on all 183 identified clients and has either closed their coverage or updated the case with the correct SSN.*

## **Auditor's Concluding Remarks**

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority'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:

- (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 435.910(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 Periodic renewal of Medicaid eligibility, states in part, (a)

[T]he eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once 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.

**2014-030**            **The Health Care Authority improperly claimed federal reimbursement for non-emergency services provided to nonqualified aliens and for payments made on behalf of deceased Medicaid clients.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	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)
<b>Federal Award Number:</b>	5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed/Unallowed Allowable Costs/Cost Principles
<b>Questioned Cost Amount:</b>	\$417,979

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$9.3 billion during fiscal year 2014.

Almost \$5.9 billion in total Medicaid spending relates to the Health Care Authority.

### *Non-Emergency Services*

Under federal law, all United States citizens and certain legal immigrants who meet Medicaid's financial and non-financial eligibility criteria are eligible to receive Medicaid benefits. Nonqualified aliens are not eligible to receive standard Medicaid benefits, but may be eligible for care and services necessary in an emergency medical situation.

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 whose symptoms are acute and severe 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

The state can choose to pay for non-emergency services for nonqualified aliens; however, the federal government will not share the cost of those services.

#### *Payments after date of death*

Federal regulations state that an overpayment is the amount that a Medicaid agency paid to a provider in excess of the amount allowable for provided services. Services cannot be provided after a beneficiary's death, and as such no medical service claims 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 Authority, Washington State's Medicaid agency, receives quarterly data from the state Department of Health which is used to identify deceased Medicaid clients. These clients are then removed from the program. The Authority also runs a data query that identifies Medicaid services paid after a client's date of death. Once identified, the Authority starts a process to recoup the overpayments made to providers.

#### **Description of Condition**

We found the Authority paid for the following unallowable expenditures:

##### *Non-emergency Services*

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

During our review of Medicaid beneficiaries, we identified 1,595 clients who were undocumented aliens. We reviewed all services provided for the undocumented aliens and identified 1,726 non-emergency services provided to 195 nonqualified aliens. The following table summarizes the results of our review:

Description	Number of services	Payments
Non-emergency services paid for nonqualified aliens	1,726	\$130,980

We are questioning \$65,490, which is the federal share of the unallowable payments. The federal share is calculated using the state's 2014 FMAP rate of 50 percent.

Payments after date of death

We reviewed all Medicaid payments recorded in the Authority's Medicaid Management Information System (ProviderOne) and performed tests to determine whether the Authority made Medicaid payments for services provided after client's date of death. We identified 1,112 services provided to 371 clients after the client's death. The following table summarizes the results of our review:

Description	Number of services	Payments
Services provided after date of death	1,112	\$704,977

We are questioning \$352,489, which is the federal portion of the unallowable payments. The federal share is calculated using the state's 2014 FMAP rate of 50 percent.

**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, these reviews are not effective to prevent or detect all unallowable payments.

**Effect of Condition and Questioned Costs**

When the state provides services to ineligible individuals, or the services are unallowable, the services cannot be claimed for federal reimbursement. During fiscal year 2014, the Authority paid \$835,957 to providers for services for unallowable activities. We are questioning \$417,979, the federal portion 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 its expenditures.

**Recommendation**

We recommend the Authority:

- Ensure Medicaid services provided to nonqualified aliens are restricted to emergency services.

- Enhance monitoring 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.

### **Authority's Response**

*The Authority concurs with the finding that services were improperly paid on behalf of nonqualified aliens. The agency is in the process of reviewing and correcting the cases identified by the State Auditor's Office. In order to comply with the conditional eligibility requirements set by the federal government for alien emergency medical service payments, the Authority will continue to refine processes to avoid these approvals wherever possible. The Authority will also implement processes to timely review alien emergency medical claims after payment to ensure all cases of inappropriate payment are corrected.*

*The Authority also concurs that improper reimbursement was made to Medicaid clients where later research and analysis showed the clients were deceased. The majority of the costs identified by the State Auditor's Office are standard monthly fees paid to managed care plans that provide services to enrolled eligible clients. The managed care plans – and the Health Care Authority - may not know a client is deceased until several months after the official date of death. Although HCA receives notice of a client's date of death from a variety of sources, official notification occurs when the Authority reviews the Department of Health's quarterly death data to identify deceased Medicaid clients. This regular review did not occur on a timely basis in 2014 because staffing resources were prioritized to ensure smooth implementation of the Affordable Care Act.*

*The Authority has reviewed all payments identified by the State Auditor's Office as paid on behalf of deceased persons, and is proceeding with recoupment of those claims. Although the identification of Medicaid client date of death and the analysis of claims paid after the date of death will always be a post-payment function, the Authority will continue regular matches to the Department of Health's quarterly death data and will continue to refine our processes to capture this information for timely recoveries.*

### **Auditor's Concluding Remarks**

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority'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:

- (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.

2014-031

**The Health Care Authority did not seek reimbursement for all eligible Medicaid outpatient drug rebate claims.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Activities Allowed/Unallowed; Allowable Costs/Cost Principles  
**Questioned Cost Amount:** \$225,439  
**Likely Questioned Cost Amount:** \$1,048,530

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$9.3 billion during fiscal year 2014, more than \$5.9 billion of which was spent by the Health Care Authority.

The Authority invoiced manufacturers for more than \$199 million in drug rebates for drug units it paid during the audit period.

The Medicaid drug program, which began in 1991, is set forth in section 1927 of the Social Security Act. For federal payments to be available for covered outpatient drugs provided under Medicaid, drug manufacturers are required to enter into a rebate agreement with the Secretary of the U.S. Health and Human Services and pay quarterly rebates to states. Under these rebate agreements, manufacturers must provide the Center for Medicare and Medicaid Services (CMS) with the average manufacturer price by national drug code for each of their covered drugs. CMS uses the average manufacturer price and best price data to calculate the unit rebate amount for each national drug code 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 unit rebate amount 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 national drug code. The manufacturers process the invoices and pay the rebates to the states within 30 days of receipt of the invoices.

Invoices must reflect only those drugs reimbursed in the reporting period (quarter). Invoices must not include any national drug codes paid for under:

- Public Health Service drug pricing agreements
- State-funded only general assistance programs; other state-funded only programs; or
- Other federal non-Medicaid funded drug programs

**Description of Condition**

We judgmentally selected five out of 1,628 total invoices which were processed during the audit period to determine if the Authority prepared them accurately and completely. The total rebate amount for the selected five invoices was nearly \$9.6 million.

We identified 844 drug rebate eligible claims, totaling \$336,000 that were not included in the five rebate invoices. As a result, the Authority failed to claim \$450,877 in owed rebates.

The following table summarizes the results of our review:

<b>Exception Type</b>	<b>Number of Claims</b>	<b>Paid Amount</b>	<b>*Rebate Amount</b>
Medicare crossover claims not included in the invoices.	686	\$234,749	\$391,697
Family planning services not included in the invoices.	113	\$2,592	\$6,719
Other claims not included in the invoices.	45	\$98,659	\$52,461
<b>Total</b>	<b>844</b>	<b>\$336,000</b>	<b>\$450,877</b>

Medicare Crossover Claims are claims submitted by Medicaid providers for Medicare/Medicaid dual eligible beneficiaries. Medicare pays the claim to the provider and applies a deductible/coinsurance or co-pay amount before submitting the claim to Medicaid.

Family Planning services are services relating to preventative health and contraceptive methods provided by Medicaid providers.

The “other claims” include professional and outpatient claims.

We are questioning the federal share of \$225,439, which is calculated using the state’s 2014 FMAP rate of 50 percent.

## Cause of Condition

The Authority failed to account for all drug rebate eligible claims when preparing drug rebate invoices for the following reasons:

When the requirement to include Medicare crossover claims took effect in 2008, the Authority intended to ask for a temporary delay in implementation until a new Medicaid Management Information System, ProviderOne, was fully implemented. However, the Authority did not request a formal waiver from CMS at that time and has not included Medicare crossover claims in drug rebates.

The Authority excluded all claims from Family Planning providers because a majority of the providers were Public Health Service providers which were not eligible for drug rebate. In addition, the majority of the claims were for clinic or bulk packaged drugs, which were not eligible for drug rebate.

The 45 “Other Claims” were excluded because the claims were not reported in the drug rebate system timely due to system interface issues.

## Effect of Condition and Question Costs

Using an average rebate percentage for claims that was provided by the Authority, we calculated estimates for the total rebate amounts that were likely not requested from drug manufacturers.

The following table summarizes the results of our calculations:

<b>Claim Type</b>	<b>Claims</b>	<b>Paid Amount</b>	<b>*Rebate Amount</b>
Medicare Crossover Claims	44,506	\$3,655,921	\$1,898,520
Family Planning	1,425	\$ 382,320	\$ 198,539
<b>Totals</b>	<b>45,931</b>	<b>\$4,038,241</b>	<b>\$2,097,059</b>

\*The Authority calculated the average rebate percentage of 51.93 percent. The rebate amount was estimated by applying the percentage to Medicaid paid amount.

We estimate the amount of unallowable costs to the entire population of Medicare Crossover and Family Planning claims could be \$1,048,530, which is the federal share of the estimated unclaimed drug rebates. The federal share is calculated using the state’s 2014 FMAP rate of 50 percent.

The total rebate amount for the claim type of “Other Claims” cannot be estimated at this time.

## Recommendation

We recommend the Authority:

- Review Medicare crossover and Family Planning claims to determine how much in drug rebates should be requested from manufacturers.
- Review the drug rebate invoice process to ensure the Authority seeks reimbursement for all eligible professional and outpatient drug rebate claims.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of questioned costs.

### **Authority's Response**

*The Authority acknowledges that the State Auditor's Office identified groups of claims that that were excluded from drug rebate invoicing in error, and appreciates SAO's identification of an issue that, when corrected, will increase Medicaid rebates.*

*To address the crossover claim oversight, staff have identified the steps necessary to include these claims for drug rebate invoicing. The work is currently under way, and is on schedule to begin testing in March 2015, with an implementation target date of May 2015.*

*Currently, family planning providers' claims for certain family planning drugs are excluded from drug rebate due to past system limitations. The Authority is developing an action plan to reverse the exclusion and notify impacted providers. This first phase of the reconfiguration will be implemented by May 2015, with final completion by December 2015.*

*The small volume of claims that were excluded for reasons other than the above were addressed by changing the timing of certain vendor claim payment interfaces. This issue has been corrected.*

*The Authority will ensure that the U.S. Department of Health and Human Services receives a copy of this finding as soon as it is published so that they may begin their process to recover questioned costs.*

### **Auditor's Concluding Remarks**

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority'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:

- (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.

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.

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).
3. Invoices must reflect only those drugs reimbursed in the reporting period (quarter).

Invoices must not include any NDCs paid for under:

- Public Health Service drug pricing agreements;
- State-funded only General Assistance programs; Other state-funded only programs; or
- Other federal non-Medicaid funded drug programs.

2014-032

**The Health Care Authority made improper Medicaid inpatient high outlier payments to hospitals.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Allowable Costs/Cost Principles  
**Questioned Cost Amount:** \$78,049

**Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$9.3 billion during fiscal year 2014, more than \$5.9 billion of which was spent by the Health Care Authority.

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 Medicaid program.

Hospitals can receive the following type of payments:

- Case-based
- Diagnosis-Related Group (DRG) - based prospective payments
- A set amount of dollars per day of inpatient stay (per-diem)
- Fees for individual services (fee-for-service)

DRG payment amounts are calculated based on a payment rate referred to as the DRG conversion factor. The Authority establishes a DRG conversion factor for each hospital.

High outlier payments are additional supplemental payments to hospitals approved by the CMS to compensate hospitals for unusually expensive cases 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 an outlier payment takes into account both operating and capital costs (estimated cost of claim) and DRG payments. The high outlier payments are calculated using the high outlier adjustment factor effective on the date of admission.

To qualify as a high outlier, the estimated costs of the inpatient claim must be:

- Greater than \$50,000; and
- Above the outlier threshold calculated by multiplying the inpatient claim's predetermined allowed amount by the specific outlier adjustment factor effective for the date of admission.

The portion of the estimated claim costs above the calculated outlier threshold is eligible to receive a high outlier payment. The final payment amount is determined by multiplying the estimated cost above the threshold with the outlier adjustment factor in effect at the time.

In fiscal year 2014, the Authority paid \$53 million for 611 high outlier claims.

In our prior audit, we found that the Authority made improper high outlier payments to hospitals. The Authority included denied services when determining high outlier payments because Washington Administrative Code did not specify that the denied services should be excluded. The Authority also did not ensure rate changes were applied to all eligible inpatient claims. The prior finding number is 2013-023.

### **Description of Condition**

Using data mining techniques, we identified 172 high outlier claims that contained denied charges. We reviewed the ten claims that contained the highest denied charge amounts and confirmed that denied charges were included in the calculation of the payment, resulting in a total overpayment of \$156,097.

In addition, we randomly selected 46 claims out of 439 that contained no denied charges. We identified four high outlier claims that were calculated using an incorrect DRG conversion factor, resulting in a total underpayment of \$9,378.

### **Cause of Condition**

During the audit period, the Authority made changes to the Washington Administrative Code specifically for the exclusion of denied charges, but the new Code did not go into effect until after the audit period.

The Authority did not ensure the correct DRG Conversion factor was entered correctly in the provider payment system, which resulted in incorrect outlier payment calculations.

## **Effect of Condition and Question Costs**

The Authority made improper inpatient high outlier payments to hospitals totaling \$156,097. We are questioning \$78,049, 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:

- Ensure denied services are removed prior to calculating high outlier payments.
- Ensure DRG conversion factors are implemented accurately.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of questioned costs.

## **Authority's Response**

*This finding was repeated because the corrective action initiated in response to last year's finding was not completed by June 30, 2014.*

- *The Authority has revised WAC 182-550-3700 (1)(b) and changed the payment system to align with the auditor's calculation methodology. Changes were effective July 1, 2014.*
- *The Authority initiated action to correct the four high outlier payments identified by the auditor that were paid with an incorrect DRG conversion factor. As part of this process, questioned costs will be automatically reimbursed to the U.S. Department of Health and Human Services through the ProviderOne payment system. This correction is expected to be completed by May 1, 2015.*
- *The Authority has reallocated the inpatient program workload in order to allow additional capacity for monitoring system and rate changes. All changes are now reviewed by Authority staff for accuracy.*

## **Auditor's Concluding Remarks**

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority'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:

- (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:

- (c) 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.

42 US Code § 1395ww (d)(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 (previous version), 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 182-550-3700 DRG high outliers, states in part:

- (1) The agency identifies a diagnosis-related group (DRG) high outlier claim based on the claim's estimated costs. The agency allows a high outlier payment for claims paid using the DRG payment method when high outlier criteria are met.
  - (a) To qualify as a DRG high outlier claim, the estimated costs for the claim must be greater than the outlier threshold effective for the date of admission...
  - (b) The agency calculates the estimated costs of the claim by multiplying the total submitted charges, minus the nonallowed charges on the claim, by the hospital's ratio of costs-to-charges (RCC).
  - (c) When a transferring hospital submits a transfer claim to the agency, the high outlier criteria used to determine whether the claim qualifies for high outlier payment is the DRG allowed amount for the claim before the transfer payment reduction.
- (2) The agency calculates the high outlier payment by multiplying the hospital's estimated cost above threshold (CAT) by the outlier adjustment factor. The outlier adjustment factors, which vary by dates of admission and inpatient payment policy, are depicted in the table at the end of this subsection.
  - (a) For inpatient claims paid under the all-patient-diagnosis-related group (AP-DRG), the agency uses a separate outlier adjustment factor for:
    - (i) Pediatric services, including all claims submitted by children-specialty hospitals;
    - (ii) Burn services; and
    - (iii) Nonpediatric services.
  - (b) For inpatient claims paid under the all-patient refined-DRG (APR-DRG), the agency uses a separate outlier adjustment factor for a:

- (i) Severity of illness (SOI) of one or two; or
  - (ii) SOI of three or four...
- (3) For state-administered programs (SAP), the agency applies the hospital-specific rateable to the outlier adjustment factor...

WAC 182-550-1050 Hospital services definitions contains:

“Nonallowed service or charge” - A service or charge billed by the provider as noncovered or denied by the agency. This service or charge cannot be billed to the client except under the conditions identified in WAC 182-502-0160.

2014-033

**The Health Care Authority made overpayments to providers for Medicaid dental services.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Activities Allowed/Unallowed Allowable Costs/Costs Principles  
**Questioned Cost Amount:** \$336,999

**Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures. The state Medicaid program spent approximately \$9.3 billion during fiscal year 2014.

In fiscal year 2014 the Authority paid \$272 million for dental services.

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 benefit. This benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

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 prior audit we recommended the Authority implement adequate internal controls within its ProviderOne system to detect and prevent improper and unallowable claims submitted by dental providers. We also recommended the Authority ensure the Medicaid

Provider Guide is consistent with the Washington Administrative Code. The prior finding number is 2013-027.

### **Description of Condition**

In our current audit we found the Authority's system is still not effectively designed to prevent improperly billed claims from being paid. We did determine that the Authority changed the Washington Administrative Code effective April 30, 2014, to align with the Medicaid Provider Guide. We selected specific dental services and performed tests to determine whether the payments made to providers were allowable.

#### Fluoride Treatments

As of July 1, 2013, Medicaid covered the following fluoride treatments:

- Up to three applications in a year for clients six years of age and younger.
- Up to two applications in a year for clients between seven and 18 years of age.
- For clients 19 years of age and older, one application in a year, unless the client is developmentally disabled. For these clients the program covers up to three applications in a 12 month period, regardless of the client's age.

The state Code was amended effective April 30, 2014, and now allows the same number of treatments listed above per client, but also per provider or clinic. For example, if over a course of a year, the same client visits two different providers who both apply three applications of fluoride, Medicaid would pay for a total of six fluoride applications for that same client.

In fiscal year 2014, \$10.7 million was paid to Medicaid providers for fluoride treatments.

Using data mining techniques, we identified 15,201 claims totaling \$228,115 paid to providers for fluoride applications that exceeded the allowed number covered by Medicaid.

#### Dental Cleanings (Prophylaxis)

Medicaid covers dental cleanings (prophylaxis) once every six-months for clients 18 years of age or younger and once every 12 months for clients 19 years of age and older. If the client is developmentally disabled, Medicaid covers up to three cleanings in a 12 month period, regardless of the client's age.

According to the Medicaid Provider Guide, prophylaxis is covered when it is performed at least six months after periodontal scaling and root planning, or periodontal maintenance services for clients from 13 to 18 years of age and at least 12 months after for clients 19 years of age and older. Prophylaxis is not reimbursed separately when performed on the same date of service as periodontal scaling and root planning, periodontal maintenance, gingivectomy, or gingivoplasty.

In fiscal year 2014, \$14.9 million was paid to Medicaid providers for prophylaxis treatments.

Using data mining techniques, we identified 770 claims totaling \$25,469 paid to providers for cleanings that exceeded the allowed number covered by Medicaid.

Oral Evaluation Services

Comprehensive oral evaluations are covered once per client, per provider or clinic, as an initial examination.

Periodic oral evaluations are covered once every six months per client. To be allowable for payment, six months must elapse between when a client received a comprehensive oral evaluation and their first periodic oral evaluation.

The state Code changed effective April 30, 2014, and now allows the same number of treatments for periodic oral evaluations listed above per client, but also per provider or clinic. If a client is developmentally disabled, Medicaid covers up to three periodic oral evaluations in a 12 month period, regardless of the client's age.

In fiscal year 2014, approximately \$18.1 million was paid to providers for these evaluations.

Using data mining techniques, we identified 13,727 claims totaling \$374,135 for evaluations that exceeded the allowed number covered by Medicaid. The following table summarizes the number of clients who received more than the allowed number of periodic oral evaluations and comprehensive oral evaluations and the amounts overpaid to providers for these claims.

Description	Number of Claims	Unallowable Payments
Payments exceeding once every six months for periodic oral evaluations.	11,053	\$304,658
Payments for periodic oral evaluation occurring less than six months after comprehensive oral evaluation.	2,621	\$67,749
Payments exceeding once from the same provider for comprehensive oral evaluation.	53	\$1,728
<b>Total overpaid to providers</b>	<b>13,727</b>	<b>\$374,135</b>

Oral Hygiene Instruction

Medicaid covers oral hygiene instruction, with some restrictions. We reviewed claims for oral hygiene instruction for clients who are eight years of age and younger. Oral hygiene instruction is covered once every six months and up to two times within a 12-month period. Oral hygiene instruction is also covered when not performed on the same date of service as prophylaxis.

In fiscal year 2014, approximately \$248,000 was paid to Medicaid providers for oral hygiene instruction.

Using data mining techniques, we identified 113 claims totaling \$1,442 where providers were paid for oral hygiene instruction that exceeded the allowed number covered by Medicaid.

### Family Oral Health Education

Medicaid covers family oral health education when limited to one visit per day, per family, and up to two visits per child in a 12-month period, per provider or clinic. In fiscal year 2014, Medicaid paid providers over \$3.3 million for family oral health education.

We identified 1,627 claims totaling \$44,836 where providers were paid for family oral health education that exceeded the allowed number covered by Medicaid.

### **Cause of Condition**

We noted inconsistencies between the state Code, the Authority's Medicaid Provider Guide and the State Plan for some dental services. We also found that some automated controls within ProviderOne did not operate effectively. Authority management is aware of these issues and is in the process of correcting them.

### **Effect of Condition and Questioned Costs**

In total, the Authority made payments of \$673,997 for services that were not allowable. We are questioning \$336,999, which is the federal portion of the unallowable payments.

### **Recommendation**

We recommend the Authority:

- Ensure the Medicaid provider guide is consistent with the state Code and State Plan.
- Develop adequate internal controls within its ProviderOne system to detect and prevent improper and unallowable claims submitted by dental providers.
- Recover the \$336,999 in unallowable claims paid to the dental providers.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of questioned costs.

### **Authority's Response**

*The Authority acknowledges that the Washington Administrative Code (WAC) was not always consistent with the Medicaid Provider Guide, and that not all dental services paid for complied with the WACs. We appreciate the State Auditor's Office's identifying these inconsistencies so they can be corrected.*

*As the State Auditor's Office reports, the Authority has revised WAC 182-535-1082 to clarify when fluoride treatments will be covered. The Authority has also revised WAC 182-535-1080 to clarify when comprehensive and periodic oral evaluations are covered. These changes were implemented in response to the audit finding published in March 2014, and were*

*effective May 1, 2014. The WACs are now consistent with the State Plan and the Medicaid Provider Guide.*

*The Authority has updated the automated controls in the ProviderOne payment system to incorporate edits needed to ensure payments are made consistent with state rules and the Medicaid State Plan. These system edits will prevent payments when the allowable number of comprehensive or periodic oral evaluations has been exceeded. Rules in the Provider One system governing payments for dental services were updated for both previously identified issues and newly discovered issues.*

### **Auditor's Concluding Remarks**

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority'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:

- (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:

- (d) 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.

The OMB Circular A-133 Compliance Supplement (June 2014), *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. 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).

2. 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).
3. 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 effective 5/18/12-4/29/14):

- (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 182-535-1079 Dental-related services -- General, states in part (effective 4/30/14):

- (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 Washington apple health (WAH) 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 (effective 5/18/12-4/29/14):

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.
  - (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.

WAC 182-535-1080 Dental-related services-Covered-Diagnostic, states in part (effective 4/30/14):

Clients described in WAC 182-535-1060 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 the following oral health evaluations and assessments, per client, per provider or clinic:
  - (a) 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) 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.

WAC 182-535-1082 Covered dental-related services-Preventative services, states in part (effective 5/18/12-4/29/14):

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.
- (1) Oral hygiene instruction. The agency covers:
  - (a) Oral hygiene instruction only for clients eight years of age and younger.
  - (b) Oral hygiene instruction, no more than once every six months, up to two times within a twelve-month period.
  - (c) Individualized oral hygiene instruction for home card to include tooth brushing technique, flossing, and use of oral hygiene aides.
  - (d) Oral hygiene instruction only when not performed on the same date of service as prophylaxis.
  - (e) Oral hygiene instruction only when provided by a licensed dentist or a licensed dental hygienist and the instruction is provided in a setting other than a dental office or clinic.

WAC 182-535-1082 Dental-related services-Covered-Preventative services, states in part (effective 4/30/14):

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;
    - (ii) Twelve months for clients nineteen years of age and older; or
    - (iii) Four months for a client residing in a nursing facility.
  - (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;
    - (ii) At least twelve months after periodontal scaling and root planing, periodontal maintenance services, for clients nineteen years of age and older; or
    - (iii) At least six months after periodontal scaling and root planing, or periodontal maintenance services for clients who reside in a nursing facility.
  - (d) Is not reimbursed for 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 developmental disabilities administration of the department of social and health services (DSHS) according to (a), (c), and (d) of this subsection and WAC 182-535-1099.
- (2) Topical fluoride treatment. The agency covers the following per client, per provider or clinic:
  - (a) Fluoride rinse, foam or gel, fluoride varnish, 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, fluoride varnish, including disposable trays, for clients from seven through eighteen years of age, up to two times within a twelve-month period.
  - (c) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, up to three times within a twelve-month period during orthodontic treatment.
  - (d) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients nineteen years of age and older, once within a twelve-month period.
  - (e) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients who reside in alternate living facilities as defined in WAC 182-513-1301, 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 developmental disabilities administration of DSHS according to WAC 182-535-1099.
- (3) Oral hygiene instruction. Includes individualized instruction for home care such as tooth brushing technique, flossing, and use of oral hygiene aids. The agency covers oral hygiene instruction as follows:

- (a) For clients eight years of age and younger. For clients nine years of age and older, oral hygiene instruction is included as part of the global fee for oral prophylaxis.
- (b) Once every six months, up to two times within a twelve-month period.
- (c) Only when not performed on the same date of service as prophylaxis.
- (d) Only when provided by a licensed dentist or a licensed dental hygienist and the instruction is provided in a setting other than a dental office or clinic.

WAC 182-535-1099 Covered dental-related services for clients of the division of developmental disabilities, states in part (effective 5/18/12-4/29/14):

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 182 535-1099 Dental-related services for clients of the developmental disabilities administration of the department of social and health services, states in part (effective 4/30/14):

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 developmental disabilities administration of the department of social and health services (DSHS). This chapter also applies to clients any age of the developmental disabilities administration of DSHS, unless otherwise stated in this section.

(1) Preventive services.

- (a) Periodic oral evaluations. The agency covers periodic oral evaluations up to three times in a twelve-month period.
- (b) 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).
- (c) Topical fluoride treatment. The agency covers topical fluoride varnish, rinse, foam or gel, up to three times within a twelve-month period, per client, per provider or clinic.

WAC 182-535-1245 Access to baby and child dentistry (ABCD) program, states in part (effective 7/1/11-4/29/14):

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;

WAC 182-535-1245 Access to baby and child dentistry (ABCD) program, states in part (effective 4/30/14)

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 agency pays enhanced fees only to ABCD-certified dentists and other agency-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; and

2014-034

**State law requiring Medicaid data exchanges with health insurers is not being followed.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**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 coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures. The state Medicaid program spent approximately \$9.3 billion in federal and state funds during fiscal year 2014. The Health Care Authority (Authority) administers the Medicaid program for the state of Washington.

Medicaid is the “payer of last resort”, meaning other payment sources should be exhausted before claims are paid by Medicaid. Third-party liability refers to the legal obligation of third-party resources, usually insurance companies, to pay medical and pharmaceutical claims for clients prior to Medicaid coverage becoming effective. 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 allow Medicaid agencies to determine whether clients have third-party coverage. The Act requires states, as a condition of receiving Medicaid funding, to enact laws requiring health insurers doing business in that state to provide the eligibility and coverage information upon the request of the state.

To comply with this requirement, the state Legislature passed RCW 74.09A in 2007 that requires the Authority to provide Medicaid client eligibility and coverage information to health insurers. As a condition of doing business with the state, the insurers are required to use that information to identify Medicaid clients with third-party coverage and provide those results to the Authority. The law requires the exchange of data to occur not less than twice per year.

Since 2008, we have reported findings regarding lack of internal controls over and noncompliance with the federal Deficit Reduction Act of 2005 and state law. Prior audit finding numbers were: 2013-020, 12-49, 11-38, 10-40, 09-19 and 08-25.

### **Description of Condition**

The Centers for Medicare and Medicaid Services developed the Payor Initiated Eligibility/Benefit (PIE) Transaction. This federal standard can be used by health insurers to transmit eligibility and benefit information to the Authority. The Authority implemented this transaction format in July 2013. During the audit period, the Authority sent letters to 10 major health insurers to invite them to begin exchanging data as required by state law. The Authority has specifically begun to work with three of the insurers to initiate data sharing.

However, as of June 30, 2014, no required data exchanges occurred nor did any insurance carriers use the information made available by the Authority to identify joint beneficiaries, as required by RCW 74.09A.

### **Cause of Condition**

The Authority believes it has no authority to compel private insurance carriers to participate in the data exchange.

We consider the condition described above to constitute significant non-compliance with federal grant requirements and, as a result, a material weakness in internal controls.

### **Effect of Condition**

When Medicaid clients with additional insurance coverage are not identified in a timely manner, the Authority is at a higher risk of paying claims that should be covered by other insurers.

### **Recommendation**

We recommend the Authority work with the Office of Insurance Commissioner, the Office of Financial Management and the Legislature to bring the state in compliance with state law.

### **Authority's Response**

*The Authority meets all requirements of RCW 74.09A by making data available to all insurers to use for Third Party Liability (TPL) reporting and by matching data directly with those*

*insurers most likely to provide third party coverage to Medicaid recipients. Data exchanges occur in real time and insurers throughout the State participate by providing information and making electronic data available to the State Medicaid program.*

*In addition, the Authority has taken steps to enhance data sharing to ensure that we continue to have strong TPL identification processes in place. Those additional efforts 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. PIE is the national standard format for data sharing prescribed by the federal government. To date, the Authority is actively working with three large carriers for implementation of the PIE transaction. The Authority will work with the Office of the Insurance Commissioner to identify opportunities to promote additional carrier implementation of the PIE transaction format and electronic data exchange.*
- Maintaining a contract with HMS, a vendor that provides supplemental identification of TPL not previously identified by HCA. HMS leverages their expansive carrier network to match Medicaid data with third party coverage; their National Eligibility Database contains over 1 billion health insurance coverage records, including more than 5.4M (89%) of Washington residents. Their team works closely with carriers to implement new data sharing agreements and expand the data they receive for data matching with the Washington Eligibility file to identify the legal liabilities of third parties. HMS receives carrier data as frequently as daily and weekly; most carrier data exchanges occur monthly. Carrier data exchanges occur electronically via secure file transfer. This contract with HMS supplements the Authority's data matching capabilities and further ensures compliance with the DRA and applicable state law.*

*The Authority will contact the Office of Insurance Commissioner and the Office of Financial Management to discuss options for enhancing direct insurer participation.*

### **Auditor's Concluding Remarks**

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority'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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 Communicating Deficiencies in Internal Control, Fraud, Noncompliance with Provisions of Laws, Regulations, Contracts, and Grant Agreements, and Abuse states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance

requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this

- title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o 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.

RCW 74.09A.030 Duties of health insurers – Providing information – Payments – Claims – Costs and fees.

Health insurers, as a condition of doing business in Washington, must:

- (1) Provide, with respect to individuals who are eligible for, or are provided, medical assistance under chapter [74.09](#) RCW, upon the request of the authority, information to determine during what period the individual or their spouses or their dependants may be, or may have been, covered by a health insurer and the nature of 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 authority;

- (2) Accept the authority's right to recovery and the assignment to the authority 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 chapter [74.09 RCW](#);
- (3) Respond to any inquiry by the authority regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of such health care item or service;
- (4) Agree not to deny a claim submitted by the authority 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:
  - (a) The claim is submitted by the authority within the three-year period beginning on the date the item or service was furnished; and
  - (b) Any action by the authority to enforce its rights with respect to such claim is commenced within six years of the authority's submission of such claim; and
- (5) Agree that the prevailing party in any legal action to enforce this section receives reasonable attorneys' fees as well as related collection fees and costs incurred in the enforcement of this section.

2014-035

**The Health Care Authority did not properly calculate a Medicaid Electronic Health Record incentive payment.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**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 coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures. The state Medicaid program spent approximately \$9.3 billion in federal and state funds during fiscal year 2014, more than \$5.9 billion of which was spent by the Health Care Authority.

The Medicaid Electronic Health Record (EHR) Incentive Program is a state-federal initiative designed to promote the use of electronic records to improve care, reduce costs and increase provider-to-provider communication across the health care industry. This program provides payments to eligible professionals, eligible hospitals and critical access hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The eligible hospital EHR payments are calculated using a one-time calculation for the total incentive payment that is then distributed over four years.

The Improper Payment Act states a payment is an improper payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments).

## **Description of Condition**

The calculation used for the Medicaid hospital EHR payment uses a discharge-related amount that is based on a hospital's total number of inpatient acute care discharges and then increases or decreases that discharge figure by an average annual rate of growth. Hospitals are given a discharge add-on of \$200 for discharges between 1,150 and 23,000.

We found one hospital did not receive the add-on for discharges up to 23,000 despite having total discharges exceeding 37,000.

## **Cause of Condition**

The hospital had a negative annual growth factor that was applied to the maximum discharge add on of 23,000, instead of being applied to the total discharges of 37,000.

The Authority was unaware that the hospitals negative average annual growth rate should be applied to the hospital's actual discharges and instead, trended down the number of discharges that were eligible for the add-on incentive.

## **Effect of Condition**

The hospital has been underpaid \$76,615 through state fiscal year 2014.

## **Recommendation**

We recommend the Authority correct the calculation and pay the hospital the proper incentive payment.

## **Authority's Response**

*The Authority appreciates the time and review of SAO into the Medicaid Incentive Payment Program. As of 2/2/2015, the Health Care Authority has paid out \$253,810,355.00 to 87 eligible hospitals and 5,127 eligible providers as part of this federal program. The underpayment represents a tiny fraction of the payouts and is limited to a specific condition that only applied to one hospital. At the time of program implementation in 2011 the discharge calculation process was not completely defined and fiscal staff were required to use their best judgment for determining hospital payments. Many rules have been clarified since program implementation and we agree that the total payment was under-calculated in this instance.*

*Because hospital payouts occur over a four year timeframe, this hospital had not yet received its final payment. The year four payment has now been adjusted to reflect the total payout under the new calculation and no additional payouts are required.*

## **Auditor's Concluding Remarks**

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority'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:

- (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 2013, *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.

42 CFR 495.310 Medicaid Provider Incentive Payments, states in part:

- (g) Calculation of the aggregate EHR hospital incentive amount. The aggregate EHR hospital incentive amount is calculated as the product of the (overall EHR amount) times (the Medicaid Share).

- (1) Overall EHR amount. The overall EHR amount for an eligible hospital is based upon a theoretical 4 years of payment the hospital would receive based, for each of such 4 years, upon the product of the following:
  - (i) Initial amount. The initial amount is equal to the sum of—
    - (A) The base amount which is set at \$2,000,000 for each of the theoretical 4 years; plus
    - (B) The discharge-related amount for a 12-month period selected by the State, but ending in the Federal fiscal year before the hospital’s fiscal year that serves as the first payment year.

The discharge-related amount is the sum of the following, with discharges over the 12-month period and based upon the total discharges for the eligible hospital (regardless of any source of payment):

- (1) For the first through 1,149th discharge, \$0.
- (2) For the 1,150th through the 23,000th discharge, \$200.
- (3) For any discharge greater than the 23,000th, \$0.
- (C) For purposes of calculating the discharge-related amount under paragraph (g)(1)(i)(B) of this section, for the last 3 of the theoretical 4 years of payment, discharges are assumed to increase by the provider’s average annual rate of growth for the most recent 3 years for which data are available per year. Negative rates of growth must be applied as such.
  - (ii) Medicare share. The Medicare share, which equals 1.
  - (iii) Transition factor. The transition factor which equals as follows:
    - (A) For the first of the theoretical 4 years, 1.
    - (B) For the second of the theoretical 4 years, 3/4.
    - (C) For the third of the theoretical 4 years, 1/2.
    - (D) For the fourth of the theoretical 4 years, 1/4.
- (2) Medicaid share. The Medicaid share specified under this paragraph for an eligible hospital is equal to a fraction—
  - (i) The numerator of which is the sum (for the 12-month period selected by the State and with respect to the eligible hospital) of—
    - (A) The estimated number of inpatient-bed-days which are attributable to Medicaid individuals; and
    - (B) The estimated number of inpatient- bed-days which are attributable to individuals who are enrolled in a managed care organization, a pre-paid inpatient health plan, or a pre-paid ambulatory health plan under part 438 of this chapter; and
  - (ii) The denominator of which is the product of—
    - (A) The estimated total number of inpatient- bed-days with respect to the eligible hospital during such period; and
    - (B) The estimated total amount of the eligible hospital’s charges during such period, not including any charges that are attributable to charity

care, divided by the estimated total amount of the hospital's charges during such period.

- (iii) In computing inpatient-bed-days under paragraph (g)(2)(i) of this section, a State may not include estimated inpatient-bed-days attributable to individuals with respect to whom payment may be made under Medicare Part A, or inpatient-bed-days attributable to individuals who are enrolled with a Medicare Advantage organization under Medicare Part C.
- (h) Approximate proxy for charity care. If the State determines that an eligible provider's data are not available on charity care necessary to calculate the portion of the formula specified in paragraph (g)(2)(ii)(B) of this section, the State may use that provider's data on uncompensated care to determine an appropriate proxy for charity care, but must include a downward adjustment to eliminate bad debt from uncompensated care data. The State must use auditable data sources.
- (i) Deeming. In the absence of the data necessary, with respect to an eligible hospital the amount described in paragraph (g)(2)(ii)(B) of this section must be deemed to be 1. In the absence of data, with respect to an eligible hospital, necessary to compute the amount described in paragraph (g)(2)(i)(B) of this section, the amount under such clause must be deemed to be 0.

2014-036

**The Health Care Authority made improper payments to Medicaid Federally Qualified Health Center providers.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Activities Allowed/Unallowed Allowable Costs/Cost Principles  
**Questioned Cost Amount:** \$104,488

**Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures. The state Medicaid program spent approximately \$9.3 billion during fiscal year 2014, more than \$5.9 billion of which was spent by the Health Care Authority.

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 an FQHC is to enhance the provision of primary care services in underserved urban and rural communities.

With few exceptions, an FQHC is paid based on a client encounter with a provider from their center regardless of the number or type of procedures provided during the encounter. An encounter is defined as 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.

When the encounter rate is established for each FQHC, incidental services are factored into the encounter rate. Those services should not be billed separately as a fee-for-service.

Services not factored into the encounter rate are paid at the appropriate fee schedule amount as a fee-for-service.

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 2014, the Authority paid more than \$195 million to FQHC providers.

In our prior audits, we found that the Authority made improper payments to Federally Qualified Health Centers due to lack of sufficient system edits within its ProviderOne system. Prior finding numbers are 2013-026 and 2012-45.

**Description of Condition**

We found the Authority made improper payments to FQHC providers totaling \$104,488.

The table below summarizes the results of our testing:

Description	Questioned costs		
	State	Federal	Total
Fee-for-service claims were paid in addition to encounter payments.	\$66,402	\$66,402	\$132,804
Encounter payments were made for encounter ineligible claims.	\$35,992	\$35,992	\$71,984
More than one encounter payment was made for the same client.	\$2,094	\$2,094	\$4,188
<b>Total</b>	<b>\$104,488</b>	<b>104,488.00</b>	<b>\$208,976</b>

**Cause of Condition**

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

In response to our prior findings, the Authority stated that it worked on developing new system edits which would better prevent overpayments and improper billings by providers. The new system edits were not fully implemented during the audit period.

## **Effect of Condition and Question Costs**

The Authority made improper payments to FQHC providers totaling \$208,976. We are questioning \$104,488, 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 its expenditures.

## **Recommendation**

We recommend the Authority:

- Develop adequate system edits within its ProviderOne system to detect and prevent improper and unallowable claims submitted by FQHC providers.
- Recoup overpayments to FQHC providers.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

## **Authority's Response**

*The Health Care Authority makes every effort to ensure all \$5.9 billion Medicaid payments are always complete and accurate. We appreciate the State Auditor's Office efforts to assist through their audits.*

*The Authority will initiate action through the Office of Payment Integrity to recoup payments made in error that were discovered in this audit, and will consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.*

*The Office of Medicaid Systems and Data (OMSD) is finalizing system updates that will help prevent overpayments. The system edits are complex but, once implemented, will eliminate paying fee-for-service claims in addition to encounter payments, paying for ineligible encounter claims. We anticipate that the system changes will take effect in June 2015.*

*The last error identified, paying for more than one encounter payment for the same client, was an isolated issue not related to a system-wide defect. That issue has also been corrected, and the \$4,188.07 overpayment has already been collected.*

## **Auditor's Concluding Remarks**

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority'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:

- (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.

OMB Circular A-133 Compliance Supplement for 2013, *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.

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.

2014-037

**The Health Care Authority improperly claimed Children’s Health Insurance Program federal funds for eligible Medicaid expenditures.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Activities Allowed or Unallowed Allowable Costs/Cost Principles  
**Questioned Cost Amount:** \$17,397

**Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures. The state Medicaid program spent approximately \$9.3 billion during fiscal year 2014, more than \$5.9 billion of which was spent by the Health Care Authority.

In Washington, Medicaid and the Children’s Health Insurance Program (CHIP) provide medical assistance for children up to 19 years of age who reside in low-income households. Both programs are jointly funded by the state and federal government. The state is reimbursed for approximately 65 percent of its CHIP expenditures and 50 percent of Medicaid expenditures.

Medicaid expenditures for children who reside in households with income between 133 percent and 200 percent of the federal poverty level are eligible for additional CHIP funding. If the Medicaid costs have already been claimed and reimbursed, the state submits a claim for the difference between the CHIP and Medicaid rates.

The Authority identifies the Medicaid expenditures eligible for additional CHIP funding by performing a data match between eligible client data and Medicaid fee-for-service and managed care payment data.

In state fiscal year 2014, the Authority claimed more than \$21 million in CHIP funds based on the eligibility of children in the Medicaid program.

### **Description of Condition**

We obtained all fee-for-service and managed care payments in which the Authority claimed additional CHIP funds.

To determine if payments were eligible for additional CHIP funding we reviewed 98 fee-for-service payments. We randomly selected a sample of 80 payments and also reviewed the 18 most expensive payments. In addition, we randomly selected 39 managed care payments to review.

We found one fee-for-service payment for \$73,126 was not eligible for additional CHIP funds. The Authority incorrectly claimed \$10,969 in CHIP funds for this payment.

We also found that the Authority miscalculated a request for additional CHIP funds, which resulted in the Authority overdrawing \$6,428. The Authority identified the overdrawn amount prior to our audit. However, it failed to return the overdrawn amount to the federal government.

### **Cause of Condition**

The Authority used specific criteria to determine which claims were eligible for additional CHIP funding. We found the criteria being used was not complete. For the overdrawn amount, the Authority believed that it already completed all corrections and returned the overdrawn amount to the federal government.

### **Effect of Condition and Questioned Costs**

In total, we are questioning \$17,397 in 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 Authority:

- Ensure correct data matching criteria is used to identify Medicaid expenditures which are eligible for additional CHIP funds.

- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

**Authority’s Response**

*The Authority acknowledges CHIP federal funds should not have been claimed for the fee-for-service payment identified by the State Auditor’s Office. Federal regulations state that family income must equal or exceed 133 percent of the federal poverty level to be eligible. In this instance the family income calculation was rounded up to 133 percent; it did not actually equal or exceed 133 percent.*

*With the implementation of the Affordable Care Act (ACA) on October 1, 2014, CHIP eligibility is now determined using payment rules in accordance with ACA rules. Income determinations are now rounded down rather than rounded up.*

*The Authority has returned the \$6,428 in overdrawn funds to the federal government, and will consult with the U.S. Department of Health and Human Services to discuss repayment of the remaining questioned costs.*

**Auditor’s Concluding Remarks**

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority’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:

- (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:

- (e) 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.

Sec.2105. [42 U.S.C. 1397ee] Payments states in part:

- (g) Authority for qualifying states to use certain funds for Medicaid expenditures. -  
 (1) State option.—

- (A) In general.—Notwithstanding any other provision of law subject to paragraph (4), a qualifying State (as defined in paragraph (2)) may elect to use not more than 20 percent of any allotment under section 1397dd of this title for fiscal year 1998, 1999, 2000, 2001, 2004, 2005, 2006, 2007, or 2008 (insofar as it is available under subsections (e) and (g) of such section) for payments under subchapter XIX of this chapter in accordance with subparagraph (B), instead of for expenditures under this subchapter .
- (B) Payments to states.—
- (i) In general.—In the case of a qualifying State that has elected the option described in subparagraph (A), subject to the availability of funds under such subparagraph with respect to the State, the Secretary shall pay the State an amount each quarter equal to the additional amount that would have been paid to the State under subchapter XIX of this chapter with respect to expenditures described in clause (ii) if the enhanced FMAP (as determined under subsection (b) of this section) had been substituted for the Federal medical assistance percentage (as defined in section 1396d(b) of this title).
- (ii) Expenditures described.—For purposes of this subparagraph, the expenditures described in this clause are expenditures, made after August 15, 2003, and during the period in which funds are available to the qualifying State for use under subparagraph (A), for medical assistance under subchapter XIX of this chapter to individuals who have not attained age 19 and whose family income exceeds 150 percent of the poverty line.
- (iii) No impact on determination of budget neutrality for waivers.—In the case of a qualifying State that uses amounts paid under this subsection for expenditures described in clause (ii) that are incurred under a waiver approved for the State, any budget neutrality determinations with respect to such waiver shall be determined without regard to such amounts paid.
- (2) Qualifying state.—In this subsection, the term “qualifying State” means a State that, on and after April 15, 1997, has an income eligibility standard that is at least 184 percent of the poverty line with respect to any 1 or more categories of children (other than infants) who are eligible for medical assistance under section [1396a\(a\)\(10\)\(A\)](#) of this title or, in the case of a State that has a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that was first implemented on August 1, 1994, or July 1, 1995, has an income eligibility standard under such waiver for children that is at least 185 percent of the poverty line, or, in the case of a State that has a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that was first implemented on January 1, 1994, has an income eligibility standard under such waiver for children who lack health insurance that is at least 185 percent of the poverty line, or, in the case of a State that had a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that was first implemented on October 1, 1993, had an income eligibility standard

under such waiver for children that was at least 185 percent of the poverty line and on and after July 1, 1998, has an income eligibility standard for children under section [1396a\(a\)\(10\)\(A\)](#) of this title or a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that is at least 185 percent of the poverty line.

- (3) Construction.—Nothing in paragraphs (1) and (2) shall be construed as modifying the requirements applicable to States implementing State child health plans under this subchapter.
- (4) Option for allotments for fiscal years 2009 through 2015.—
  - (A) Payment of enhanced portion of matching rate for certain expenditures.—

In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State's allotment made under section 1397dd of this title for any of fiscal years 2009 through 2015 (insofar as the allotment is available to the State under subsections (e) and (m) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under subchapter XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section [1396d\(b\)](#) of this title).
  - (B) Expenditures described.—For purposes graph (A), the expenditures described in this subparagraph are expenditures made after February 4, 2009, and during the period in which funds are available to the qualifying State for use under subparagraph (A), for the provision of medical assistance to individuals residing in the State who are eligible for medical assistance under the State plan under subchapter XIX or under a waiver of such plan and who have not attained age 19 (or, if a State has so elected under the State plan under subchapter XIX, age 20 or 21), and whose family income equals or exceeds 133 percent of the poverty line but does not exceed the Medicaid applicable income level.

2014-038

**The Health Care Authority did not have adequate controls in place to ensure all Medicaid 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:** 93.775 State Medicaid Fraud Controls 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Allowable Costs/Costs Principles  
**Questioned Cost Amount:** None

## **Background**

Medicaid is a jointly funded state and federal partnership providing health coverage for low-income individuals who otherwise might go without medical care. At the federal level, the Centers for Medicare & Medicaid Services (CMS), the fiscal intermediary, administers the program. The Health Care Authority administers the Medicaid program for the state of Washington.

The Critical Access Hospital 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 critical access hospitals is administered by the Department of Health. Currently, the state has 39 Department of Health Medicare-certified and Authority approved hospitals, which 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 needs, simplify billing methods and create incentives to develop local integrated health delivery systems.

In fiscal year 2014, the HCA paid more than \$70 million to critical access hospitals.

Over the course of a year, the hospitals receive estimated payments that are calculated based on historical costs. The estimated payments are provisional in nature and subject to interim and final settlement after the end of the hospitals' fiscal year.

All hospitals are required to submit cost reports to CMS within six months after the end of the cost reporting period, or after the end of their fiscal year. Critical access hospitals are also required to submit a copy of their “as-filed” version of the Medicare cost report and its corresponding revenue codes to the Authority for the cost settlement for its most recently completed hospital fiscal year. In addition, hospitals are required to submit the “final settled” cost report received from CMS to the Authority by the 60th day of the hospital's receipt of the approved report. Interim and final cost settlements are performed to reconcile claim payments to first the “as-filed” and then the “finalized” cost reports.

Current critical access hospital claims are paid based on estimated cost-to-charge ratios derived from two year old cost report data. The interim and final settlements are intended to ensure hospitals are paid accurately.

In our prior audit, we reported in a finding that the Authority did not perform final settlements on cost reports even though approved reports were available. The prior finding number is 2013-021.

### **Description of Condition**

In our current audit, we performed follow-up work and found the Authority did not perform final settlements on the 70 cost reports included in the prior year’s finding. Furthermore, we found the Authority did not perform final settlements on an additional 28 approved cost reports available in the federal Hospital Cost Report Information System.

### **Cause of Condition**

Due to staff changes within the Critical Access Hospital unit and a significant upgrade to the unit’s settlement model, the Authority did not take corrective action during fiscal year 2014 and did not perform any final cost settlements during the audit period.

We consider this control deficiency to be a material weakness.

### **Effect of Condition**

If payments made to critical care hospitals are greater than total reimbursable costs, the lack of final settlements could reduce Medicaid resources available for other Medicaid services. Conversely, if payments already made to critical access hospitals are less than total reimbursable costs, underpayments for a prolonged period could affect the quality of services hospitals provide to Medicaid clients.

### **Recommendation**

We recommend the Authority:

- Establish adequate internal controls to monitor the status of final Medicare approved cost reports and perform final settlements timely.

- Perform final settlements on 98 Medicare approved cost reports as required by WAC 182-550-2598 (11).

### **Authority's Response**

*This finding was repeated because the corrective action initiated in response to last year's finding was not completed by June 30, 2014. The Authority hired a staff person in May 2014 to work on final settlements, and can now report that corrective action is complete. All 98 settlements identified above were completed before December 31, 2014. In addition, 23 hospitals not identified in this audit had final settlement by December 31, 2014.*

*The Authority has also established the following internal controls to ensure all Critical Access Hospitals' (CAH) costs are settled timely:*

- *CAH program staff now check the federal Hospital Cost Report Information System for finalized cost reports on a monthly basis and initiate the reports for final settlement.*
- *The CAH model was revamped to ensure efficient and accurate final settlements.*

### **Auditor's Concluding Remarks**

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority'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.

*Government Auditing Standards*, December 2011 Revision, paragraph 4.23 Communicating Deficiencies in Internal Control, Fraud, Noncompliance with Provisions of Laws, Regulations, Contracts, and Grant Agreements, and Abuse states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or

regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in internal controls over compliance in its *Codification of Statements on Auditing Standards*, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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.
  - (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.
- (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.)
  - (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.
- (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.

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

**2014-039**

**The Health Care Authority did not have adequate controls in place to investigate Medicaid service verification surveys returned in a foreign language.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Special Tests and Provisions - Utilization Control and Program Integrity  
**Questioned Cost Amount:** None

## **Background**

The state Medicaid program spent approximately \$9.3 billion in federal and state funds in fiscal year 2014. More than \$5.9 billion of these funds were spent by the Health Care Authority. Federal regulations require states to have processes in place to verify with Medicaid clients whether they actually received services billed by providers. This intent is to improve program integrity and identify potential fraud and abuse in the Medicaid program.

Federal regulations do not require 100 percent verification; a sampling method may be used. The Authority selects claims to verify every 45 days.

The Authority sends clients a Medical Services Verification survey asking if they received certain services. Staff review surveys that are returned and follows up when questions about the legitimacy of a claim arise. Regulations require the Authority to follow up on surveys when clients indicate they did not receive the service or paid for the service listed out of their own pocket and conduct a preliminary investigation to determine if there is sufficient information to warrant a full investigation.

If credible suspicions of fraud or abuse are identified, the Authority is required to forward that information to the State Attorney General's Office, Medicaid Fraud Control Unit, for investigation.

In prior audits we reported findings regarding service verification surveys. The prior finding numbers were: 11-39, 12-54 and 2013-031.

### **Description of Condition**

In fiscal year 2014, the Authority sent out 5,905 verifications, of which 1,727 (29 percent) were returned.

We found the Authority received 212 survey responses written in a foreign language (approximately 12 percent of the total responses received) that were not translated and reviewed.

In addition, 29 (14 percent) of the foreign language verifications returned indicated services may not have been provided or that the client may have paid for the services out of their own pocket. These responses are identified as “negative responses”. The Authority did not perform a review or refer them for further investigation.

### **Cause of Condition**

The Authority stated it does not have the resources to use translators during the verification process.

We consider this internal control deficiency to be a material weakness.

### **Effect of Condition**

The lack of adequate follow-up on foreign language surveys increases the risk that Medicaid fraud may go undetected and cause the Authority to be out of compliance with federal requirements.

### **Recommendation**

We recommend the Authority strengthen its survey review process to include a follow-up on all negative responses that require translation.

### **Authority’s Response**

*The State Auditor’s Office correctly identified 29 surveys written in a foreign language either answered “no” or did not answer the question, “Did you receive this service?” The dollar amount of services included in these 29 surveys totaled \$1,570.08. The Authority acknowledges the oversight in not following up, and has now made arrangements to use professional translation services to follow up on negative survey responses written in a foreign language.*

## **Auditor's Concluding Remarks**

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority'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.
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- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in internal controls over compliance in its *Codification of Statements on Auditing Standards*, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

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Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

42 CFR 433.116, FFP for operation of mechanized claims processing and information retrieval systems, states in part:

- (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.)

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 455.14 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.

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).

**2014-040**

**The Department of Social and Health Services, Developmental Disabilities Administration, did not pay Medicaid 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:** 93.775 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Activities Allowed or Unallowed  
**Questioned Cost Amount:** \$147  
**Likely Questioned Cost Amount:** \$36,506

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$9.3 billion during fiscal year 2014, more than \$5.5 billion of which was federal dollars.

Almost \$3.4 billion, in total Medicaid spending relates to the Department of Social and Health Services, which paid over \$322 million directly to supported living providers.

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 assists clients in activities of daily living and help the clients learn, improve, and retain the social and adaptive skills necessary to live in the community and avoid institutionalization. The Department offers four Home and Community based Services waivers:

- Basic Plus Waiver
- Children's Intensive In-home Behavioral Supports waiver
- Community Protection waiver, and
- Core waiver

Rates are developed by case managers who work with clients to perform assessments that determine the hours of support a client will need to be successful in the community. Assessments are completed at least annually and more often if there is a change in a client's condition. The rates developed during the assessments are then entered into an electronic approval spreadsheet and, once approved by the Department, the rate is manually transferred from the spreadsheet to the Social Service Payment System in an inactive status. The provider is sent an amended contract with the new rate and when a signed copy is received by the Department, the case manager manually terminates the prior rate and manually activates the new rate in the Social Service Payment System.

During our previous audit we reported the Department made payments to supported living providers at unauthorized daily rates. The prior audit finding number was 2013-039.

### **Description of Condition**

To determine whether the Department paid supporting living providers using the proper rate in fiscal year 2014, we selected and reviewed a statistically valid sample of 173 monthly payments totaling nearly \$1.3 million from the total population of 42,962 payments totaling \$322 million.

We found the Department had adequate internal controls in place to ensure daily rates paid to supported living providers for Medicaid clients were properly authorized and accurate. However, we found one payment was paid at rates greater than the authorized rates.

### **Cause of Condition**

The Department maintained sufficient 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.

For the exception we noted, the prior authorization was not deleted and the new, approved rate was not authorized. As a result, the incorrect rate was paid for a period of 28 days.

### **Effect of Condition and Questioned Costs**

The one payment where the Department used an inaccurate daily rate for calculating a monthly payment to a provider resulted in a \$294 unallowable payment. We are questioning \$147 of this amount, which is the federal portion of the unallowable payment.

The use of statistical sampling is widely adopted in auditing because it offers the opportunity for the auditor to obtain the minimum amount of audit evidence, which is both sufficient and appropriate, in order to form valid conclusions on the population. When we project our sample results into the entire population of Home and Community Based supported living payments, we estimate the amount of unallowable monthly payments made by the Department to supported living providers is \$73,011. We are questioning \$36,506 of this amount, which is the federal portion of the unallowable payments.

Federal regulations require us to report known and projected questioned costs 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.*

*Of the 174 monthly payments comprising the statistical sample just one overpayment in the amount of \$10.50 for a total of 28 days resulting in \$147 federal share was found. Prior review findings and our subsequent actions to resolve those findings have proven to be working. In addition, the implementation of our new payment system will prevent discrepancies.*

*In July 2014 we started reinforcing our reconciliation process by adding more frequent reviews of provider payments by rate analysts.*

*On January 1, 2015 DDA converted to the Provider 1 payment system from the SSPS payment system for processing payments to providers. This new process and payment system with the edits in place does not allow payment of two authorizations for the same client/provider location combination. The payment error that was made and discovered during this audit will not be possible with our new payment system.*

*Provider 1 will now pay an invoice greater than \$10,000 whereby split rates are now no longer needed. Typically this would be identified and corrected during our payment reconciliation process during rate settlement.*

*Any overpayment as a result of an incorrect rate is identified and repaid to the federal government through the financial recovery process. This is a scheduled ongoing standard process.*

### **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.

## Sample Design

The sample size consisted of 173 monthly payments from a total population of 42,962 monthly payments the Department made during the period of July 1, 2013 to June 30, 2014.

## 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)
42,962	\$322,369,842	173	\$1,284,112	\$294	\$147

## 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 \$294 to \$193,509.

<i>Precision at the 90-Percent Confidence Level</i>	
	<b>Variable Appraisal</b>
Midpoint	\$73,011
Lower Limit	\$294
Upper Limit	\$193,509

## Applicable Laws and Regulations

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

Section 300, states in part:

The auditee shall:

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

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.

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.)

**2014-041**            **The Department of Social and Health Services, Developmental Disabilities Administration, does not have adequate internal controls to ensure cost of care adjustments paid to Medicaid supported living service providers are authorized, supported and reasonable.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	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)
<b>Federal Award Number:</b>	5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed or Unallowed
<b>Questioned Cost Amount:</b>	None

## **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 assists clients in activities of daily living and help the clients learn, improve and retain the social and adaptive skills necessary to live in the community and avoid institutionalization.

The Department uses an evidence-based assessment to evaluate a client’s support needs. The results of the assessment are used to calculate the number of daily direct support hours a client needs to live in the community. The assessment predicts these hours as if the client lives alone, but the vast majority of supported living clients live with other clients. Many supports, such as nighttime supervision and meal preparation, can be shared with other members of the household and the Department looks for these opportunities, called “economies of scale”, to help providers care for their clients in the most time and cost-efficient manner.

When a client is temporarily out of the home, a provider can request a cost of care adjustment to cover the costs of non-variable staff support and administration necessary to maintain the residence and the client’s affairs. In addition, if a client permanently leaves the household, providers can request a care adjustment to maintain the household’s shared supports until a new housemate can be found.

Providers are required to submit a cost of care adjustment request form (DSHS 06-124) for a cost of care adjustment. These adjustments can be approved for up to three months. Any adjustments beyond three months must be approved by a Department regional administrator. In fiscal year 2014, the Department paid \$3,077,101 in care adjustments to 114 providers.

In our prior audit we reported a finding regarding the Department’s inadequate controls to ensure care adjustments were allowable and supported. The prior audit finding number is 2013-038.

**Description of Condition**

We randomly selected 44 care adjustment payments from a total population of 730 to determine if the Department had adequate internal controls in place to ensure the adjustments were allowable and supported. We found two adjustment forms were not properly approved by the Resource Manager. We also found four care adjustment approvals did not include justification for payments, which is needed to ensure payments were for the loss of certain economies of scale (or shared hours) and other fixed administrative costs that resulted from a temporary absence of a client.

The table below summarizes the results of our review:

Description	Number of COCAs	Exception Rate
Care adjustments not properly approved	2	4.5%
Care adjustments did not include proper justification	4	9.1%
<b>Total adjustments not authorized in accordance with the Department’s policies and procedures</b>	<b>6</b>	<b>13.6%</b>

In total we found 6 out of 44 care adjustments (13.6 percent) were not authorized in accordance with Department policies and procedures.

**Cause of Condition**

In our prior audit we reported a finding regarding the Department’s inadequate controls to ensure cost of care adjustments were allowable and supported. To address our recommendation, the Department issued a memo to staff in an effort to strengthen internal controls over the cost of care adjustment review process. However, the Department’s efforts did not become fully effective during the audit period.

We consider this control deficiency to be a material weakness.

## **Effect of Condition**

The Department cannot ensure that cost of care adjustments charged to the Medicaid program were accurate, supported and reasonable.

## **Recommendation**

We recommend the Department follow its policies and procedures to ensure cost of care adjustment payments to providers are authorized and supported.

## **Department's Response**

*The Department concurs with this finding.*

*Based on implementing guidelines on Cost of Care Adjustments (COCA) DDA now has a consistent process and effective means for reviewing and decision making. The guidelines were developed for adult services in December 2013 and in June of 2014 for children's services. The training by DDA on these new guidelines began in late December 2014 for adult services and in June for children's services. The dates of the four COCAs found during the review which did not include justification were:*

- *For the adults: One on 12/5/2014 and 2 on 12/18/2014. The dates of the COCAs are around or before training started;*
- *For the children: There is one and it is dated 4/11/2014. The date of this COCA is before training started for children.*

*It should be noted there were no findings for dates of services after DDA started formal training.*

*In addition, the form utilized for requesting a COCA was modified to include space for justifying the need for the COCA. This new addition to the form helps provide additional information for making a decision without additional calls or routing.*

*Since the training began, the Resource Manager (RM) Administrator has continued, and will continue, to train on COCA justification and decision making. In addition, RMs monitor justification as part of their review and they provide training to agency providers as the need arises.*

## **Auditor's Concluding Remark**

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

## **Applicable Laws and Regulations**

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

The auditee shall:

- (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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 Communicating Deficiencies in Internal Control, Fraud, Noncompliance with Provisions of Laws, Regulations, Contracts, and Grant Agreements, and Abuse states:

- 4.2 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in internal controls over compliance in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows: ...

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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.

The DDA Policy 6.02, issued July of 2013, 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.

**2014-042**            **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.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	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)
<b>Federal Award Number:</b>	5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed/Unallowed; Allowable Costs/Cost Principles
<b>Questioned Cost Amount:</b>	\$50,054
<b>Likely Questioned Cost Amount:</b>	\$12,430,042

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$9.3 billion in federal and state funds during fiscal year 2014.

Almost \$3.4 billion in total Medicaid spending relates to the Department of Social and Health Services.

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. Staff assist clients in activities of daily living and help the clients with the social and adaptive skills necessary to live in the community.

The Department pays the supported living providers 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.

Department case managers use the Client Authorization Services Input System 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. The Department's payment system 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.

During fiscal year 2014, the Department paid more than \$327 million to supported living services providers for the care of more than 3,876 clients.

In our prior audit 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. The prior finding number is 2013-036, 12-39.

### **Description of Condition**

We found the Department's internal controls were still not effective to ensure Medicaid payments to supported living service providers are allowable.

We selected a random sample of 173 monthly payments totaling approximately \$1.3 million from a total population of 42,962 monthly payments. We reconciled payments with individual provider timesheets to verify if payments were adequately supported.

For 102 payments totaling \$728,002, we found \$100,107 was not supported with any payroll records. We are questioning \$50,054, which is the federal portion of the unallowable payments.

For 27 payments totaling \$180,061, we could not determine whether monthly payments were allowable because timesheets were not designed to show the number of hours provided to a specific client or household.

We consider this control deficiency to be a material weakness.

### **Cause of Condition**

During the audit period the Department began to implement a program to conduct detailed reviews of provider's payroll records to ensure reported instruction and support services hours were supported. However, the Department's efforts to bring supported living providers into compliance with time and effort requirements were not fully effective during the audit period.

## **Effect of Condition and Questioned Costs**

When we project the results of our audit tests to the entire population of supported living payments, we estimate the amount of unallowable payments to individuals could be \$24,860,083. The federal portion of this amount is \$12,430,042.

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:

- Improve internal controls by strengthening its monitoring of providers' payroll records to ensure payments to providers are adequately supported.
- Seek recovery of the funds paid to providers that did not maintain required payroll documentation.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of questioned costs.

## **Department's Response**

*The Department does not concur with this finding.*

*RCW 71A.12.060 clearly provides the Secretary of the Department of Social and Health Services (DSHS) authority to authorize payments for individuals in community residential programs. To date the Secretary has authorized a system that requires payment for the total annually contracted Instruction and Support Services (ISS) hours to be reconciled to the actual hours provided. The approved system allows for more efficient use of taxpayer resources (by allowing additional staffing for peak demand), and allows better service and flexibility (by allowing providers to move resources to meet the daily needs). The terms of this policy are further outlined in DSHS DDA Policy 6.04.*

*Using the annual cost report process (described in DDA Policy 6.04), the DSHS Developmental Disabilities (DDA) / Management Services Division (MSD) verifies that the ISS hours provided are equal to or exceed the total hours of service DDA has authorized. Through this verification system, if the actual ISS hours reported in the annual cost report are less than the total authorized hours for all clients served by the SL provider, 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)). The system is designed to allow for resource flexibility by the SL provider throughout the year to enable the provider to meet the changing needs of the individual client. DDA requires that, over a year, clients receive all authorized ISS hours. To maintain the flexibility needed for the provider to address client needs, DDA does not require the SL provider to reconcile the delivery of the hours on a weekly or monthly basis. Through this process SL providers are audited on their entire contract. Any SAO audit finding*

*that considers a limited time frame does not accurately capture the entire delivery of service, or any corresponding annual underpayment or overpayment.*

*SL providers 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 provider who fails to meet either standard (delivery of hours or expenditure of dollars). The SL provider attests to the accuracy of the cost report.*

*DDA has additional measures in place to further review or audit the provider cost reporting. DSHS Enterprise Risk Management Office (ERMO) will periodically audit selected providers. 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 RCS certification evaluation, MSD/DDA will conduct an audit of the SL provider.*

*An additional audit/ review measure began in October 2013 when DDA/MSD dedicated an FTE to conduct audits of selected residential providers. The scope of this compliance audit includes provider reconciliation of employee hours provided by households and providing consultation and training to service providers related to the tracking / documenting of ISS hours. DDA/MSD audits 20 % of the SL agencies per year. In 2013 eight service providers were reviewed. In 2014 twenty-nine service providers were reviewed. In January/February 2015 three service providers have had reviews. Overall, 40 of the approximate 145 contracted service providers have had reviews and received consultation on their payroll documentation system. During these reviews, it was found that most service providers had an adequate payroll documentation system established to track ISS hours by location delivered.*

*Of the 40 service providers reviewed, five did not have an adequate payroll documentation system. For these service providers, additional training and consultation were provided. After several months of implementation, the internal auditor returned and conducted a follow up audit for those providers to ensure that the changes to their payroll system were implemented and were effective in capturing the necessary documentation. The re-audits were completed between September 2014 and February 2015. The internal compliance review audits of service providers continue at approximately two service providers per month. The current SAO review period of July 2013 through June 2014 only captures minimal results of this new practice.*

*The SAO audit recommends that DDA continue to improve internal controls to insure SL providers maintain adequate documentation to support payments claimed against payroll records. Beginning with the 2014 cost report, additional schedules were added to report ISS hours in a format reconcilable to payroll records. DDA/MSD will continue to dedicate a full time staff person to continue compliance audits over the next two years.*

*Through policy revision, DDA will clarify the expectations that the service provider's payroll system adequately documents services hours delivered by household or cluster. Additionally, DDA policy will outline acceptable margins of flexibility of ISS hour delivery. Training to*

*these new policies will occur over the summer and fall of 2015. Implementation is anticipated to occur in 2016. These policies will be attached to provider contracts.*

**Auditor’s Concluding Remarks**

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

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 supported living providers flexibility to meet the needs of clients. OMB Circular A-87 states that to be allowable under federal awards costs must be adequately documented.

We reaffirm our finding and will 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, 2013 to June 30, 2014.

**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*

<b>Payments In Universe</b>	<b>Value of Universe</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Unallowable Payments</b>	<b>Value of Questioned Costs (federal share)</b>
42,962	\$322,369,842	173	\$1,284,112	\$100,107	\$50,054

**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 (\$19,066,687) and the upper limit (\$30,653,479).

**Table 2: Projected value of unallowable payments**

<b>Precision at the 90-Percent Confidence Level</b>	
	<b>Variables Appraisal</b>
Midpoint	\$24,860,083
Lower Limit	\$19,066,687
Upper Limit	\$30,653,479

**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.

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.

*Government Auditing Standards*, December 2011 Revision, paragraph 4.23 Communicating Deficiencies in Internal Control, Fraud, Noncompliance with Provisions of Laws, Regulations, Contracts, and Grant Agreements, and Abuse states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in internal controls over compliance in its *Codification of Statements on Auditing Standards*, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows: ...

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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.

**2014-043                    The Department of Social and Health Services, Developmental Disabilities Administration, made overpayments to Medicaid supported living providers.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Activities Allowed or Unallowed  
**Questioned Cost Amount:** \$75,818

**Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures. The state Medicaid program spent approximately \$9.3 billion in federal and state funds during fiscal year 2014.

Almost \$3.4 billion in total Medicaid spending relates to the Department of Social and Health Services.

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. Staff assist clients in activities of daily living and help the clients with the social and adaptive skills necessary to live in the community.

The Department pays supported living providers a daily rate for each day of service provided to a client. The daily rate for each client is individualized and adjusted as necessary based on changes to the client’s support needs and the administrative component of the rate. Case managers use the Client Authorization Services Input System to enter the authorized daily rate into the Department’s Social Service Payment System and relies on edits in the system to prevent improper payments.

Based on the authorized rate and the number of service days the client received from the provider, the payment system generates a service invoice each month and sends the invoice to the provider for validation. The provider is then responsible for either confirming that the authorized rate and number of service days are correct, or submitting necessary corrections or changes. The Department relies solely on a provider's attestation for services provided during the month to make payments.

### **Description of Condition**

We selected 251 payments totaling \$1,313,671 to review when providers received three or more payments for the same client in a month. We found 27 of these payments, totaling \$151,637, resulted in overpayments.

### **Cause of Condition**

When original authorizations are not removed from the Social Service Payment System, providers receive invoices for multiple authorizations for the same client. Reliance is placed on providers to notify the Department that one of the invoices is incorrect, otherwise the system issues payments for both authorizations.

We found instances where duplicate payments were made to providers for the same services because edits in SSPS did not prevent the invoices providers submitted for duplicate services from being paid.

### **Effect of Condition and Questioned Costs**

The Department continues to strengthen its monitoring and review processes to ensure that it does not pay providers for the same services more than once. However, it still does not prevent or detect all overpayments.

We identified a total of \$151,637 in overpayments to providers. We are questioning \$75,818, which is the federal share 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 Department forward the overpayments identified by the audit to its Office of Financial Recovery and consult with its federal grantor to determine what, if any, of the questioned costs should be repaid.

### **Department's Response**

*The Department has strengthened its process of reducing overpayments, as evidenced by the reduction in overpayments during this audit period. The previous audit identified \$236,000 in overpayments; this audit identified \$151,000 in overpayments, a significant reduction of 47%.*

*This improvement was in part, due to Management Services Division (MSD) addition of a staff position to assist in the reconciliation process (February 2014). This enabled a review to occur mid-year in addition to the annual cost settlement process.*

*Overpayments are initiated throughout the year when identified by Resource Managers. Additionally they are identified by the Rate Analysts during the cost settlement process. All overpayments identified in this audit have been forwarded to OFR for collection, consistent with DDA practices. Most, if not all would have been identified during the 2014 cost settlement process which is scheduled to occur in the spring of 2015 (for calendar year 2014).*

*The Department has a cost settlement reconciliation process that corrects and adjusts supported living payments over the period of a calendar year. The state auditor's review is done by a state fiscal year, July 1 through June 30. The conflict in timeframe results in findings and the overstating of overpayments; half of the year audited by the SAO had yet to be reconciled by the department. If the audit had matched the department's reconciliation period, they would have reviewed what we have already reconciled, not what we have yet to reconcile. Review of fiscal year 2014 cost settlement will be completed by August 2015. Any additional overpayments not previously identified will be sent to the Office of Financial Recovery.*

*The department is confident our settlement process identifies overpayments.*

*On January 1, 2015 DDA converted to the Provider 1 payment system from the SSPS payment system for processing payments to providers. This new process and payment system has edits in place that does not allow payment of two authorizations for the same client/provider location combination. Provider 1 will limit the number of payment errors by not allowing the payment to occur. Provider 1 will also now pay an invoice greater than \$10,000 whereby split rates are no longer needed. It is no longer possible for a rate to be authorized with overlapping time periods.*

*MSD will continue to review for overpayments twice annually.*

### **Auditor's Concluding Remarks**

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

### **Applicable Laws and Regulations**

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 300, states in part:

The auditee shall:

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

Section 510, states in part:

- (f) 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.

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 (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.

**2014-044**            **The Department of Social and Health Services, Developmental Disabilities Administration, made overpayments to Medicaid supported living providers who did not ensure all staff with access to developmentally disabled clients receive a proper background check and are authorized to have access to vulnerable supported living clients.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	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)
<b>Federal Award Number:</b>	5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT
<b>Applicable Compliance Component:</b>	Allowable Costs/Cost Principles, Special Tests and Provisions - Provider Eligibility
<b>Questioned Cost Amount:</b>	\$58,917

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures. The state Medicaid program spent approximately \$9.3 billion in federal and state funds during fiscal year 2014.

Almost \$3.4 billion in total Medicaid spending relates to the Department of Social and Health Services of which it paid more than \$327 million, to supported living services providers for the care of more than 3,700 clients.

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. Staff assist clients in activities of daily living and help the clients with the social and adaptive skills necessary to live in the community. DDA clients receiving supported living services reside in private residents within the community. Client support may vary from a few hours per month to up to 24 hours per day of one-to-one support.

DDA contracts with private agencies to provide supported living services to clients with various developmental disabilities. As of June 2014, there were 117 contracted providers serving more than 3,700 supported living 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 the Department's Background Check Central Unit (BCCU). Both a state and federal background check are 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 the Department 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.

The condition noted in this finding was previously reported in finding 2013-034.

### **Description of Condition**

We identified 3,796 supported living clients who received Medicaid services during fiscal year 2014. We randomly selected 170 clients and identified 1,987 supported living staff serving these clients and their roommates.

We performed tests to determine if all staff had passed background checks necessary to have unsupervised access to the supported living clients before they began working with them, and to ensure the following eligibility requirements were met:

- A proper BCCU background check had been completed within the last three years.
- No individuals with disqualifying crimes listed on the Secretary's List were employed at the time of the audit, or during the month(s) in which they worked.
- Staff with criminal records that were not listed on the Secretary's passed a Character, Competency and Suitability (CCS) review.
- The entire period in which the individual had access to Medicaid clients was covered by a completed background check.
- Individuals who have not lived in Washington State for at least three consecutive years completed a fingerprint background check as required by state law.

We found:

- Four individuals working with disqualified background check results.
- 22 Individuals serving the client without a background check during part of the audit period.

- Two individuals with no background check completed. The provider performed a name/date of birth background check on the employee prior to hire, but did not perform a fingerprint check as required by state law.

Disqualified individuals were permitted to work with clients if they passed a Character, Competence, and Suitability (CCS) review by the provider. During the audit, we found three caregivers with disqualifying backgrounds had worked with supported living clients. Two of the employees did not have a CCS review performed. One employee did receive a CCS review, but this did not occur until one full year after the employee received the “Disqualify” result. All of the individuals were terminated by their respective providers during or after the audit period.

### **Cause of Condition**

During the audit period, the Department performed extensive provider training to ensure all supported living providers are aware of all program eligibility requirements. In April 2014, the Department’s facility inspectors began performing on-site review of background check results for 100 percent of current employees of providers. In addition, the Department increased random background check testing of supported living providers. However, the Department’s monitoring of providers remains limited and infrequent due to lack of available resources.

### **Effect of Condition and Questioned Costs**

Any caregiver, or person who has direct, unsupervised contact with a client, who does not meet the background check requirements is not eligible to provide services to Medicaid clients. Allowing individuals who do not meet background check requirements to have unsupervised access to vulnerable Medicaid clients could potentially expose the vulnerable Medicaid clients in the supported living program to neglect, harm, exploitation and abuse.

The Department issues payment directly to supported living providers, who then pay their employees for services rendered to the client. We followed up with the Department and reviewed payroll documentation for the periods in which the employees were ineligible.

The following table summarizes the \$117,834 in unallowable payments we identified in the audit by condition:

Condition	Number of Caregivers	Unallowable Payments
Individuals working with disqualified background check results.	3	\$ 21,937
Individuals serving the client without a background check during part of the audit period.	12	\$ 95,897
Individuals with no background check completed.*	2	-
Individuals we could not confirm received payment for services due to incomplete information or no response from provider.*	11	-
<b>Total individuals ineligible to provide services.</b>	<b>28</b>	<b>\$ 117,834</b>

\*We could not confirm the total questioned payments made to these caregivers due to incomplete or missing information from the provider.

We are questioning \$58,917, which is the federal portion of the unallowable payments. The federal share is calculated using the state's 2014 FMAP rate of 50 percent.

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:

- Follow-up on background check results of supported living providers to ensure ineligible individuals do not have access to vulnerable Medicaid clients and that all individuals renew their background checks in a timely manner.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

### Department's Response

*The Department (the Developmental Disabilities Administration) concurs with this finding.*

*Developmental Disabilities Administration (DDA) has demonstrated substantial improvement in background check compliance. DDA has achieved this through updating the Background Authorization policy and providing training to residential contracted providers and DDA employees. Training occurred within each region at the Regional Provider Meetings each*

quarter through the year. Training will continue into the next year. Review measures were implemented in April 2014, to review provider background check results during certification reviews. Additional review measures were implemented by the Enterprise Risk Management Office (ERMO) to conduct random background check testing. Additionally, in 2014, DDA worked collaboratively with AL TSA to consolidate and simplify background check standards and Rule/WAC across administrations. Through this process the list of disqualifying crimes was consolidated. It was consistent with LEAN process gaining efficiencies and clarity. It has reduced the need to process duplicate background checks across administrations.

The improvement is demonstrated by:

- Results with the number of staff working with disqualified background checks were reduced from 52 individuals during the last audit period to only 3 individuals this audit period. This is a 94 percent improvement.
- Of the 1,987 staff sampled during this audit period, only 12 individuals worked during a portion of the audit period without a background check.
- DDA verified that no sampled staff with disqualifying background check results continued to be employed by the provider.

DDA will continue to take the following measures to ensure this positive trend:

- Provide ongoing training to DDA employees and to the provider group.
- Dedicate a DDA headquarters position available to provide direct support and consultation to providers on interpretation of result letters.
- Monitor for background check compliance through reviews conducted by ERMO and Residential Care Services (RCS) certification reviews.
- Partner with the background check unit to simplify result letters sent to providers and background check 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

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, states in part:

- (g) 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.

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 in part:

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) 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 388-06-0140 “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.

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
  - (c) 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 – Requirements for service providers, 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 department's 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 prevent that person from having unsupervised access to clients:
- (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; and
  - (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.

WAC 388-101-3255 Background checks—Provisional hire—Pending results.

Persons identified in WAC 388-101-3250 (2) and who have lived in Washington state less than three years, or who are otherwise required to complete a fingerprint-based background check, may be hired for a one hundred twenty-day provisional period when:

- (1) The person is not disqualified based on the initial results of the background check from the department; and
- (2) A national fingerprint-based background check is pending.

**2014-045**            **The Department of Social and Health Services, Aging and Long-Term Support Administration, did not respond in a timely manner to complaints/allegations of abuse, neglect, exploitation, inadequate care or supervision in Medicaid residential facilities.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Special Tests and Provisions - Provider Health and Safety Standards  
**Questioned Cost Amount:** None

**Background**

Medicaid is a jointly funded state and federal partnership providing medical coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. The Centers for Medicare & Medicaid Services (CMS), which administers the program at the federal level, allows states to provide long-term care services to Medicaid beneficiaries that require daily nursing services. Medicaid coverage for nursing homes and intermediate care facilities for intellectually disabled clients is only authorized when services are provided in a residential facility licensed and certified by the state survey agency. The state survey agency is also responsible for investigating complaints and allegations of abuse, neglect or misappropriation.

Residential Care Services, under the Department of Social and Health Services Aging and Long-Term Support Administration, is the Medicaid survey agency for the state of Washington. Residential Care Services manages the Complaint Resolution Unit, which is the front line response system for addressing complaints from staff, residents, family members and the general public.

Complaints can be submitted to the Complaint Resolution Unit’s Hotline by mail, email, fax and telephone. Voicemail messages can also be left on the unit’s hotline 24 hours a day seven days a week. Messages received after hours and on weekends are responded to the next

business day. The Unit uses the Tracking Incidents of Vulnerable Adults (TIVA) case management system to input, prioritize and track complaints.

Initial intake of a complaint is performed by a program specialist who assigns a priority assessment. Program specialists have 24 hours to create an intake record and assign the priority assessment. This timeliness requirement is established by state law (RCW 74.34.063). Clinical triage nurses then review the priority assessment of each complaint.

The following table lists the five different levels of prioritization for new complaints and the respective required response times.

<b>Prioritization</b>	<b>Required Response</b>
Immediate Jeopardy	Initiate investigation within 2 working days of receipt
Non Immediate Jeopardy - High	Initiate investigation within 10 working days of prioritization
Non Immediate Jeopardy - Medium	Initiate investigation within 20 working days of prioritization
Non Immediate Jeopardy - Low	Initiate investigation within 45 working days of prioritization
Quality Review	None required

Complaints are prioritized as a quality review for two reasons. First, the matter has already been or is in the process of being investigated. Secondly, the initial intake assessment indicates there is no threat to the resident or appropriate steps have already been taken to safeguard the resident. By classifying complaints as a quality review it makes the information accessible to field staff, but an investigation is not performed.

Complaints are prioritized to ensure the level of response corresponds to the severity of the allegation. All complaints not prioritized as quality reviews are assigned to the Department’s field unit offices within two working days of receipt of the complaint. State law requires all nursing home complaints to be assessed by an individual who is professionally qualified to evaluate the nature of the problem. These complaints are then assigned to field staff.

In fiscal year 2014 the Department received 32,237 complaints through the Hotline. Of these, 13,240 were assigned a priority and sent to the Residential Care Services field units to be investigated. The other 18,997 complaints were categorized as Quality Reviews.

The following table shows the number of complaints received for each provider type served by the Complaint Resolution Unit:

<b>Provider type</b>	<b>Number of complaints received</b>
Nursing home	13,328
Adult family home	3,779
Assisted living facility	7,361
Intermediate care facility/ ID	1,802
Supported living	5,310
Other	657
<b>Total complaints</b>	<b>32,237</b>

Field staff investigate the complaint and perform follow-up within the assigned time frame determined by the severity of the issue.

The condition noted in this finding was previously reported in our 2013 single audit (finding number 2013-033).

### **Description of Condition**

We found the Department does not have adequate internal controls in place to ensure complaints are responded to properly and in a timely manner. We tested all provider type complaints for initial response and then performed further tests to determine if the Department responded specifically to nursing home and intermediate care facility complaints in a timely manner. We identified the following exceptions:

#### *Timeliness of responses to complaints*

We found 7,854 (24 percent) of all complaints received in fiscal year 2014 were not entered into the TIVA system within 24 hours. The following table shows the number of complaints that were not assessed timely and the range of days in which they were responded to.

<b>Working days to initiate a response</b>	<b>Number of complaints</b>
2-10 days	7,823
11 – 20 days	23
21-77 days	8
<b>Total responses over 24 hours</b>	<b>7,854</b>

#### *Timeliness of onsite survey-Immediate Jeopardy*

The CMS State Operations Manual, which covers nursing homes and intermediate care facilities, requires the Department to initiate an onsite survey for immediate jeopardy cases within two working days of receipt.

We found 41 of 124 nursing home (33 percent) and two of eight (25 percent) of intermediate care facility complaints involving immediate jeopardy cases were not investigated within two working days of receipt.

#### *Assessment of nursing home complaints by qualified individuals*

The CMS State Operations Manual requires an assessment of each nursing home complaint be made by an individual who is professionally qualified to evaluate the nature of the problem based upon his or her knowledge and experience of current clinical standards of practice and federal requirements. We determined from December 2013 until July 2014 the clinical triage nurse only reviewed complaints that were considered clinical in nature and did not review each nursing home complaint as required by federal requirements.

#### *Timeliness of prioritization and referrals to the Residential Care Services field unit*

The CMS State Operations Manual also requires that all nursing home and intermediate care facility complaints be prioritized and referred to the field unit offices 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 field unit offices triggers the onsite survey.

We found the following complaints were not prioritized or referred to the field unit offices within two working days of receipt of the complaint:

- 2,169 for nursing homes (46.0 percent)
- 193 for intermediate care facilities (37.4 percent)

#### *Data reliability and completeness*

From the various methods that a complaint can be received by the Department, they must all be manually entered into the TIVA system. The entry into TIVA requires the input of the date the complaint was received in the unit. This date defaults to the current date and time if no entry is made. This date is instrumental in determining the Departments compliance for timeliness.

Complaints received in the unit, whether by voicemail, fax, mail, or live calls are not tracked to ensure all complaints are input into the TIVA system.

#### **Cause of Condition**

The Department has continued to make improvements to their policies and procedures, training and systems. The Department began using a new digital voicemail system in December 2013. It was anticipated that this new system, along with modifications made to the complaint intake system, would offer improved response times for the Complaint Resolution Unit. However, transcription of the complaints from the voicemail system continues to be a very time consuming process. The Department asserts that they would need to increase staffing to transcribe the complaints timely.

We consider these internal control deficiencies to be a material weakness.

### **Effect of the Condition**

When complaints are not received, prioritized and investigated timely, vulnerable residents are at a higher risk.

### **Recommendation**

We recommend the Department strengthen its internal controls to ensure all complaints are accounted for and responded to in a timely manner.

### **Department's Response**

The Department concurs with this finding.

The Department of Social and Health Services, Aging and Long-Term Support Administration agrees that a timely response to complaints/allegations of abuse, neglect, exploitation, inadequate care or supervision is paramount to the safety and protection of adults who are vulnerable.

After review of audit findings the Department has the following response:

The Department has continued to make improvements to the Complaint Resolution Unit (CRU) policies and procedures, training and systems. The Department agrees transcription of the complaints received by the toll free hotline is a time consuming process and crucial to the timeliness of prioritization and referral. In late August 2014, the CRU began a pilot program utilizing transcriptionists to retrieve hotline calls. Preliminary findings reveal this has significantly decreased both complaint prioritization and referral processing times. The development and implementation of improved standard operating procedures has also positively influenced processing time.

Other implemented internal controls since the audit include Tracking Incidents of Vulnerable Adults (TIVA) changes and changes to the hotline scripts. Tracking systems have been implemented for all types of received reports. These reports and tracking system are monitored daily to ensure complaints are processed, prioritized and referred in a timely manner. Staffing vacancies and shortages impact the department's compliance to meet the standards.

The department's ability to ensure complaints are responded to properly and in a timely manner is directly relational to the number of complaints being called in (and which subsequently require an investigation) and having sufficient departmental staffing to process same. The current CRU staffing model is insufficient to keep up with incoming complaint intake workload volume. The department has tried to manage the timely processing of complaint intake workload through the utilization of temporary staff. It will prove difficult for the department to maintain the timely processing of complaint intakes absent additional

staff in the future. It should also be noted the Department has activated recruitment and retention strategies, and made legislative requests for additional staffing, including the support of CMS to request an additional 15 FT Nursing Home surveyor/investigator staff to help the department keep current on its Nursing Home survey and investigatory workload. It will prove difficult for the department to obtain and sustain the timely processing of Nursing Home annual facility surveys and/or the timely processing of all Nursing Home complaints received, absent of the department being funded for the additional 15 requested Nursing Home surveyor/investigatory staff.

### **Auditor's Concluding Remarks**

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

### **Applicable Laws and Regulations**

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.

*Government Auditing Standards*, December 2011 Revision, paragraph 4.23 Communicating Deficiencies in Internal Control, Fraud, Noncompliance with Provisions of Laws, Regulations, Contracts, and Grant Agreements, and Abuse states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in internal controls over compliance in its *Codification of Statements on Auditing Standards*, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows: ...

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

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) of this section, 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) 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.

Residential Care Services Operational Principles and Procedures Complaint Resolution Unit Prioritization of Intakes – IV. Operational Procedures (A) July 2014:

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".

**2014-046**            **The Department of Social and Health Services, Aging and Long-Term Support Administration, did not complete surveys for Medicaid nursing home and intermediate care facilities for individuals with intellectual disabilities in a timely manner.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	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)
<b>Federal Award Number:</b>	5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT
<b>Applicable Compliance Component:</b>	Special Tests and Provisions – Provider Health and Safety Standards
<b>Questioned Cost Amount:</b>	None

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures. The state Medicaid program spent approximately \$9.3 billion in federal and state funds during fiscal year 2014.

Almost \$3.4 billion in total Medicaid spending relates to the Department of Social and Health Services.

Residential Care Services, under the Department of Social and Health Services, Aging and Long-Term Support Administration, is the state survey agency for the state of Washington.

### *Nursing Homes*

In fiscal year 2014 the state had 224 nursing homes that were Medicare and/or Medicaid certified. The survey for certification of a nursing home is a resident-centered inspection that gathers information about the quality of service furnished in a facility to determine compliance with the requirements of participation. The survey focuses on the nursing home’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.

### Intermediate Care Facilities for Individuals with Intellectual Disabilities

The state has 13 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). An ICF/IID is an institution that meets federal conditions of participation with its primary purpose being the provision of health or rehabilitation services to individuals with intellectual disabilities or related conditions and is receiving care and services under the Medicaid program.

The principal focus of the survey is on the "outcome" of the facility's implementation of ICF/IID active treatment services. Active treatment refers to the aggressive, consistent implementation of a program of specialized and generic training, treatment, health, and related services directed toward the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible.

States are required to complete a standard survey within 15.9 months following the previous survey and the state-wide average must not exceed 12.9 months for both Nursing Homes and ICF/IID's. If deficiencies are found in the facility then the Department is responsible for mailing a statement of deficiency to the facility within 10 working days of the survey date. In turn the facility is required to submit a plan of correction to the Department within 10 calendar days of receipt. The Centers for Medicare and Medicaid services measures state agencies using the federal fiscal year and our audit period looked at surveys during the state fiscal year.

### **Description of Condition**

#### Nursing Homes

We found the Department did not ensure nursing home surveys were performed in accordance with the frequency stipulated by state and federal laws. Of the state's 224 nursing homes, 24 (11 percent) surveys exceeded the 15.9 month requirement. In addition, the statewide average of 13.15 exceeded the requirement of 12.9.

We randomly selected 26 nursing homes to ensure the Department mailed the Statement of Deficiency within 10 working days of the survey date. We found six (23 percent) exceeded the required timeframe for mailing the statement of deficiency. We also reviewed these same nursing homes to determine if the plan of correction was received within 10 calendar days and found that eight (31 percent) were submitted late.

### Intermediate Care Facilities for Individuals with Intellectual Disabilities

All 13 ICF/IID facilities were surveyed within the required timeframe and met the required statewide average. However, the Department did not mail the statement of deficiencies within 10 working days as required. Ten ICF/IID facilities (77 percent) did not receive their statement of deficiency within the required timeframe and 11 (85 percent) facilities did not submit their plan of correction within the required 10 calendar days.

## **Cause of Condition**

In October 2013 the Department's Complaint Resolution Unit had a backlog of almost 1,880 complaints. Surveyors, who are also complaint investigators, were instructed to assist in reducing the backlog and focus only on complaint investigations. The redirection of surveyors to complaint investigations impacted the timeliness of surveys for several months.

Additionally, the survey follow up for statement of deficiencies and plan of corrections is not a formally tracked process.

We consider these control deficiencies to be a material weakness.

## **Effect of Condition**

When the Department does not conduct surveys and follow up on deficiencies timely as required for nursing homes and ICF/IID, 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 nursing home and ICF/IID surveys in accordance with the frequency required by federal and state laws. We also recommend internal controls be put in place to track statement of deficiencies and plan of corrections.

## **Department's Response**

*The Department partially concurs with this finding.*

### *NH Inspection Intervals and Statewide Averages*

*The Department agrees it did not meet its inspection intervals. It used surveyors to conduct backlogged complaint investigations resulting in untimely surveys. The Department will schedule and monitor surveys to meet standards. Staffing vacancies and shortages impact the Department's compliance to meet the standards, and the Department is making concerted efforts to address the staffing shortfall. The Department has activated recruitment and retention strategies, and made legislative requests for additional staffing, including the support of CMS.*

*The Department's ability to ensure Nursing Home surveys are conducted timely is directly relational to the department having sufficient staffing to comply with said requirement. The Department has requested an additional 15 FT Nursing Home surveyor/investigator staff to help the department keep current on its Nursing Home survey and investigatory workload. It will prove difficult for the department to obtain and sustain the timely processing of Nursing Home annual facility surveys and/or the timely processing of all Nursing Home complaints received, absent of the department being funded for the additional 15 requested Nursing Home surveyor/investigatory staff.*

### Statement of Deficiency Mailing NH and ICF/IID

*The Department agrees mailing of Statement of Deficiency reports exceeded required timelines. Mailing at times goes beyond timelines due to administrative enforcement decision-making, technical delays, and/or staffing issues. The Department will enhance mailing by implementing a formal tracking system. However, NH and ICF/IID staffing issues challenges the Department to meet the timeframes. The Department has activated recruitment and retention strategies, and made legislative requests for additional staffing, including the support of CMS.*

### Plan of Correction Tracking

*The Department does not agree that not tracking formally the receipt of plans of correction is a material weakness. The CMS State Operational Manual guidelines do not require formal tracking. The Department informally tracks Plan of Correction receipt statewide. RCS will enhance its monitoring of Plan of correction receipt by implementing a formal tracking system.*

### **Auditor's Concluding Remarks**

We appreciate the Department's response regarding their informal process to track plan of corrections. Although CMS guidelines do not mandate a formal tracking process, they do however; require the submission of an acceptable plan of correction within 10 calendar days. The identification and notification of deficiencies alone is not adequate to ensure compliance.

We reaffirm this portion of the finding.

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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 Communicating Deficiencies in Internal Control, Fraud, Noncompliance with Provisions of Laws, Regulations, Contracts, and Grant Agreements, and Abuse states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

Center for Medicare and Medicaid Services, State Operations Manual, Chapter 7 - Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities states in part:

7205 - Survey Frequency: 15-Month Survey Interval and 12-Month State-wide Average

7205.2 - Scheduling and Conducting Surveys

(Rev. 63, Issued: 09-10-10, Effective: 09-10-10, Implementation: 09-10-10)

The State must complete a standard survey of each skilled nursing facility and nursing facility not later than 15 months after the previous standard survey. Facilities with excellent histories of compliance may be surveyed less frequently to determine compliance, but no less frequently than every 15 months and the State-wide standard survey average must not exceed 12 months.

7319.1 - Non-State Operated Skilled Nursing Facilities and Nursing Facilities or Dually participating Facilities (Rev. 63, Issued: 09-10-10, Effective: 09-10-10, Implementation: 09-10-10)

1. The State conducts the survey and certifies compliance.
2. The State sends the facility Form CMS-2567 and if applicable, the “Notice of Isolated Deficiencies Which Cause No Actual Harm With the Potential for Minimal Harm” (Form A), within 10 working days of the last day of survey.
3. If the facility is in substantial compliance, but deficiencies constitute a pattern or widespread findings causing no actual harm and potential for only minimal harm, the State instructs the facility to submit a plan of correction to the State’s office. (This must be submitted within 10 calendar days after the facility has received its Statement of Deficiencies.) There is no requirement for the State to conduct a revisit to verify correction, but the facility is expected to comply with its plan of correction.

Center for Medicare and Medicaid Services, State Operations Manual, Chapter 2- The Certification Process states in part:

2138G - Schedule for Recertification

(Rev. 91, Issued: 09-27-13, Effective: 09-27-13, Implementation: 09-27-13)

The SA completes a recertification survey an average of every 12 months and at least once every 15 months (see §2141).

2141 - Recertification - ICFs/IID

(Rev. 91, Issued: 09-27-13, Effective: 09-27-13, Implementation: 09-27-13)

- The regulation at §442.15 provides that provider agreements for ICF/IID’s would remain in effect as long as the facility remains in compliance with the Conditions Of Participation (COP’s). Regulations at §442.109 through §442.111.

- Beginning on May 16, 2012, ICF/IID's are no longer subject to time-limited agreements. However, they are to be surveyed for re-certification an average of every 12 months and at least once every 15 months.
- If during a survey the survey agency finds a facility does not meet the standards for participation the facility may remain certified if the survey agency makes two determinations – The facility may maintain its certification if the survey agency finds Immediate Jeopardy doesn't exist, and if the facility provides an acceptable plan of correction.

Title 42, Code of Federal Regulations, Section 488.402 General provisions. States in part:

- (d) Plan of correction requirement. (1) Except as specified in paragraph (d)(2) of this section, regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements must submit a plan of correction for approval by CMS or the survey agency. (2) Isolated deficiencies. A facility is not required to submit a plan of correction when it has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

**2014-047**

**The Department of Social and Health Services, Aging and Long-Term Support Administration, did not adequately document inspections of Medicaid Adult Family Home providers.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 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:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Special Tests and Provisions – Provider Eligibility  
**Questioned Cost Amount:** None

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures. The state Medicaid program spent approximately \$9.3 billion in federal and state funds during fiscal year 2014.

Almost \$3.4 billion in total Medicaid spending relates to the Department of Social and Health Services.

The Medicaid program is the major source of public funding for long-term care services. The Medicaid Residential Long-Term Care program permits states to provide long-term care services to Medicaid beneficiaries in community settings, avoiding institutionalization.

Services are provided in adult family homes, which are residential homes licensed to care for up to six non-related clients. They provide room and board, laundry, necessary supervision and assist clients with daily living activities, personal care, and social services. All licensed adult family homes must meet basic qualifications to provide services to Medicaid clients, which include home inspections conducted by the Department.

The Department, Aging and Long-Term Support Administration, Residential Care Services Division is responsible for licensure oversight and compliance to ensure the safety, health, and well-being of residents and to continue providing services to Medicaid clients. Inspections

are performed by Department field office licensors. All adult family homes licensed by the Department are required to be inspected at least every 18 months. These requirements are intended to identify potential fraud, neglect, and abuse and to ensure program integrity and the ongoing safety of all adult family home residents. The documentation of these inspections is critical to support whether complete inspections took place and to support citations written due to provider or licensee noncompliance.

In fiscal year 2014, the Department paid approximately \$154 million to more than 2,400 licensed adult family home providers that provided services to Medicaid clients.

### **Description of Condition**

The Department's Inspection Operational Principles and Procedures Manual requires licensors to perform 13 processes for each inspection.

We randomly selected 28 of the 2,625 adult family homes that were inspected during the audit period and performed tests to determine whether Department licensing staff performed and documented adult family home inspections as required.

We found six of the 28 (21 percent) facility inspections lacked adequate documentation to support at least one of the required inspection processes was performed. The most common process that lacked documentation was interviews. These six facilities were cited for a deficiency.

### **Cause of Condition**

The Department has policies and procedures in place to ensure adult family home licensing staff document inspections as required in order for providers to remain eligible to provide services to Medicaid clients. However, due to limited resources and lack of monitoring of staff in certain field offices to perform the required inspections, the Department is at times unable to ensure all inspections are fully and adequately documented.

Additionally, the Department does not have controls to ensure facility inspections are reviewed for completeness in accordance with the Department's policies and procedures. The Department's documentation requirements are not effectively communicated to licensors and field office managers, leaving licensors to rely on their own judgment for adequately completing home inspections.

We consider this control deficiency to be a material weakness.

### **Effect of Condition**

An adult family home that does not receive a full inspection is not eligible to provide services to Medicaid clients, which could potentially endanger the safety and well-being of Medicaid clients residing in the adult family home. Licensing staff must document all required areas of inspection when a citation for deficiency is issued to ensure the provider has met all provider

eligibility requirements, and communicate any deficiencies to Residential Care Services management.

### **Recommendation**

We recommend the Department strengthen its internal controls by:

- Effectively communicating to staff facility inspection documentation requirements.
- Implementing a secondary review to ensure all required processes for inspections are adequately documented.

### **Department's Response**

*The Department partially concurs with this finding.*

*The Department wants to recognize there are a number of documents that make up an inspection. Several documents were used to record evidence in an inspection. If the audit found some documents were not located in working paper files or were documented incomplete, there was no audit evidence to reveal these audit findings constituted the lack of a full inspection. There was also no evidence to reveal the audit findings had any negative outcome on residents. The Department conducted full inspections.*

*Historically it was not part of the Department's inspection quality assurance activities to audit the documentation in working papers for every full inspection. The Department management staff periodically review documentation in discussion with inspectors related to the Statement of Deficiencies report, especially when there is harm involved and any need for enforcement. This is an internal control to review documentation. The Department does not have the resources to audit every document collected in a full inspection.*

*The Department trains staff to document evidence in an inspection in orientation and when the inspection process and forms are updated. The Adult Family Home Quality Assurance Training Program Manager has conducted periodic sample record reviews checking required documentation. In addition, the Department is committed to continuous quality improvement and will strengthen standard operating procedures to clearly communicate that it is a required process to follow for Adult Family Home inspections and that forms must be consistently used to document observations and findings. Furthermore, as part of the Department's commitment to help ensure policy and training, staff will train Adult Family Home licensors to the inspection standard operating procedures and on the consistent required use of all applicable forms.*

### **Auditor's Concluding Remarks**

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

## Applicable Laws and Regulations

U.S. Office of Management and Budget (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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 Communicating Deficiencies in Internal Control, Fraud, Noncompliance with Provisions of Laws, Regulations, Contracts, and Grant Agreements, and Abuse states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in internal controls over compliance in its Codification of Statements on Auditing Standards, section 935, as follows:

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Probable. The future event or events are likely to occur.

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

RCW 70.128.070, License – Inspections – Corrections 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 70.128.090 Inspections – Generally.

- (1) During inspections of an adult family home, the department shall have access and authority to examine areas and articles in the home used to provide care or support to residents, including residents' records, accounts, and the physical premises, including the buildings, grounds, and equipment. The personal records of the provider are not subject to department inspection nor is the separate bedroom of the provider, not used in direct care of a client, subject to review. The department may inspect all rooms during the initial licensing of the home. However, during a complaint investigation, the department shall have access to the entire premises and all pertinent records when necessary to conduct official business. The department also shall have the authority to interview the provider and residents of an adult family home.
- (2) Whenever an inspection is conducted, the department shall prepare a written report that summarizes all information obtained during the inspection, and if the home is in violation of this chapter, serve a copy of the inspection report upon the provider at the same time as a notice of violation. This notice shall be mailed to the provider within ten working days of the completion of the inspection process. If the home is not in violation of this chapter, a copy of the inspection report shall be mailed to the provider within ten calendar days of the inspection of the home. All inspection reports shall be made available to the public at the department during business hours.
- (3) The provider shall develop corrective measures for any violations found by the department's inspection. The department shall upon request provide consultation

and technical assistance to assist the provider in developing effective corrective measures. The department shall include a statement of the provider's corrective measures in the department's inspection report.

Residential Care Services (RCS) Operational Principles and Procedures for Adult Family Home Licensing Inspections, states in part:

### III – Operational Principles

A. Residential Care Services will conduct unannounced inspections in a licensed adult family home (AFH) at least every 18 months, except that:

1. RCS may inspect every 24 months if the AFH has:
  - a. No citations for the past three consecutive inspections; and
  - b. Received no conditions or citations resulting from complaint investigations during the same time period.

### IV – Inspection Procedures

A. The field staff will use the following inspection processes:

1. Preparation for the on-site inspection
2. Entrance on-site
3. Tour
4. Interviews
5. Observations
6. Medication Service
7. Food Service
8. Abuse/Neglect Prevention
9. Resident Record Review
10. Administrative Staff Record Review and Staff Interview
11. Exit Preparation
12. Exit
13. Follow-up Inspection (if needed)

RCS Community Programs - Principles of Documentation – Legal Aspects of the Statement of Deficiencies, states, in part:

“Licensors are required to record all of the facts and information that citations of provider/licensee noncompliance are based on. The licensor must be able to provide consistent and accurate records of the facts and information at any time.”

**2014-048**

**The Department of Social and Health Services, Aging and Long-Term Support Administration, did not adequately monitor Medicaid Adult Family Home providers to ensure all providers, caregivers and resident managers who are employed directly or by contract have proper background checks.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	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)
<b>Federal Award Number:</b>	5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed/Unallowed, Allowable Costs/Cost Principles, Special Tests and Provisions – Provider Eligibility
<b>Questioned Cost Amount:</b>	\$1,082,213

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$9.3 billion in federal and state funds during fiscal year 2014.

Almost \$3.4 billion in total Medicaid spending relates to the Department of Social and Health Services, of which it paid approximately \$154 million to more than 2,400 licensed providers that provided adult family home services to about 9,100 Medicaid clients.

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. These services are provided in adult family homes by individuals or agencies most often chosen by the Medicaid client or their family.

All providers must meet basic qualifications to provide services to Medicaid clients, which include background checks, certifications and training. Adult Family Home providers and

their employees must complete a state background check and after January 7, 2012, a national fingerprint background check through the Department’s Background Check Central Unit.

The Department’s Aging and Long-Term Support Administration, Residential Care Services unit is responsible for ensuring that all adult family homes and their providers meet and maintain minimum licensing requirements to continue providing services to Medicaid clients. The Department performs an inspection of all adult family homes at least every 18 months to ensure the adult family home provider is in compliance with all requirements to remain eligible to provide Medicaid services to clients. During the inspection, Department staff review background check result letters for the provider, resident manager and adult family home employee to ensure they are eligible to work and have completed the required background check every two years.

The Secretary of the Department 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 the previous audit, we reported the Department did not ensure providers completed background checks before providing services to Medicaid clients. The prior finding number was 2013-037.

**Description of Condition**

*Adult Family Home providers:*

We tested to determine whether adult family home providers were qualified to provide services to Medicaid clients. These providers were found in the Department’s background check database using their social security number, or name and date of birth.

We reviewed records for 1,271 adult family home providers and found 111(8.7 percent) did not renew their background checks in a timely manner and received payments from the Department for those months while providing ineligible Medicaid services.

<b>Number of months clients received services paid by Medicaid by a provider without a background check</b>	<b>Number of Providers</b>
1-3 Months	53
4-6 Months	25
7-11 Months	13
1 Year or More	20
<b>Total</b>	<b>111</b>

In addition, we randomly selected a sample of 31 providers out of 109 identified as having non-disqualifying criminal records. We found the Department did not document a Character, Competence and Suitability review on six of the 31 licensed providers. Ten providers in the sample did not respond to our request, and therefore we cannot determine whether or not they are eligible to provide Medicaid services.

#### *Adult Family Home employees*

Using wage information reported by employers, we identified 8,951 employees working for adult family home providers in fiscal year 2014. In addition, a social security number match was performed with the Department's background check database to determine if background checks were completed for each employee.

We found:

- Background checks for 187 staff were not completed within the last two years.
- A Character, Competence and Suitability Review was not completed for 50 staff with criminal histories.
- Five individuals provided services for at least one full month while having an automatically disqualifying criminal history. Two of these individuals were terminated by their employers prior to our audit. However, the providers did not present evidence of termination for the remaining three individuals. The Department is currently following up on this matter.

#### **Cause of Condition**

The Department has procedures in place to ensure adult family homes meet minimum licensing requirements. However, there is a high rate of turn-over in employees in adult family homes, which increases the risk of provider noncompliance with state and federal background check requirements.

During the audit period, Residential Care Services revised its inspection policies to test 100% of staff for background checks during their on-site visits. However, this measure is only effective in detecting individuals who are *currently* working without a background check at the time of inspection. Up to 18 months may pass before an adult family home receives another inspection from the Department, which could allow a significant period of time for an individual to work without a background check and then be terminated by their provider.

In addition, the Department does not have adequate controls in place to ensure providers renew background checks in a timely manner, and that disqualified employees do not have access to vulnerable adults.

We consider this control deficiency to be a significant deficiency.

## **Effect of Condition and Questioned Costs**

The Department paid a total of \$2,164,626 to 111 providers who did not complete a required background check at the time the services were provided.

We are questioning \$1,082,313, which is the federal portion of the unallowable payments. The federal share of expenditures is calculated using the state's 2014 FMAP rate of 50 percent.

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. Any payments made by the Department to ineligible providers are unallowable.

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:

- Improve internal controls to ensure adult family home providers complete background checks in a timely manner.
- Strengthen its monitoring of adult family home providers to ensure they perform adequate background checks of all caregivers, representatives and resident managers who are employed directly or by contract.
- Follow-up on background check results and ensure disqualified caregivers do not have access to vulnerable adults.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

## **Department's Response**

*The Department agrees that compliance with all adult family home regulations is paramount to ensuring vulnerable clients are safe from neglect, harm and abuse.*

*The Residential Care Services conducts unannounced inspections within 18 months (with a 15-month average) of all adult family homes. In April 2014, the Department changed its policies and procedures to check backgrounds for all employees, the provider, and resident manager at the time of inspection. In addition to inspecting 100% of background checks for employees employed at the time of inspection, the Department does investigate adult family home complaints, including those related to background checks.*

*Adult family homes have a high employee turnover rate. The Department does not have the resources to visit an Adult Family Home between inspections each time a caregiver changes to validate the background check. 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. As part of the inspections, the staff record review process determines if the home has a system to check that all staff are qualified and required background checks have been performed.*

*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.*

*The Department will continue to tighten up its monitoring of AFH providers staff background checks. These efforts will continue to be accomplished through the Department's facility licensing, annual facility survey and investigatory business protocols.*

### **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 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.

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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in internal controls over compliance in its *Codification of Statements on Auditing Standards*, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows: ...

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

Significant deficiency in internal control over compliance. A deficiency, or a combination of deficiencies, in internal control over compliance that is less severe

than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

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 388-76-10015, 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.

- (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 388-76-10165 Background checks – Washington State name and date of birth background check – Valid for two years – National fingerprint background check – Valid indefinitely, states:

- (1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The adult family home must ensure:

- (a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for each individual listed in WAC 388-76-10161;
  - (b) There is a valid Washington state background check for all individuals listed in WAC 388-76-10161.
- (2) A national fingerprint background check is valid for an indefinite period of time. The adult family home must ensure there is a valid national fingerprint background check for individuals hired after January 7, 2012 as caregivers, entity representatives or resident managers. To be considered valid, the individual must have completed the national fingerprint background check through the background check central unit after January 7, 2012.

WAC 388-76-10166 Background checks – Household members, noncaregiving and unpaid staff – Unsupervised access.

- (1) The adult family home must not allow individuals specified in WAC 388-76-10161(3) to have unsupervised access to residents until the home receives results of the Washington state name and date of birth background check from the department verifying that the person does not have convictions or findings described in WAC 388-76-10180.
- (2) If any background check results show that the person has a conviction or finding that is not automatically disqualifying under WAC 388-76-10180, then the adult family home must:
- (a) Determine whether or not the person has the character, competence and suitability to have unsupervised access to residents; and
  - (b) Document in writing the basis for making the decision.

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 background check, provided the home:

- (1) Submits the Washington state name and date of birth background check no later than 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 of the individual, as defined in WAC 388-76-10000; 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 check.

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 (2) if the individual has any 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 (g), 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 Substances 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 WAC 388-76-10176.

WAC 388-76-10181 Background checks – Employment – Nondisqualifying information.

- (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
- (2) Nothing in this section should be interpreted as requiring the employment of any person against the better judgment of the adult family home.

**2014-049**

**The Department of Social and Health Services, Aging and Long-Term Support Administration, made unallowable payments to Medicaid providers who did not meet background check requirements for in home care providers.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	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)
<b>Federal Award Number:</b>	5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed/Unallowed, Allowable Costs/Cost Principles, Special Tests and Provisions - Provider Eligibility
<b>Questioned Cost Amount:</b>	\$257,875

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$9.3 billion in federal and state funds during fiscal year 2014.

Almost \$3.4 billion in total Medicaid spending relates to the Department of Social and Health Services, of which it paid approximately \$194 million to more than 19,000 in-home service individual providers for their services.

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. These services are provided in the client's home by individuals or agencies often chosen by the Medicaid client.

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 Department's minimum training requirement.

In addition, individual providers must successfully complete state and national fingerprint-based background checks every two years. Effective January 8, 2012, both state and national fingerprint background checks must be conducted for all providers, or for applicants who have not lived in Washington State for three consecutive years.

The Secretary of the Department 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.

### **Description of Condition**

During the previous audit, we reported the Department did not ensure providers completed background checks before providing services to Medicaid clients. The prior finding number was 2013-040, 12-41, 11-34.

We reviewed all 19,433 providers who provided in-home care during fiscal year 2014 to ensure that:

- A proper background check had been completed within the last two years.
- No individuals with disqualifying crimes listed on the Secretary’s List were employed at the time of the audit, or during the month[s] in which they worked.
- Staff with criminal records that were not listed on the Secretary’s List passed a Character, Competence and Suitability (CCS) Review permitting them to work unsupervised with vulnerable adults.
- The entire period in which the provider had access to Medicaid clients was covered by a Washington State background check.

We found:

- Background checks for 28 providers were not completed in a timely manner, ranging from 1 to 10 months after the provider had begun to provide care to a Medicaid client without a cleared background check.
- The Department paid 69 providers who worked with automatically disqualifying criminal histories. The Department terminated 34 providers before verification of background checks were requested by our office. The Department is in the process of reviewing the remaining 35 providers.
- The Department did not ensure that a required fingerprint-based background check was performed for one provider after their 120-day provisional hire period while employed.

### **Cause of Condition**

The Department has adequate procedures in place to materially ensure individual providers meet the background check requirements. However, in some instances, the Department did not confirm that provider background checks were completed every two years as required by state rules.

The Department has improved the overall communication of Departmental policies and procedures to unit managers at AAA's that oversee provider contracts.

### **Effect of Condition and Questioned Costs**

Providers who do not meet the background check requirement are not eligible to provide services to Medicaid clients. Any payments made by the Department to ineligible providers are unallowable.

The following table summarizes the unallowable payments we identified in the audit by condition:

<b>Condition</b>	<b>Number of providers</b>	<b>Total unallowable payments</b>
Providers working without a background check	28	\$210,979
Providers who worked with disqualifying criminal histories	69	\$293,446
Providers who did not complete a required fingerprint background check	1	\$11,326
	<b>98</b>	<b>\$515,751</b>

We are questioning \$257,875, which is the federal portion of the unallowable payments. The federal share is calculated using the state's 2014 FMAP rate of 50 percent.

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

### **Recommendation**

We recommend the Department:

- Follow-up on background check results and ensure ineligible providers do not have access to vulnerable Medicaid clients.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

## **Department's Response**

*The Department concurs with this finding.*

*The Department is pleased that its efforts, and the efforts of its partners, have resulted in 99.5% compliance with background check requirements.*

*The Department will continue to work with the Background Check Central Unit to strengthen processes that may provide a timelier and more consistent way to inform field staff about disqualifying background check results. In addition, the Department will continue to work with field offices to improve timely background check tracking and explore additional tools to assist in this tracking.*

*The Department will determine the federal portion of the unallowable expenditures that should be returned.*

## **Auditor's Concluding Remarks**

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

## **Applicable Laws and Regulations**

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:

- (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.

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 states 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).

WAC 388-71-0513 Is a background check required of a long-term care worker employed by a home care agency licensed by the department of health?

In order to be a long-term care worker employed by a home care agency, a person must:

- (1) Complete the required DSHS form authorizing a background check.
- (2) Disclose any disqualifying criminal convictions and pending charges as listed in WAC [388-113-0020](#), and also disclose civil adjudication proceedings and negative actions as those terms are defined in WAC [388-71-0512](#).
- (3) 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.
- (4) Effective January 8, 2012, be screened through the Washington state and national fingerprint-based background check, as required by RCW [74.39A.056](#).

- (5) Results of background checks are provided to the department and the employer or potential employer 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 based on his or her character, competence, and/or suitability.
- (6) Disqualifying crimes, civil adjudication proceeding, and negative actions are listed in WAC 388-71-0540 (4), (5) and (6).
- (7) For those providers listed in RCW [43.43.837](#)(1), a second 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.
- (8) The department may require a long-term care worker 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.

WAC 388-71-0514 Can an individual provider or licensed home care agency long-term care worker work pending the outcome of the national fingerprint-based background check?

An individual provider or licensed home care agency long-term care worker may work up to one hundred twenty days pending the outcome of the Washington state and national fingerprint-based background check, provided that the person is not disqualified as a result of Washington state's name and date of birth background check or for character, competence, or suitability.

WAC 388-101-3090 The department must deny - Application

- (1) The department must deny an application for initial certification or change of ownership if any person named in the application has:
  - (a) Been convicted of a crime listed under WAC 388-06-0170(1);
  - (b) Been convicted of a disqualifying crime under WAC 388-06-0180;
  - (c) Been found by a court in a criminal proceeding, a protection proceeding, or a civil damages lawsuit under chapter 74.34 RCW, to have abused, neglected, abandoned, or financially exploited a vulnerable adult;
  - (d) Been found to have abused, neglected, financially exploited, or abandoned a minor or vulnerable adult by a 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 proceedings under Title 26 RCW, and vulnerable adult protection proceedings under chapter 74.34 RCW;
  - (e) A substantiated finding of abuse or neglect of a child that is:
    - (i) Listed on the department's background check central unit (BCCU) report; or
    - (ii) Disclosed by the individual, except for findings made before December 1998; or

- (f) A substantiated finding of abuse, neglect, financial exploitation, or abandonment of a vulnerable adult that is:
  - (i) Listed on any registry, including the department's registry;
  - (ii) Listed on the department's background check central unit (BCCU) report;  
or
  - (iii) Disclosed by the individual, except for adult protective services findings made before October 2003.
- (2) The department must deny an application for initial certification or change of ownership if any person named in the application has a pending charge for a crime that is disqualifying under this section.

**2014-050**            **The Department of Social and Health Services improperly claimed federal reimbursement for non-emergency services provided to nonqualified aliens and for payments made on behalf of deceased Medicaid clients.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	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)
<b>Federal Award Number:</b>	5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed or Unallowed
<b>Questioned Cost Amount:</b>	\$715,768

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.63 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures. The state Medicaid program spent approximately \$9.3 billion in federal and state funds during fiscal year 2014.

Almost \$3.4 billion in total Medicaid spending relates to the Department of Social and Health Services.

### *Non-Emergency Services*

Under federal law all United States citizens and certain legal immigrants who meet Medicaid’s financial and non-financial eligibility criteria are eligible to receive Medicaid benefits. Nonqualified aliens are not eligible to receive standard Medicaid benefits, but may be eligible for care and services necessary in an emergency medical situation.

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 whose symptoms are acute and severe 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 an emergency situation 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; however, the federal government will not share the cost of these services.

#### Payments after date of death

Federal regulations state that an overpayment is the amount that a Medicaid agency paid to a provider in excess of the amount allowable for provided services. Services cannot be provided after a beneficiary's death, and as such no medical service claims 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 quarterly data from the state Department of Health which is used to identify deceased Medicaid clients. These clients are then 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 overpayments made to providers.

## Description of Condition

We found the Department paid for the following unallowable expenditures:

### Non-emergency Services

We identified 578 non-emergency services provided to 27 nonqualified aliens. The following table summarizes the results of our review:

Description	Number of claims	Total Payments	Federal Share*	State Share
Non-emergency services paid for nonqualified aliens	578	\$1,376,162	\$688,081	\$688,081

\* The federal share is calculated using the state's 2014 FMAP rate of 50 percent.

### Payments after date of death

We identified 63 payments for services that occurred after a client's death. The following table summarizes the results of our review:

Description	Number of claims	Total Payments	Federal Share*	State Share
Services provided after date of death	63	\$55,373	\$27,687	\$27,686

\* The federal share is calculated using the state's 2014 FMAP rate of 50 percent.

## Cause of Condition

The Department performs a quarterly review to detect unallowable Medicaid payments for services provided to nonqualified aliens and payments for services provided after a client's death. However, these reviews are not effective to prevent or detect all unallowable payments.

## Effect of Condition and Questioned Costs

When the state provides services to ineligible individuals, or the services are unallowable, the services cannot be claimed for federal reimbursement. During fiscal year 2014, the Department paid \$1,431,535 to providers for services for unallowable activities. We are questioning \$715,768, the federal portion 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 its expenditures.

## **Recommendation**

We recommend the Department:

- Ensure Medicaid services provided to nonqualified aliens are restricted to emergency services.
- Enhance monitoring 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.

## **Department's Response**

*This finding involved several administrations within the Department. Each administration responded individually.*

### **Economic Services Administration (ESA)**

*The Economic Services Administration (ESA) concurs with the finding for the one Community Services Division (CSD) case identified as an exception. CSD has reviewed and taken necessary action to correct the case.*

### **Aging and Long Term Support Administration (ALTSA/HCS)**

#### ***Regarding Non-emergency Services –***

*ALTSA (Home and Community Services (HCS)) concurs with the finding.*

*When the Recipient Aid Codes (RACs) for these services was previously changed, the account coding in Provider One was updated for the Developmental Disabilities Administration clients but due to staff error, the correction was missed for the ALTSA clients. The RACs were updated in Provider One and all questioned costs returned to CMS in November 2014.*

#### ***Regarding HCS Payments after Death***

*ALTSA found errors in the exceptions issued by the State Auditor's Office in the preliminary draft. These were discussed with the auditor. As a result, the SAO revised the final exceptions. Based on the revised exceptions, ALTSA concurs with this finding and agrees that the federal portion of the unallowable expenditures should be returned. The agreed on amount to be returned by ALTSA for the HCS cases based on this revision is \$21,159.*

*The Department will continue its work to strengthen processes that may provide a timelier and more consistent way to inform field staff about deceased clients. Currently field staff receive this information from a variety of sources, including relatives, death notices in the papers, ACES-Social Security Data Exchange matches, and other sources. The availability and consistency of this information will improve with upgrades to our payment system as*

*ProviderOne is fully implemented this year. At that time, staff should have uniform access to the same data sources for information about client deaths.*

*In the interim, the Department will continue to monitor the Invalid Payments Report that was implemented in December 2012. It identifies potentially invalid payments (payments for services/equipment that appear to have been provided after the client's date of death). The report is reviewed monthly by the AL TSA/HCS Quality Assurance Unit for AL TSA cases.*

*HCS distributed a management bulletin (MB H14-062 dated 8/28/14) to educate all field offices about how to prevent and correct invalid payments. The result was more accurate use of authorization start and termination dates by the field offices, and also a decrease in the number of cases that appear on the Invalid Payments Report.*

*HCS overpayments have been submitted to the DSHS Office of Financial Recovery for the questioned costs. The recovery will be returned to CMS and reported on the CMS-64 when recovered or if not recovered timely, through the MOMS process.*

### **Developmental Disabilities Administration (DDA)**

#### ***Non-Emergency Services***

*DDA did not have findings for payments of non-emergency services paid for nonqualified aliens. We will continue to monitor authorizations to ensure that services continue to be authorized correctly.*

*DDA is also confident that as of January 1, 2015, when claims started being paid through Provider 1, that the edits within that payment system will also prevent payments of non-emergency services to nonqualified aliens.*

#### ***Payments after date of death***

*The SAO review found nine instances of payments totaling \$10,051.57 for DDA services provided after the client's date of death. DDA has processed overpayments for the findings.*

*DDA acknowledges that the target for payment of services, provided after the date of death is zero and we seek to reach that mark but note that the findings are minimal and demonstrate that current methods are working well and reducing future audit findings to zero may be attainable.*

*Current practice includes training for staff to ensure payment of services does not extend past the date of death. Monitoring is done monthly to ensure that all authorizations are terminated on or before the date of death and any payments that may have been made are quickly processed as an overpayment. Additional monitoring is done by an external agency via an algorithm to ensure that any payments not found via the monthly monitoring are collected via the overpayment process. Few payments after the date of death are found via the external audit.*

- 1) *The DDA SSPS Program Manager will continue to provide quarterly reports of SSPS monitoring to management. Regions will report the level of compliance in their quarterly reviews. These reports include monitoring of authorizations open after the date of death.*
- 2) *DDA will continue its partnership with the Health Care Authority and external audit agency Optum, to monitor for payments after the date of death using an algorithm. The algorithm will continue to be run quarterly.*
- 3) *DDA will continue to provide training and direction to staff to ensure authorizing staff understand the need to end date authorizations with a date matching the date of death or earlier as soon as they learn of a client's passing.*
  - a) *DDA participates in the design of the ProviderOne payment system for W2 providers, which will be developed to prevent payments after the death of the client.*
  - b) *Providers receiving a W2 tax form are schedule to transition to ProviderOne in January 2016.*
  - c) *All other providers began receiving payment through ProviderOne January 1, 2015.*
- 4) *Repayment will be made to the US Department of Health and Human Services as required.*

### **Children's Administration (CA)**

*CA concurs with this finding.*

*Of the exceptions, three pertain to CA. CA will work to strengthen the review of these cases to help minimize the possibility that funds are allocated to Medicaid funding in error.*

*The federal funds for these clients will be returned and we will communicate the information for the Centers for Medicare and Medicaid Services.*

### **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:

- (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 440.255, Limited services available to certain aliens' states:

- (a) FFP for services. FFP is available for services provided to aliens described in this section which are necessary to treat an emergency medical condition as defined in paragraphs (b)(1) and (c) or services for pregnant women described in paragraph (b)(2).
- (b) Legalized aliens eligible only for emergency services and services for pregnant women. Aliens granted lawful temporary resident status, or lawful permanent resident status under sections 245A, 210 or 210A of the Immigration and Nationality Act, who are not in one of the exempt groups described in §§435.406(a)(3) and 436.406(a)(3) and who meet all other requirements for Medicaid will be eligible for the following services—
  - (1) Emergency services required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
    - (i) Placing the patient's health in serious jeopardy;
    - (ii) Serious impairment to bodily functions; or
    - (iii) Serious dysfunction of any bodily organ or part.
  - (2) Services for pregnant women which are included in the approved State plan. These services include routine prenatal care, labor and delivery, and routine post-partum care. States, at their option, may provide additional plan services for the treatment of conditions which may complicate the pregnancy or delivery.
- (c) Effective January 1, 1987, aliens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of law must receive the services necessary to treat the condition defined in paragraph (1) of this section if—
  - (1) The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
    - (i) Placing the patient's health in serious jeopardy;
    - (ii) Serious impairment to bodily functions; or
    - (iii) Serious dysfunction of any bodily organ or part, and

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

Title 42, Code of Federal Regulations, Section 435.406, Citizenship and alienage states:

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

Washington Administrative Code (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.

Washington Administrative Code (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 pre-evaluations, 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.

**2014-051**            **The Department of Social and Health Services did not have adequate internal controls in place, and did not comply with, the level of effort requirements for the Block Grants for Prevention and Treatment of Substance Abuse.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.959 Block Grants for Prevention and Treatment of Substance Abuse  
**Federal Award Number:** 2B08TI010056-12; 2B08TI010056-13; 2B08TI010056-14  
**Applicable Compliance Component:** Level of Effort  
**Questioned Cost Amount:** None

### **Background**

The Department of Social and Health Services, Division of Behavioral Health and Recovery, administers the Block Grants for Prevention and Treatment of Substance Abuse. The Department subawards some of the funds to counties, tribes, nonprofit organizations and other state agencies to develop prevention programs and provide treatment and support services. The Department spent almost \$32 million in Block Grants for Prevention and Treatment of Substance Abuse federal funds during fiscal year 2014.

Federal regulations require the Department to maintain state spending at certain levels in order to meet federal grant requirements. This includes the following:

1. Maintain state spending for authorized activities at a level that is not less than the average of the previous two years spending for the program.
2. Maintain state spending for substance abuse treatment services for pregnant women and women with dependent children at a level that is not less than the amount spent for the same services in 1994.
3. Maintain state spending for tuberculosis services at a level that is not less than the average calculated in fiscal year 1991 and 1992.

### **Description of Condition**

During our audit period the Department did not have internal controls in place to ensure compliance with any of the three requirements listed above. In each case the Department had no ongoing monitoring and was waiting until the end of each fiscal year to determine whether they were in compliance.

During the audit we were told by Department staff the Department did not meet the requirement to maintain certain state spending at the average of the last two years' spending levels for fiscal year 2013. Despite this, the Department did not monitor or take other actions to ensure compliance with this requirement and again did not meet the requirement for fiscal

year 2014. Additionally, for the requirement related to tuberculosis services, the Department was relying on expenditures made at the Department of Health to meet the requirement, but the Department of Health staff stated they were unaware the Department of Social and Health Services was using their expenditures to meet this requirement.

### **Cause of Condition**

Accounting staff do not monitor any of the maintenance of effort requirements throughout the fiscal year. For the requirement the Department did not meet, staff stated they obligate enough state funds to meet the requirement through contracts with county entities. County entities, however, have two years to spend the funds. Because the Department believed the counties would spend all funds within one year, they assumed the maintenance of effort requirement would be met based on the amount obligated in their contracts.

We consider these control deficiencies to be a material weakness.

### **Effect of Condition**

Without adequate internal controls in place, the Department could not ensure it would meet all level of effort requirements during the audit period. By not properly monitoring and documenting that level of effort requirements are being met, the Department is not in compliance with federal requirements for its Block Grant.

For the requirement to maintain state spending at a level that is not less than the average spending during the previous two years, we determined the Department spent \$6,921,621 less than what was required for fiscal year 2014.

### **Recommendation**

We recommend the Department establish policies, procedures and other internal controls sufficient to ensure the monitoring and documentation of level of effort requirements is performed. The Department should also actively monitor state-funded spending to ensure it spends at least the minimum required amount each year for the grant. Additionally, if the Department determines it will not meet one of the requirements, it should contact its federal grantor to determine an appropriate course of action.

### **Department's Response**

*The Department concurs with the State Auditor Office finding.*

*The Department's Behavioral Health and Service Integration Administration will:*

- 1. Develop policy, procedures and internal controls to ensure monitoring and documentation of level of effort requirements is performed.*

2. *Actively monitor the state-funded spending. Produce monthly reports showing the status of the state-funded spending and review the monthly reports in order to monitor the capability of meeting the minimum required amount each year.*
3. *Continue to remain in constant communications with our Federal Grantors in order to keep them apprised of our ability to meet the annual minimum required state-funded spending and will work with our Federal Grantors to determine an appropriate course of action if the requirement cannot be 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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

- 11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows:

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in *design* exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in *operation* exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

Reasonably possible. The chance of the future event or events occurring is more than remote but less than likely.

Remote. The chance of the future event or events occurring is slight.

Probable. The future event or events are likely to occur.

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

United States Code, Title 42

§ 300x–30. Maintenance of effort regarding State expenditures

(a) In general

With respect to the principal agency of a State for carrying out authorized activities, a funding agreement for a grant under section 300x–21 of this title for the State for a fiscal year is that such agency will for such year maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

U.S. Office of Management and Budget Circular A-133, Compliance Supplement 2014, Part 4  
– Department of Health and Human Services, states in part:

CFDA 93.959 – Block Grants for Prevention and Treatment of Substance Abuse

2.1 Level of Effort – *Maintenance of Effort*

- a. The State shall for each fiscal year maintain aggregate State expenditures for authorized activities by the principal agency at a level that is not less than the average level of such expenditures maintained by the State for the 2 State fiscal years preceding the fiscal year for which the State is applying for the grant. The “principal agency” is defined as the single State agency responsible for planning, carrying out and evaluating activities to prevent and treat SA and related activities. The Secretary may exclude from the aggregate State expenditures funds appropriated to the principal agency for authorized activities which are of a non-recurring nature and for a specific purpose (42 USC 300x-30; 45 CFR sections 96.121 and 96.134; and *Federal Register*, July 6, 2001 (66 FR 35658) and November 23, 2001 (66 FR 58746-58747) as specified in II, “Program Procedures – Availability of Other Program Information”).
- b. The State must maintain expenditures at not less than the calculated fiscal year 1994 base amount for SA treatment services for pregnant women and women with dependent children. The fiscal year 1994 base amount was reported in the State’s fiscal year 1995 application (42 USC 300x-27; 45 CFR section 96.124(c)).
- d. The State shall maintain expenditures of non-Federal amounts for tuberculosis services at a level that is not less than an average of such expenditures maintained by the State for the 2 year period preceding the first fiscal year for which the State receives such a grant (42 USC 300x-24; 45 CFR section 96.127).

**2014-052**

**The Department of Health does not have adequate internal controls over, and did not comply with, the Federal Funding Accountability and Transparency Act reporting requirements for the Maternal and Child Health Services Block Grant.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.994 Maternal and Child Health Services  
Block Grant to the States  
**Federal Award Number:** B04MC26703; B04MC25378; B04MC23416  
**Applicable Compliance Component:** Reporting  
**Questioned Cost Amount:** None

### **Background**

The Washington State Department of Health administers the Maternal and Child Health Service Block Grant. This grant addresses the lives and health of pregnant and reproductive-age women, infants, children and adolescents. The Maternal and Child Health Service programs take a broad approach to disease prevention and health promotion to provide benefits across the lifespan.

The Department distributes money to local health jurisdictions, hospitals and health centers who address the issues of preventive and primary care services for children and for services for children with special health care needs. The Department spent approximately \$9.4 million in Maternal and Child Health Services Block Grant funds during fiscal year 2014.

Under the Federal Funding Accountability and Transparency Act (Accountability Act), the Department is required to collect and report information on each subaward or amendment of \$25,000 or more in federal funds in the Federal Funding Accountability and Transparency Act Subaward 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.

The Department's process for Accountability Act reporting starts with staff entering contract information into the agency's financial reporting system after a subaward is executed. When staff are ready to submit an Accountability Act report, they run a report from the financial reporting system to determine what subawards need to be reported. These subawards are then entered into the federal reporting system and a supervisor reviews the information and submits it.

## **Description of Condition**

The Department did not have adequate internal controls in place to ensure the fiscal year 2014 Accountability Act reports were filed correctly. Specifically, the Department did not have internal controls in place that would ensure all subawards are entered into the agency's financial reporting system. We tested 17 subawards and amendments, totaling \$1,271,675, and determined five, totaling \$250,334, were not reported during the audit period. These five subawards did not appear on the financial reports used to determine what should be reported for the Accountability Act.

## **Cause of Condition**

Although the Department has procedures in place for collecting subaward information, it does not have a written process for how to ensure all subawards are entered into the financial reporting system. Additionally, the secondary review the Department has established does not include comparing financial report information to source documents. By comparing only to the financial system reports, subawards not entered into the system would not be detected.

We consider these internal control weaknesses to constitute a material weakness.

## **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 written policies and procedures to ensure all Accountability Act reports are submitted accurately. We also recommend that the Department's secondary review includes verifying the accuracy of the reported information.

## **Department's Response**

*We agree that five subawards totaling \$250,334 were not reported during the audit period. This was in part caused by the awards being omitted from our monthly FFATA reporting list due to an error in the criteria used to extract the reporting data from our financial system. This error was discovered and corrected in September 2013.*

*It is currently the practice of the Department for the Grants Unit Supervisor to review and approve FFATA data prior to being submitted in FSRS.*

*The Department will update its written procedures for submitting Accountability Act reports, adding additional detail. The procedures will include the review and approval of FFATA data by the Grants Unit Supervisor prior to being submitted in FSRS and the necessary steps for ensuring all FFATA data is submitted in a timely manner.*

## Auditor's Concluding Remarks

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

## Applicable Laws and Regulations

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.

Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

- 4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its Codification of Statements on Auditing Standards, section 935, as follows:

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Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

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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.



## **Description of Condition**

We found the Department did not competitively procure any of the 59 social research service contracts in effect during the audit period. The Department believed that these types of contracts were still exempt from competitive procurement requirements. There were no internal controls in place to ensure state law was followed when procuring these services.

## **Cause of Condition**

The individuals responsible for executing contracts at DDS have multiple job duties, many of which are unrelated to contracting. These individuals were not aware of the requirement to competitively procure the social research service contracts. The Department does have a Central Contract Services unit that oversees all contracts at the Department. This unit was responsible for implementing the new state procurement laws and working with ESA and DDS. We determined the individuals executing contracts at the program did not receive adequate guidance from Central Contract Services directing them to the changes with the new state law. We consider this control deficiency to be a material weakness.

## **Effect of Condition**

By not competitively procuring contracts the Department was not in compliance with state law. Because of this the Department may be at risk the federal grantor will take actions that could adversely affect the program and/or the program funding.

## **Recommendation**

We recommend the Department competitively procure its social research service contracts as required by state law or obtain an exemption from these requirements from the Department of Enterprise Services. We also recommend the Department ensure individuals that execute contracts have adequate guidance and training from Central Contract Services.

## **Department's Response**

*The Department concurs with this finding.*

*The Department agrees that the contracts in question were not competitively procured according to the changes in state law.*

*The Department's Economic Services Administration (including DDDS) will work with Central Contract Services to change the contracts process to ensure that future contracts comply with RCW 39.26.*

*The DDDS will continue to participate in ESA and DSHS contracts meetings in an effort to stay informed regarding any updates or changes in law and process.*

*Appropriate DDDS staff will continue to complete contracts training provided by the Department.*

*DDDS will share these audit result with the Social Security Administration.*

### **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:

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Revised Code of Washington 39.26.120

#### Competitive solicitation

- (1) Insofar as practicable, all purchases of or contracts for goods and services must be based on a competitive solicitation process. This process may include electronic or web-based solicitations, bids, and signatures. This requirement also applies to procurement of goods and services executed by agencies under delegated authority granted in accordance with RCW 39.26.090 or under RCW 28B.10.029.

Title 20, Code of Federal Regulations, Part 437 —UNIFORM ADMINISTRATIVE REQUIREMENTS FOR GRANTS AND COOPERATIVE AGREEMENTS TO STATE AND LOCAL GOVERNMENTS, Subpart C—Post-Award Requirements states in part:

§437.36 Procurement.

- (a) *States.* When procuring property and services under a grant, a State must follow the same policies and procedures it uses for procurements from its non-Federal funds. The State must ensure that every purchase order or other contract includes any clauses required by Federal statutes and executive orders and their implementing regulations. Other grantees and subgrantees must follow paragraphs (b) through (i) in this section.

**2014-054**            **The Department of Social and Health Services does not have adequate internal controls to ensure providers were qualified to perform consultative examinations for the Disability Insurance and Supplemental Security Income programs.**

**Federal Awarding Agency:** U.S. Social Security Administration  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 96.001 Social Security—Disability Insurance (DI)  
96.006 Supplemental Security Income (SSI)  
**Federal Award Number:** 12-0404WAD100, 13-0404WAD100, 14-0404WAD100  
**Applicable Compliance Component:** Special Tests and Provisions  
**Questioned Cost Amount:** None

**Background**

The Department of Social and Health Services administers the Disability Insurance and Supplemental Security Income programs. The programs are overseen by Disability Determination Services (DDS), which is part of the Department’s Economic Services Administration. DDS adjudicates medical claims for the Social Security Administration (SSA) to make disability determinations for Washington State.

The Department contracts with doctors to perform consultative examinations (CE) and provide an expert opinion in regards to the client’s functional limitations due to medical problems. In state fiscal year 2014, the Department spent approximately \$42.6 million in federal funds for the program. There were 304 medical providers who received approximately \$8.6 million in funds during state fiscal year 2014.

Federal rules require the Department ensure only qualified providers perform CE’s. Qualified means the provider must:

- (1) Be currently licensed in the state and have the training and experience to perform the type of examination or test the Department requests; and
- (2) Not be barred from participation in Medicare or Medicaid programs or other Federal or federally assisted programs.

Prior to using the services of any CE provider, the Department must check the Health and Human Services, Office of Inspector General List of Excluded Individuals and Entities (LEIE). The Department must also verify with the Department of Health that medical licenses are current. The Department is also required to review the LEIE for each provider at least annually and to verify licenses were properly renewed.

## **Description of Condition**

We found the Department did not have adequate written procedures in place to ensure only qualified providers were performing CE's. The written procedures, if followed, were adequate to ensure new providers were qualified, but were not sufficient to ensure the required periodic checks were performed.

We reviewed all 12 provider agreements the Department entered into during the audit period and determined five providers (42 percent) were not cross-referenced with the LEIE before the contract was executed. Additionally, the medical license for one provider was not checked on the Department of Health website before the contract was executed.

We reviewed 26 of the 291 provider agreements in place during the audit period to determine if a periodic review was performed and found:

- 25 providers were not checked annually on the LEIE.
- 20 providers did not have their medical licenses checked on the Department of Health website before their license expired.

## **Cause of Condition**

Department staff were assigned to verify the qualifications of providers, but did not do so in a timely manner. Management did not sufficiently monitor or review the work of Department staff to ensure it was accurate, complete and timely.

The Department did not have written procedures that were sufficient to ensure providers were qualified. We consider these control deficiencies to be material weaknesses.

## **Effect of Condition**

Without adequate written procedures and internal controls in place, the Department cannot ensure only qualified providers are performing consultative examinations. Additionally, by contracting with providers whose qualifications were not verified, the Department risks making unallowable payments with federal funds.

## **Recommendation**

We recommend the Department establish written procedures and internal controls to ensure only qualified providers are performing consultative examinations. We also recommend these procedures include a secondary review or other form of managerial oversight to ensure compliance with federal requirements.

## **Department's Response**

*The Department concurs with this finding.*

*The Department's Division of Disability Determination Services (DDDS) agrees the license and qualification verification for the providers in question did not take place in a timely manner. The DDDS did not have written procedures in place to monitor the verification duties.*

*As of July 1, 2014, the DDDS implemented the use of comprehensive written procedures (for new contractors), a thorough verification plan, and multiple Quality Assurance (QA) processes.*

*Existing contractors will be reviewed twice a year to ensure they are qualified to provide consultative examinations. Each month, DDDS will create a list of all expiring licenses and will check to ensure licenses have been renewed as appropriate. Additionally, all contractors will be compared with the Office of Inspector General List of Excluded Individuals and Entities (LEIE).*

*DDDS management (or their designee) will perform a quarterly review to ensure license renewals for contractors are performed as appropriate. In addition, DDDS Professional Relations staff will perform a secondary QA check once per month on 10% of the files to ensure accuracy of both the LEIE and license renewal checks.*

*DDDS will share these audit results with the Social Security Administration.*

## **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.
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Government Auditing Standards, December 2011 Revision, paragraph 4.23 states:

4.23 When performing GAGAS financial audits, auditors should communicate in the report on internal control over financial reporting and compliance, based upon the work performed, (1) significant deficiencies and material weaknesses in internal control; (2) instances of fraud and noncompliance with provisions of laws or regulations that have a material effect on the audit and any other instances that warrant the attention of those charged with governance; (3) noncompliance with provisions of contracts or grant agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

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Social Security Administration: *Program Operations Manual System (POMS)*

DI 39545.075 – Management of the Consultative Examination (CE) Process, states in part:

B. Procedure

DDSs at a minimum must provide procedures for:

- Performing medical license verifications to ensure only qualified providers perform CEs for disability determination services

DI 39569.300 – Disability Determination Services Requirements for Ensuring Proper Licensure of Consultative Examination Providers

A. Consultative exam (CE) licensure policy

1. E providers

Use only qualified medical sources to perform CEs (see DI 22510.001 Introduction to Consultative Examinations (CE)). By "qualified," we mean that the medical source must:

- be currently licensed in the State and have the training and experience to perform the type of examination or test we will request; and
- not be barred from participation in Medicare or Medicaid programs or any other Federal or federally assisted programs.

B. Verifying medical licenses

1. New CE providers

Prior to using the services of any CE provider:

- check the Health and Human Services, Office of the Inspector General (HHS OIG) List of Excluded Individuals and Entities (LEIE); and
- verify medical licenses, credentials, and certifications with state medical boards.

2. Periodic professional license checks

Conduct periodic license checks of CE providers used by the Disability Determination Services (DDS), including providers who perform CEs near and across the borders of neighboring States.

- Review the HHS-OIG LEIE for each CE provider at least annually.
- Verify license renewals.

NOTE: If you have no process in place to perform periodic license checks, you must require all CE providers to include their professional license numbers and expiration dates on all CE reports.



## **Description of Condition**

The Department does not have adequate internal controls in place to ensure that Accountability Act reports are filed correctly for subawards or amendments using federal funds.

We randomly selected and reviewed 11 reportable subawards for the Homeland Security Grant and determined that three subawards were improperly reported. All three subaward reports listed the wrong subaward amount. This is because the Department included reductions in subawards that occurred later, which should not have been reported. Total amount of misreported subawards reviewed for this program was \$580,017.

We reviewed all 14 reportable subawards for the Fire Management Assistance Grant and determined that six subawards were not reported. The total amount of the unreported subawards for this program was \$2.74 million.

## **Cause of Condition**

The Department had one employee assigned to file the required reports for both programs with a manager performing a secondary review. Both the assigned employee and the manager did not have sufficient knowledgeable of proper Accountability Act reporting requirements.

Departmental procedures require Fire Management Program subawards to be specifically monitored by staff responsible for filing Accountability Act reports. This was not being done sufficiently and caused the six identified subawards to not be filed. Additionally, management did not monitor sufficiently to ensure all subawards were reported.

We consider these internal control deficiencies to constitute a material weakness.

## **Effect of Condition**

By not correctly submitting the required 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. We further recommend that a secondary review is conducted prior to reports being submitted.

## Department's Response

*We concur with the finding. Procedures have been modified to ensure that proper reporting is being performed and that all agreements are reported. FFATA reports are reviewed by the Contracts Office Supervisor, and SI's are confirmed by program managers.*

## 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

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