Federal Findings and Questioned Costs

11-01 The Department of Social and Health Services, Economic Services Administration did not have controls in place to comply with federal regulations regarding costs of salaries charged to federal grants.

Federal Awarding Agency:	U.S. Department of Agriculture	
	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	10.551	Supplemental Nutrition Assistance Program
	10.561	State Administrative Matching Grants for the Supplemental Nutrition Assistance Program
	93.558	Temporary Assistance for Needy Families (TANF)
	93.714	Emergency Contingency Fund for Temporary Assistance for Needy Families (TANF) State Program American, Recovery and Reinvestment (ARRA) Temporary Assistance for Needy Families
	93.716	Supplemental Grants, American Recovery and Reinvestment Act (ARRA)
	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	Multiple	
Applicable Compliance Component:	Cost Principles	
Questioned Cost Amount:	None	

Background

Federal regulations require the Department of Social and Health Services to maintain appropriate supporting documentation for salaries paid to employees charged to federal awards. For those employees working on multiple funding sources, a personnel activity report or equivalent documentation must be kept in order to meet this requirement. This documentation must be based on actual activity and be prepared at least monthly.

Budget estimates or other distribution percentages determined before services are performed do not qualify as support for charges to federal awards. However, this information may be used for interim accounting purposes, provided that estimates are reasonable approximations of activity actually performed, the Department compares actual costs to budgeted distributions quarterly, and revises estimates at least quarterly, if necessary, to reflect changed circumstances. The Department may record differences in costs annually if the differences are less than 10 percent (otherwise they must be recorded at the time of comparison).

The Department's Economic Services Administration estimates expected time to be spent on programs and documents this information on Position Action Requests for each employee charging multiple activities.

These expected amounts are the basis for costs charged to federal grants throughout the year. Employees also keep monthly timesheets documenting the exact time spent on each federal activity. The Department is to complete comparisons of estimates on Position Action Requests to actual time documented on timesheets quarterly.

Description of Condition

The Department did not compare actual costs to budgeted distributions for employees charging multiple federal activities. Costs charged to the federal awards were based upon estimates and were not adjusted to actual time.

Cause of Condition

The Department did not understand that costs charged to federal awards for employees charging multiple federal activities could not be based upon estimates without year-end adjustments to actual costs. The Department revised these estimates when needed and considered this enough to meet the requirements. However, it must adjust costs as well.

Effect of Condition

When grantees do not follow federal requirements for documentation of salaries to multiple activities, grantors cannot ensure charges to federal grants are accurate. Overall questioned costs calculated during our review were minimal due to differences causing both increases and decreases to specific grants. However, this was limited to a selection of employees over a single month period. Without controls in place to meet federal requirements, the risk of material questioned costs still exists.

Recommendation

We recommend the Department establish policies and procedures to comply with appropriate federal requirements involving the use of budget estimates for staff charging multiple federal activities. The Department should ensure these procedures are in place for any Division using estimates for payroll purposes.

Department's Response

The Department concurs with this finding.

ESA will take additional steps to ensure that actual charges to federal activities match actual time worked. We will review al split coded positions and reduce the total number of these positions. We will also consolidate time certification in ESA's headquarters office to a single employee wholely responsible for ensuring time certification policies and procedures comply with federal requirements.

We will assign an employee to perform a monthly review of all split coded positions. This employee will also be responsible for reviewing all PA40/PARs to ensure proper coding and minimize the number of split coded positions, and will be required to transfer costs on a monthly basis, helping to ensure actual expenditures match time worked. ESA will continue to look for and implement ways to improve our future cost allocation methodology.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

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

> Appendix B, Section 8(h) - Support of salaries and wages. These standards regarding time distribution are in addition to the standards for payroll documentation.
>
> (4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection (5) unless a statistical sampling system (see subsection (6)) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:
>
> (a) More than one Federal award,
>
> (b) A Federal award and a non-Federal award,
>
> (c) An indirect cost activity and a direct cost activity,
>
> (d) Two or more indirect activities which are allocated using different allocation bases, or
>
> (e) An unallowable activity and a direct or indirect cost activity.
>
> (5) Personnel activity reports or equivalent documentation must meet the following standards:
>
> (a) They must reflect an after-the-fact distribution of the actual activity of each employee,
>
> (b) They must account for the total activity for which each employee is compensated,
>
> (c) They must be prepared at least monthly and must coincide with one or more pay periods, and
>
> (d) They must be signed by the employee.
>
> (e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:
>
> (i) The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;
>
> (ii) At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and
>
> (iii) The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

11-02 The Department of Social and Health Services, Economic Services Administration did not issue retroactive food assistance payments in accordance with federal law.

Federal Awarding Agency:	U.S. Department of Agriculture
Pass-Through Entity:	None
CFDA Number and Title:	10.551 Supplemental Nutrition Assistance Program 10.561 Supplemental Administrative Matching Grants for the Supplemental Nutrition Assistance Program
Federal Award Number:	Multiple
Applicable Compliance Component:	Activities Allowed / Cost Principles
Questioned Cost Amount:	$11,300 (Approximate)

Background

The Economic Services Administration at the Department of Social and Health Services administers the Supplemental Nutrition Assistance Program for the state. The program provides food assistance benefits to low-income households. It paid more than $1.5 billion in benefits to eligible households in fiscal year 2011.

Federal law requires the Department to restore benefits to households underpaid or denied due to Department error or court action. The Department restores underpaid benefits to clients for any of the 12 months prior to the month the client requests restoration or the month the Department discovers the underpayment. The Department issues a retroactive payment equal to the amount of benefits lost during that time period, regardless of the household's current eligibility status. More than 7,000 retroactive payments totaling about $2.1 million were issued during fiscal year 2011.

In 2009 and 2010, we identified $4,460 and $15,000 in retroactive food assistance payments to clients beyond the 12 months allowed by law.

Description of Condition

We reviewed a list of all retroactive payments issued during fiscal year 2011. We identified 136 instances in which the payment issue date was more than 12 months beyond the first corrected month and selected the 20 largest payments, representing approximately 58 percent of the total dollars at risk, for additional review. We found 17 of the 20 payments were issued improperly, resulting in approximately $11,300 in unallowable benefits. Since we did not review 100 percent of the payments at risk, it is likely the total amount of inappropriate payments is higher.

Cause of Condition

While the Department has taken steps to train employees regarding food assistance payment requirements, low staffing and high workloads have made it difficult for the Department to identify all payment errors. To eliminate errors, the Department has requested a system change to prevent payments beyond the 12-month criteria. This automated control has yet to be put in place.

Effect of Condition and Questioned Costs

Some individuals received food assistance benefits to which they were not entitled. Inappropriate benefit payments related to the files we reviewed totaled approximately $11,300. It was not possible to establish an exact amount of questioned costs as staff did not include underpayment information for each specific month as required by Department policy.

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 establish controls to ensure retroactive food assistance benefit payments are only made for allowable timeframes. We further recommend the Department review all retroactive payments identified as potentially inappropriate to identify the total unallowable costs.

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

Department's Response

The Department concurs with this finding.

In April and May of 2011, Community Services Division (CSD) field staff received training on the proper calculation of retroactive payments. The training focused on when a retroactive payment is indicated and allowed, and the time limitations required by law. This training is also required for all new employees who are responsible for issuing benefits.

Training ensures staff understand policy and procedures in this area, however, lower staffing levels and increased workloads are also contributing factors to these errors. As such, CSD has requested a system change to prevent payments beyond the 12-month criteria.

CSD will review the 136 cases cited in this audit to determine the correct supplement amount for which each client was eligible. For cases where unallowable payments were made, the department will follow existing rules and policies for establishing overpayments.

Audit results will be shared with the respective federal agency. If the federal agency determines questionable costs will be repaid, ESA will negotiate these costs with the federal agency.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

The auditee shall:

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

Title 7 Code of Federal Regulations Sec. 273.17 states in part:

(a) Entitlement.

(1) The State agency shall restore to households benefits which were lost whenever the loss was caused by an error by the State agency or by an administrative disqualification for intentional Program violation which was subsequently reversed as specified in paragraph (e) of this section, or if there is a statement elsewhere in the regulations specifically stating that the household is entitled to restoration of lost benefits. Furthermore, unless there is a statement elsewhere in the regulations that a household is entitled to lost benefits for a longer period, benefits shall be restored for not more than twelve months prior to whichever of the following occurred first:

(i) The date the State agency receives a request for restoration from a household; or

(ii) The date the State agency is notified or otherwise discovers that a loss to a household has occurred.

(2) The State agency shall restore to households benefits which were found by any judicial action to have been wrongfully withheld. If the judicial action is the first action the recipient has taken to obtain restoration of lost benefits, then benefits shall be restored for a period of not more than twelve months from the date the court action was initiated. When the judicial action is a review of a State agency action, the benefits shall be restored for a period of not more than twelve months from the first of the following dates:
   (i) The date the State agency receives a request for restoration:
   (ii) If no request for restoration is received, the date the fair hearing action was initiated; but
   (iii) Never more than one year from when the State agency is notified of, or discovers, the loss.
(3) Benefits shall be restored even if the household is currently ineligible.

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

(2) All food assistance benefits underpaid are restored when:
   (a) An underpayment was caused by department error;
   (b) An administrative disqualification for intentional program violation was reversed;
   (c) A rule or instruction specifies restoration of unpaid benefits; or
   (d) A court action finds benefits were wrongfully withheld.
(3) A client is eligible for restoration of underpaid benefits for any of the twelve months prior to:
   (a) The month the client requests restoration;
   (b) The month the department discovers an underpayment;
   (c) The date the household makes a fair hearing request when a request for restoration of benefits was not received; or
   (d) The date court action was started when the client has taken no other action to obtain restoration of benefits."

11-03 The Recreation and Conservation Office did not support more than $220,000 in payroll costs as required by federal regulations for the Pacific Coast Salmon Recovery-Pacific Salmon Treaty Program.

Federal Awarding Agency:	U.S. Department of Commerce
Pass-Through Entity:	None
CFDA Number and Title:	11.438 Pacific Coast Salmon Recovery
Federal Award Number:	NA05NMF4381269, NA06NMF4380091 NA07NMF4380301, NA08NMF4380608 NA09NMF4380363, NA10NMF4380435
Applicable Compliance Component:	Allowable Costs / Cost Principles
Questioned Cost Amount:	$220,859.57

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 Office received more than $26 million from the U.S. Department of Commerce for salmon recovery efforts during fiscal year 2011. It passed on approximately 97 percent of this money to state agencies, as well as sub-recipients such as cities, towns, counties, special-purpose districts, non-profit organizations, Indian tribes and private landowners to pay for approved projects.

Grants may be used to pay only for costs that are allowable and related to their purpose. Federal regulations specify the documentation grantees must keep 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, semi-annually, in writing, that he or she worked solely on that program. In contrast, payroll costs for employees who work on multiple programs or cost objectives must be supported by personnel activity reports or equivalent documentation, such as timesheets. These reports must:

- Reflect how much time the employee worked on each program 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 costs based on an estimate of time worked may be used for interim accounting purposes so long as an adjustment to actual time worked is made at least quarterly. Closely related programs with differing funding sources may be deemed a single cost objective, and therefore are subject only to the semi-annual certifications. This designation must be applied for and approved by the federal grantor. The Office has not applied for approval for this designation for the Pacific Coast Salmon Recovery – Pacific Salmon Treaty Program. The federal requirements are detailed in the federal Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Tribal Governments*.

Description of Condition

The Office administers a number of closely related federal and state programs and administrative and program staff support multiple programs. Employees complete monthly timesheets but the timesheets do not account for the actual activity spent on the program. We determined the Office charged a portion of the payroll costs for 20 employees to the grant based on budgeted percentages. The Office did not have documentation to support the charges and they were not reconciled to actual time employees worked on programs. These payroll costs totaled $220, 859.57.

Cause of Condition

Office management responsible for allocating payroll costs stated they allocated costs to the grant based on a budgeted percentage determined by the agency. They were unaware that this would not meet the requirements of Circular A-87 for allocating costs to federal programs.

Effect of Condition and Questioned Costs

We identified $220,859.57 in direct payroll charges to the Pacific Coast Salmon Recovery – Pacific Salmon Treaty Program grant that were not supported in accordance with federal requirements. We are questioning those costs as unallowable charges for salaries and benefits. The federal grantor could disallow these charges and require the Department to pay back the money.

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.

Recommendations

We recommend the Office establish policies and procedures to ensure payroll charges are adequately supported. The Office should consult with its grantor to determine what, if any, of the questioned costs should be repaid.

Office's Response

We agree with the auditors' finding. The following actions will be taken to address the finding: We will base all administrative costs on our federally approved indirect rate. We will work with U.S. Department of Commerce, National Oceanic and Atmospheric Administration to amend our grant agreements to include indirect costs in the grant budget. In the past we incorrectly understood that the three percent administrative limit set the only basis for our administrative charges.

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*, Section 300, states:

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

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

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

(1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a reasonable official(s) of the governmental unit.
(2) No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.
(3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi annually and will be signed by the employee or supervisory official having first hand knowledge of the work performed by the employee.
(4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection 8.h.(5) of this appendix unless a statistical sampling system (see subsection 8.h.(6) of this appendix) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:
    (a) More than one Federal award
    (b) A Federal award and a non Federal award
    (c) An indirect cost activity and a direct cost activity
    (d) Two or more indirect activities which are allocated using different allocation bases, or
    (e) An unallowable activity and a direct or indirect cost activity
(5) Personnel activity reports or equivalent documentation must meet the following standards:
    (a) They must reflect an after the fact distribution of the actual activity of each employee.
    (b) They must account for the total activity for which each employee is compensated
    (c) They must be prepared at least monthly and must coincide with one or more pay periods, and
    (d) They must be signed by the employee
    (e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:
        (i) The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;
        (ii) At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and
        (iii) The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.
(6) Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort.
    (a) Substitute systems which use sampling methods (primarily for Temporary Assistance to Needy Families (TANF), Medicaid, and other public assistance programs) must meet acceptable statistical sampling standards including:
        (i) The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results except as provided in subsection 8.h.(6)(c) of this appendix;
        (ii) The entire time period involved must be covered by the sample; and
        (iii) The results must be statistically valid and applied to the period being sampled.

(b) Allocating charges for the sampled employees' supervisors, clerical and support staffs, based on the results of the sampled employees, will be acceptable.

(c) Less than full compliance with the statistical sampling standards noted in subsection 8.h.(6)(a) of this appendix may be accepted by the cognizant agency if it concludes that the amounts to be allocated to Federal awards will be minimal, or if it concludes that the system proposed by the governmental unit will result in lower costs to Federal awards than a system which complies with the standards.

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

11-04 The Recreation and Conservation Office did not support more than $62,000 in administrative costs as required by federal regulations for the Pacific Coast Salmon Recovery Pacific Salmon Treaty Program.

Federal Awarding Agency:	U.S. Department of Commerce
Pass-Through Entity:	None
CFDA Number and Title:	11.438 Pacific Coast Salmon Recovery
Federal Award Number:	NA05NMF4381269, NA06NMF4380091 NA07NMF4380301, NA08NMF4380608 NA09NMF4380363, NA10NMF4380435
Applicable Compliance Component:	Allowable Costs / Cost Principles
Questioned Cost Amount:	$62,643

Background

The Recreation and Conservation Office manages grants that pay for outdoor recreation opportunities, protect the state's wildlife habitat and farmland, and helps restore salmon habitat. The Office received more than $26 million from the U.S. Department of Commerce for salmon recovery efforts during fiscal year 2011. It passed on approximately 97 percent of this money to state agencies and sub-recipients such as cities, towns, counties, special-purpose districts, non-profit organizations, Indian tribes and private landowners to pay for approved projects.

Description of Condition

The Office administers a number of closely related federal and state programs. We found administrative costs were charged to the grant based on budgeted percentages. For example, 40 percent of the Office's administrative costs were charged to the grant, but the Office did not have documentation supporting this methodology and could not show how the costs were directly related to actual program activity. These administrative costs totaled $62,643.

Cause of Condition

Office management responsible for allocating administrative costs to federal programs stated they were unaware allocations based on budgeted amounts does not meet federal requirements.

Effect of Condition and Questioned Costs

We identified $62,643 in administrative charges to the Pacific Coast Salmon Recovery Pacific Salmon Treaty Program grant that were not supported in accordance with federal requirements. We are questioning those costs as unallowable charges. 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 its expenditures.

Recommendations

We recommend the Office work with its grantor to determine a method to charge administrative expenditures to the grant and to establish policies and procedures to ensure administrative charges are adequately supported. The Office should consult with its grantor to determine what, if any, of the questioned costs should be repaid. We recommend the Office provide adequate training to ensure all staff responsible for allocating administrative costs to federal programs understand federal requirements.

Office's Response

We agree with the auditors' finding. The following actions will be taken to address the finding: We will base all administrative costs on our federally approved indirect rate. We will work with U.S. Department of Commerce, National Oceanic and Atmospheric Administration to amend our grant agreements to include indirect costs in the grant budget. In the past we incorrectly understood that the three percent administrative limit set the only basis for our administrative charges.

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*, Section 300, states:

The auditee shall:

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

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

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

Appendix A

C. *Basic Guidelines*

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
   - b. Be allocable to Federal awards under the provisions of 2 CFR part 225…
   - j. Be adequately documented.
3. Allocable costs.
   - a. A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received.
   - b. All activities which benefit from the governmental unit's indirect cost, including unallowable activities and services donated to the governmental unit by third parties, will receive an appropriate allocation of indirect costs.
   - c. Any cost allocable to a particular Federal award or cost objective under the principles provided for in 2 CFR part 225 may not be charged to other Federal awards to overcome fund deficiencies, to avoid restrictions imposed by law or terms of the Federal awards, or for other reasons.
   - d. Where an accumulation of indirect costs will ultimately result in charges to a Federal award, a cost allocation plan will be required as described in Appendices C, D, and E to this part.

F. *Indirect Costs*

1. General. Indirect costs are those: Incurred for a common or joint purpose benefiting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved. The term "indirect costs," as used herein, applies to costs of this type originating in the grantee department, as well as those incurred by other departments in supplying goods, services, and facilities. To facilitate equitable distribution of indirect expenses

to the cost objectives served, it may be necessary to establish a number of pools of indirect costs within a governmental unit department or in other agencies providing services to a governmental unit department. Indirect cost pools should be distributed to benefitted cost objectives on bases that will produce an equitable result in consideration of relative benefits derived.

2. Cost allocation plans and indirect cost proposals. Requirements for development and submission of cost allocation plans and indirect cost rate proposals are contained in Appendices C, D, and E to this part.

Appendix B, Section 8

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

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

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

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

(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.

11-05 The Military Department did not support $155,647 in payroll costs in accordance with federal regulations for its National Guard Operations and Maintenance grant.

Federal Awarding Agency:	U.S. Department of Defense
Pass-Through Entity:	None
CFDA Number and Title:	12.401 National Guard – Operations and Maintenance 12.401A National Guard – Operations and Maintenance – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	W91K23-06-2-1000; W91K23-11-2-1000; W912K3-09-2-9006
Applicable Compliance Component:	Allowable Costs / Cost Principles
Questioned Cost Amount:	$155,647

Background

The Military Department administers the National Guard Operations and Maintenance grant to provide support to the Army National Guard and Air National Guard for the construction of military facilities, real property improvements, design services and other projects authorized and directed by Congress or the U.S. Department of Defense. The Department spent $18.1 million from this grant in fiscal year 2011, including $381,009.88 in American Recovery and Reinvestment Act funds.

Grants may be used to pay only for costs that are allowable and related to the grant's purpose. Federal regulations specify documentation must be kept to support employee compensation charged to federal grants. If an employee works solely on the grant program and all related payroll costs are charged to that grant, minimal documentation is required: the employee must certify, semiannually, in writing, that he or she worked solely on that program. In contrast, payroll costs for employees who work on multiple programs or cost objectives must be supported by personnel activity reports or equivalent documentation, such as timesheets. These reports must:

- Reflect how much time the employee worked on each program 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.

The Department requires employees to complete hourly timesheets semi-monthly or certifications quarterly to meet federal time and effort requirements.

Description of Condition

We obtained all 46 quarterly certifications during fiscal year 2011. We also selected a random sample of 54 timesheets for different employees and time periods during fiscal year 2011.

We found five employees who charged time to the grant were either missing certifications for one or more quarters or did not fill out timesheets semi-monthly. Further, we found two of the employees have been charging to the grant since they became employed with the Department (1989 and 2009) and have never filled out a timesheet or certification.

Cause of Condition

The Department did not have a clear understanding of who is required to submit time and effort documentation. It did not have a system to track employees to ensure it received time sheets or quarterly certifications.

Effect of Condition and Questioned Costs

We identified $155,647.19 in direct payroll charges to the National Guard Operations and Maintenance grant that were not supported in accordance with federal requirements. We are questioning those costs as unallowable charges. We are only questioning the salaries charged in state fiscal year 2011 for the two employees who had unsupported charges to the grant for multiple years. The federal grantor could disallow these charges and require the Department to pay back the money.

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

Recommendations

We recommend the Department establish policies and procedures to ensure payroll charges 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

The Military Department concurs with this finding. The following steps will be taken.

1. *The Military Department will change its hiring procedures to include a notation on the Personnel Action Form to include whether or not the employee is required to submit quarterly certifications. This notation will be noted by the hiring program authority.*
2. *The Payroll Section will maintain a listing of employees who are required to submit quarterly certifications.*
3. *The Payroll Section will be responsible for collecting the required certifications on each employee and maintaining records*

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

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

> Appendix B, Section 8(h):
>
> Support of salaries and wages. These standards regarding time distribution are in addition to the standards for payroll documentation.
>
> (1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted

practice of the governmental unit and approved by a reasonable official(s) of the governmental unit.

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

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

(4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection 8.h.(5) of this appendix unless a statistical sampling system (see subsection 8.h.(6) of this appendix) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:
   (a) More than one Federal award
   (b) A Federal award and a non Federal award
   (c) An indirect cost activity and a direct cost activity
   (d) Two or more indirect activities which are allocated using different allocation bases, or
   (e) An unallowable activity and a direct or indirect cost activity

(5) Personnel activity reports or equivalent documentation must meet the following standards:
   (a) They must reflect an after the fact distribution of the actual activity of each employee.
   (b) They must account for the total activity for which each employee is compensated
   (c) They must be prepared at least monthly and must coincide with one or more pay periods, and
   (d) They must be signed by the employee
   (e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:
      (i) The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;
      (ii) At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and
      (iii) The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

(6) Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort.
   (a) Substitute systems which use sampling methods (primarily for Temporary Assistance to Needy Families (TANF), Medicaid, and other public assistance programs) must meet acceptable statistical sampling standards including:
      (i) The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results except as provided in subsection 8.h.(6)(c) of this appendix;
      (ii) The entire time period involved must be covered by the sample; and
      (iii) The results must be statistically valid and applied to the period being sampled.
   (b) Allocating charges for the sampled employees' supervisors, clerical and support staffs, based on the results of the sampled employees, will be acceptable.

(c) Less than full compliance with the statistical sampling standards noted in subsection 8.h.(6)(a) of this appendix may be accepted by the cognizant agency if it concludes that the amounts to be allocated to Federal awards will be minimal, or if it concludes that the system proposed by the governmental unit will result in lower costs to Federal awards than a system which complies with the standards.

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

11-06 The Military Department does not have controls to ensure it complies with Davis-Bacon (prevailing wage) requirements.

Federal Awarding Agency:	U.S. Department of Defense
Pass-Through Entity:	None
CFDA Number and Title:	12.401 National Guard – Operations and Maintenance 12.401A National Guard – Operations and Maintenance – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	W912K3-09-2-9006
Applicable Compliance Component:	Davis Bacon ARRA
Questioned Cost Amount:	None

Background

The National Guard Bureau enters into cooperative agreements with the state for administration of the National Guard Operations and Maintenance program. The program provides support to the Army and Air National Guard in minor construction, maintenance, repair or operation of facilities.

In 2009, the National Guard Bureau awarded operations and maintenance funds to the Military Department under the American Recovery and Reinvestment Act (ARRA). The Department was awarded approximately $2.3 million in Recovery Act money to be used to maintain, restore, and modernize National Guard facilities.

In fiscal year 2011, the Department spent $381,010 in Recovery Act funding.

Description of Condition

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

The Department included the Davis-Bacon requirements as standard language in all Recovery Act funded contracts signed by the contractor and the Department, stating contractors are required to submit the Statement of Intent to pay Prevailing Wages. However, the Department failed to collect the weekly certified payrolls for all contractors reviewed during the fiscal year 2011 audit as required by the Davis-Bacon Act.

We reviewed all contractors who received Recovery Act funds in fiscal year 2011. We found four contractors were required to comply with the Davis-Bacon Act. The total paid to the four contractors was $374,529.61. Further we found the Department failed to comply with the Davis-Bacon Act for these same four contractors during fiscal year 2010.

Cause of Condition

Department staff was not aware of the requirements of the Davis-Bacon Act and failed to collect weekly certified payrolls from contractors.

Effect of Condition

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

Recommendation

The Department should:

- Establish a Department-wide monitoring system to ensure an accurate and consistent understanding of the Davis-Bacon Act, and that it complies with the Act.

- Ensure all employees who oversee Davis Bacon compliance are trained in how to meet federal requirements. It should monitor to ensure staff follows these requirements.

- Collect and review weekly certified payrolls from contractors and sub-recipients to ensure prevailing wages are paid.

Department's Response

The Military Department concurs with this finding. The Military Department has taken the following actions to correct this deficiency.

1. *The responsibility for monitoring compliance with Davis-Bacon (prevailing wage) requirements will be assigned to the Contracting Section of the Military Department.*
2. *The Contracting Section is familiar with Davis-Bacon reporting requirements and will incorporate the collection and review of weekly certified payrolls into contracts requiring such reporting.*
3. *The Contracting Section will be responsible for collecting certified payrolls and will monitor compliance as needed.*

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

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

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

Title 29, Code of Federal Regulations, Sections 3.3 and 3.4 state in part:

> 3.3(b)…Each contractor or subcontractor engaged on the construction, prosecution, completion, or repair of any public building or public work, or building or work financed in whole or in part by loans or grants from the United States, shall furnish each week a statement with respect to the wages paid each of it's employees engaged on work covered by this part 3 and part 5 of this chapter during the preceding weekly payroll period…
>
> 3.4(a)…Each weekly statement required under Sec. 3.3 shall be delivered by the contractor or subcontractor, within seven days after the regular payment date of the payroll period, to a representative of a Federal or State agency in charge at the site of the building or work . . . After such examination and check as may be made, such statement, or a copy thereof, shall be kept available, or shall be transmitted together with a report of any violation, in accordance with applicable procedures prescribed by the United States Department of Labor…

11-07 The Washington Housing Finance Commission did not ensure funding it provided to sub-recipients of the Tax Credit Assistance Program was reported and audited in accordance with federal regulations.

Federal Awarding Agency:	U.S. Department of Housing and Urban Development
Pass-Through Entity:	None
CFDA Number and Title:	14.258 Tax Credit Assistance Program – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	M09-ES530100
Applicable Compliance Component:	Sub-recipient Monitoring
Questioned Cost Amount:	None

Background

The Tax Credit Assistance Program provides partial funding for eligible low-income housing projects. This federal money is paid to the State Housing Finance Commission. The Commission was awarded more than $43 million in program funds that it passed through to nine housing authorities and non-profit organizations. These sub-recipients used the money to construct or rehabilitate 652 low-income rental housing units. In fiscal year 2011, federal costs charged to the program totaled $32 million.

Federal regulations require the Commission to notify sub-recipients of federal award information and compliance requirements and to monitor the grant-funded activities. This includes ensuring the organizations receive an audit of these funds in accordance with the federal Office of Management and Budget Circular A-133. This requirement is fundamental to good sub-recipient monitoring activities, and helps ensure that federal awards are used for authorized purposes and in compliance with laws, regulations, and grant and contract provisions. Sub-recipients are required to report grants on a Schedule of Expenditures of Federal Awards (SEFA). This schedule forms the basis for selecting federal programs to audit. The results of these audits, along with the schedule, must be submitted to a federal clearinghouse within nine months of the organization's fiscal year end.

Description of Condition

For all nine sub-recipients, we found the Commission did not:

- Obtain evidence a federal audit was performed if total federal expenditures were $500,000 or more.
- Examine federal audit reports to ensure program funds were accurately reported on the SEFA.
- Adequately communicate the requirement to obtain a federal audit in accordance with federal regulations. In the audit section of the loan agreement, the only mention of audit responsibilities is: "Except as otherwise approved by the Commission, Borrower shall provide the Commission an annual audit that meets the reasonable requirements of the Commission and HUD [Housing and Urban Development]".
- Communicate the Catalog of Federal Domestic Assistance (CFDA) number that pertains to the grant.

Further, we noted the Commission approved a $23,903 reimbursement to a sub-recipient that had paid for estimated land use and permit inspection fees. The payment made by the sub-recipient was based on estimated staff time that would be incurred during the life of the project rather than for services actually received.

Lastly, the U.S. Department of Housing and Urban Development's Office of Inspector General (OIG) reviewed payments made by sub-recipients with program funds from February to August 2010 and found the Commission did not always properly monitor the sub-recipients to ensure only allowable costs are charged to the grant.

Cause of Condition

The Commission was unaware of the federal requirement to ensure its sub-recipients receive an audit in accordance with federal regulations or that federal awards it passes through are properly reported on a Schedule of Expenditures of Federal Awards (SEFA).

The Commission believed the estimated vendor payment submitted by the sub-recipient for reimbursements was allowable since it was an otherwise allowable cost given the nature of the project. According to the OIG audit report, the Commission's monitoring process at the time of the OIG audit was limited to reviewing the eligibility of costs when a project was completed and a final cost certification was submitted by the sub-recipient.

Effect of Condition

Three sub-recipients are housing authorities. Our Office audits these entities when they notify us that one is needed. We reviewed prior audit reports issued by our Office and found:

- One did not report $500,000 in program funds on its SEFA and did not receive the required audit. Two reported the program funds in their SEFA totaling $25 million. During a previous audit, we reported a finding for one of these sub-recipients regarding inadequate financial reporting

The Commission is required to follow up on sub-recipient audit findings. The Commission did not follow up on findings because it was not aware it needed to ensure sub-recipients received a federal audit.

The remaining six sub-recipients were non-profit organizations, which are not within our audit authority. The Commission requested federal audit reports for the remaining sub-recipients as a result of our audit. We found three did not report their Recovery Act program expenditures on their SEFAs.

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

The Commission reimbursed one sub-recipient for payment of services not actually received at the time the bill was submitted for payment. The amount reimbursed was $23,903. We have since obtained documentation from the vendor that the billed service will be provided by the end of the project and will not question this cost.

The OIG audit identified $187,104 in questioned costs. Of that amount, $170,036 was for ineligible loan fees, appraisal fees and legal fees. The remaining $17,068 was for legal fees that did not have adequate support to show how they were related to the program. The Commission has reimbursed HUD for the questioned costs.

Recommendation

We recommend the Commission:

- Ensure its sub-recipients receive audits as required and accurately report program expenditures on the SEFA.
- Communicate federal grant information to sub-recipients and clarify the sub-recipient's responsibility to obtain federal audits.

  Monitor its sub-recipient's costs that are submitted for reimbursement to ensure they are allowable and meet federal regulations.

Commission's Response

The Commission agrees with the determination of the SAO that we did not assure our sub-recipients received federal audits as required. As noted by the auditor, we subsequently corrected our error by receiving and reviewing such audits and will continue to do so for any subsequent years in which the Commission provides TCAP funds to a sub-recipient.

The CFDA number was not published online at CFDA.gov nor was it available from HUD website for this grant until after contracts and agreements were executed with the sub-recipients. The Commission will increase our diligence in communicating the federal grant information to sub-recipients, including adding clarity on the specific requirements of the sub-recipient to receive a federal audit as appropriate, and providing the CFDA number.

OIG Finding: The Commission continues to take exception to the characterization by the OIG that no eligibility review existed until final cost certification. Rather, each draw presented by the sponsor was subject to a review by a project management consultant for appropriateness, reviewed by our program staff for compliance with the approved budget and then reviewed by finance staff for completeness prior to the draw's approval in IDIS for payment. During the period of the OIG audit, these reviews did not identify the noted items and program staff did rely on the final cost certification to correct any such oversights. However, subsequent to the OIG's audit, program staff enhanced the review to improve confidence that draws did meet the program eligibility guidelines. We therefore believe that we properly remedied the OIG finding and no further action on this recommendation is necessary.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

Section .300-Auditee responsibilities.

The auditee shall:

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

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

Section .400, states in part:

(d) <u>Pass-through entity responsibilities</u>. 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.

11-08 The Employment Security Department did not comply with U.S. Department of Labor requirements for determining the accuracy of Unemployment Insurance benefit payments.

Federal Awarding Agency:	U.S. Department of Labor
Pass-Through Entity:	None
CFDA Number and Title:	17.225 Unemployment Insurance 17.225A Unemployment Insurance – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	UI-21133-11-55-A-53; UI-19616-10-55-A-53; UI-18054-09-55-A-53
Applicable Compliance Component:	Special Tests – U.I. Benefit Payments
Questioned Cost Amount:	None

Background

The Employment Security Department administers the Unemployment Insurance program that provides benefits to workers for periods of involuntary unemployment. The federal government and employers in Washington State primarily fund the program. In fiscal year 2011, Employment Security paid approximately $1.4 billion in benefits paid for by employers and more than $2.3 billion with money from the federal government.

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

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

Federal guidelines for the BAM program state: "Regardless of the method used, it is intended that states obtain the information needed to complete their BAM cases. States must attempt to obtain the information required for investigations using any and all of the following methods: in-person, telephone, FAX, mail or e-mail. States have the option of using any of these methods that it determines to be the most efficient and effective based on the circumstances of each case. States are to document all attempts made in procuring needed information in each case's summary. Within this framework, it is important to note that the audit process differs substantially from normal UI operations in terms of cost, time, and effort. **BAM investigators must exhaust all avenues in obtaining information."** The Department has created a BAM Procedures Manual that establishes written procedures to ensure federal guidelines are met.

Employment Security's procedures manual directs investigators to document at least six attempts to contact claimants. At least two of the attempts must be done by mail. If unsuccessful, the investigator is to document the attempts and may close the investigation. The Department provides minimum requirements for investigations, but gives investigators wide latitude to pursue the investigation beyond the minimum.

Investigators are required to verify employer data, job search contacts and third-party information for each case. Federal regulations do not provide any option other than verifying the data directly and specifically states "BAM investigators must exhaust all avenues in obtaining information." Because federal guidelines also require at least 70 percent of cases to be closed within 60 days, and 95 percent within 90 days, the state procedures manual allows investigators to cease attempting to make contact with employers if they have documented a minimum of six attempts to contact employers for data, at least two by mail or fax.

Federal guidelines require the Department to examine 480 paid claims and 450 denied claims each year. According to the U.S. Department of Labor, for the three-year period ending June 30, 2011, Washington had an average improper payment error rate of 13.5 percent. This improper payment rate is based on the percentage of payments determined to be improper by the BAM program.

We reported a finding for the fiscal year 2009 and 2010 audits, noting that the Department did not comply with Department of Labor requirements for the BAM program. Specifically, Employment Security investigators did not obtain all information needed to complete their cases and did not use all required methods to do so. The Labor Department requires states to try to collect information using all of the following methods: in-person, telephone, facsimile or mail. Employment Security does not require investigators to collect information from a claimant if he or she cannot be contacted or chooses not to respond. However, if a claimant does not respond, the case is to be forwarded to a local employment center for a job search review to be scheduled which could result in benefit denial.

Description of Condition

The Department still is not complying with Labor Department requirements for the BAM Program. For this audit we randomly selected 78 claims the Department had investigated: 41 paid claims and 37 denied claims, and found:

- In 11 cases, the investigator did not verify wage or other data with prior employers or third parties. When contact was not made with the employer, the case file stated that the investigator was using previously reported data assumed to be accurate. In five of the 11 cases, the investigator contacted the employer who provided data conflicted with the Department's wage and hour records for the employer. However, the investigator did not resolve this issue.
- In five cases from the 41 paid claims, the investigator did not verify reported job searches.
- In two cases, the investigator accepted wage data from employers that did not match the Department's records. The summary of investigation did not document that the records did not match.
- In four cases, the investigator should have coded a payment as improper in the federal reporting system but did not. In one of those cases, the investigator determined the whole claim should have been disallowed but did not report the error.
- Files for seven of the cases did not document enough attempts to contact the claimant.

Employment Security does not have sufficient internal controls to ensure compliance with federal regulations. The primary opportunity to detect noncompliant investigations is during the supervisory review of the BAM investigation. Employment Security did this for approximately 31 percent of the investigations we examined. Among those cases, 30 percent did not comply with BAM requirements. Of the cases we examined that no one reviewed, 27 percent did not comply. Having a higher noncompliance rate for cases receiving a supervisory review show the review process is not effective.

Cause of Condition

During the audit period the Department adopted several procedural improvements. It

- Hired a new supervisor with BAM experience in another state.
- Updated job expectations for BAM investigators to more precisely convey the expectations of properly completing BAM cases.
- Began a weekly control review meeting to help ensure consistent standards are used throughout the unit.
- Revised the documentation used for investigations to include more details on what work the investigator performed.

Management stated the new procedures took effect on January 1, 2011. We determined the rate of improperly conducted BAM investigations was 37 percent prior to January 1, 2011, and 19 percent after that date.

The Department's supervisory reviews of BAM investigations did not detect noncompliance because the reviews performed were not always thorough. The reviews ranged from a cursory review to a review taking one to two hours. Because the Department does not have an established policy or procedure to specify what is required for a review to be adequate, supervisors performing the reviews determine how extensive they will be.

Effect of Condition

The Department may not be identifying potential issues with benefit claim approvals and denials. The Department could be paying invalid claims or denying valid claims.

In September of 2011 the Labor Department designated the state as an improper payment "High Priority" state for fiscal year 2012. The designation was based on improper payment rates as reported by the BAM unit during the last three years. This will require Employment Security to commit significant resources to address the Labor Department's concerns.

Recommendation

We again recommend Employment Security ensure all BAM program investigations include contacting the claimant, prior employers, job search contacts and third parties as required by the Department of Labor. We also recommend Employment Security ensure investigators properly identify and address all issues. Additionally, we recommend the Department ensure supervisors properly review completed cases to ensure procedures were followed.

Department's Response

ESD concurs with the finding and has been making improvements in unit processes to ensure all BAM program investigations are compliant with U.S. Department of Labor requirements. These improvements will ensure BAM investigations include all required contact information; that BAM investigators properly identify and address all issues raised during investigations and supervisory reviews are conducted to confirm proper procedures are followed.

The Employment Security Department appreciates that the auditor acknowledges the significantly increased compliance rate of BAM investigations during the course of the fiscal year audit ending June 30, 2011, but we recognize this effort must be ongoing.

Following is a list of improvements implemented and planned that will result in accurate, complete and fully compliant BAM investigations:

Personnel and Training

- *Revised investigator position descriptions with more rigorous requirements to improve the recruitment and retention of experienced and knowledgeable investigators.*
- *Increased feedback to and training of investigators to develop their knowledge, skills and abilities. This will include a three-day intensive investigator training offered by the Washington State Department of Personnel.*
- *Weekly formal internal peer case reviews.*
- *Regular unit meetings to review and discuss unusual or particularly challenging cases and share best practices.*
- *Increased communication and cooperation with other departments within ESD resulting in quicker turnaround times and resolution of issues.*

- *Increased communication and cooperation with DOL Region VI, National Office and BAM Units in other states.*
- *Increased development of support staff, including cross-training, to better understand and anticipate the needs of investigators.*

Forms and Manuals

- *Substantial revision and updating of the BAM Procedural Manual.*
- *Creation of a detailed contact log form showing time, date and method of contact and fact finding notes.*
- *Emphasis on narrative summaries detailing complexities of the case, identification and resolution of potential issues, unusual coding or other unusual circumstances.*
- *Revision and updating of all BAM forms to improve accuracy, effectiveness and response rate. The non-response rate (claimants not returning the questionnaire) for paid BAM cases has dropped from over 12% in 2010 to 6% during the first half of 2011.*
- *Increased use of all available reference resources within the Department and with DOL including published Questions and Answers and the Minnesota Training Center website.*

Procedures

- *Creation of internal tracking folders on a shared drive capturing unusual investigative issues, recommended procedures to increase consistency and accuracy in coding.*
- *Application of an open-ended denial of benefits for claimants who do not accurately or fully respond to requests for information within 10 days of case assignment and initial contact attempts.*
- *Increased Supervisory Review.*
- *Revision of timelines for each audit including initial contact attempts and follow-up attempts.*
- *More efficient, realistic and consistent case assignment.*

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

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

> § 602.21 Standard methods and procedures.
>
> Each State shall:
>
> (a) Perform the requirements of this section in accordance with instructions issued by the Department, pursuant to § 602.30(a) of this part, to ensure standardization of methods and procedures in a manner consistent with this part;
>
> (b) Select representative samples for QC study of at least a minimum size specified by the Department to ensure statistical validity (for benefit payments, a minimum of 400 cases of weeks paid per State per year);

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

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

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

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

11-09 The Department of Transportation did not support over $768,000 in payroll costs in accordance with federal regulations for the Formula Grants for Other Than Urbanized Areas.

Federal Awarding Agency:	U.S. Department of Transportation, Federal Transit Administration
Pass-Through Entity:	None
CFDA Number and Title:	20.509 Formula Grants for Other Than Urbanized Areas 20.509A Formula Grants for Other Than Urbanized Areas – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	WA-18-X025; WA-18-X039; WA-18-X043; WA-18-X048; WA-85-X001; WA-85-X002; and WA-86-X001
Applicable Compliance Component:	Allowable Costs / Cost Principles
Questioned Cost Amount:	$643,146.33 Non ARRA $125,631.22 ARRA

Background

The Public Transportation Division of the State Department of Transportation administers the federal Formula Grants for Other Than Urbanized Areas grant to help pay for public transportation in rural areas. The Department distributes this grant funding to public and private entities that provide these services and retains 10 percent to 15 percent to pay administrative costs. The Department spent $19,123,310 from this grant in fiscal year 2011, including $9,358,778 in American Recovery and Reinvestment Act funds.

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

- Reflect how much time the employee worked on each program 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 costs based on an estimate of time worked may be used for interim accounting purposes so long as an adjustment to actual time worked is made at least quarterly.

In our fiscal year 2009 and 2010 audits, we reported the Department did not support more than $740,000 and $759,000 respectively, in payroll costs charged to the grant in accordance with federal regulations. The Public Transportation Division administers a number of closely related federal and state programs and the work performed by administrative and program staff supports multiple programs. We determined the Division charged a portion of the payroll costs for 16 employees to the grant based on budgeted percentages. The Division did not have documentation to support the charges and they were not reconciled to actual time employees worked on programs.

Description of Condition

The Division charged a portion of the payroll costs for 16 employees to the Formula Grants for Other Than Urbanized Areas based on budgeted percentages. The Division did not have documentation to support the

charges and they were not reconciled to actual time employees worked on programs. The Division did not change how it allocates salaries and benefits to the grant until June 16, 2011.

Cause of Condition

Public Transportation Division management responsible for allocating payroll costs stated it had not changed the method of allocating payroll costs because they had not received approval of a modified version of its current allocation method. The Division was instructed not to use the modified allocation method until it had been reviewed and approved. The Department submitted its request to the Federal Transit Administration in June 2010 and was informed in June of 2011 that it would not be approved.

Effect of Condition and Questioned Costs

We identified $768,777.55 in direct payroll charges to the Formula Grants for Other Than Urbanized Areas grant that were not supported in accordance with federal requirements, including $125,631.22 funded through the American Recovery and Reinvestment Act. We are questioning those costs as unallowable charges for salaries and benefits. The federal grantor could disallow these charges and require the Department to pay back the money.

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.

Recommendations

We recommend the Department establish policies and procedures to ensure payroll charges 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

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

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

After receiving a similar finding in 2009, the Department's Public Transportation Division developed and submitted a formalized direct payroll cost allocation plan, known as a substitute system, to the FTA to meet the federal regulations (OMB Circular A-87). Upon receipt of the plan, the FTA requested that the Department continue to allocate payroll costs under the current FTA approved method until such time as the new plan can be reviewed and approved. The FTA staff conducted fieldwork for their review in January 2011, and provided their results in June 2011. The FTA report offered recommendations that the Department will continue to implement to receive grantor approval of the cost allocation plan. Once approved, the Public Transportation Division will allocate direct payroll costs using the new method and will incorporate the new method into policies and procedures. Until FTA approval is received, allocations are being based on actual time worked, which is in compliance with federal regulations.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

The auditee shall:

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

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

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

Appendix B, Section 8(h):

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

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

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

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

(4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection 8.h.(5) of this appendix unless a statistical sampling system (see subsection 8.h.(6) of this appendix) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:

(a) More than one Federal award

(b) A Federal award and a non Federal award

(c) An indirect cost activity and a direct cost activity

(d) Two or more indirect activities which are allocated using different allocation bases, or

(e) An unallowable activity and a direct or indirect cost activity

(5) Personnel activity reports or equivalent documentation must meet the following standards:

(a) They must reflect an after the fact distribution of the actual activity of each employee.

(b) They must account for the total activity for which each employee is compensated

(c) They must be prepared at least monthly and must coincide with one or more pay periods, and

(d) They must be signed by the employee

(e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:

(i) The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;
(ii) At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and
(iii) The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

(6) Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort.
   (a) Substitute systems which use sampling methods (primarily for Temporary Assistance to Needy Families (TANF), Medicaid, and other public assistance programs) must meet acceptable statistical sampling standards including:
      (i) The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results except as provided in subsection 8.h.(6)(c) of this appendix;
      (ii) The entire time period involved must be covered by the sample; and
      (iii) The results must be statistically valid and applied to the period being sampled.
   (b) Allocating charges for the sampled employees' supervisors, clerical and support staffs, based on the results of the sampled employees, will be acceptable.
   (c) Less than full compliance with the statistical sampling standards noted in subsection 8.h.(6)(a) of this appendix may be accepted by the cognizant agency if it concludes that the amounts to be allocated to Federal awards will be minimal, or if it concludes that the system proposed by the governmental unit will result in lower costs to Federal awards than a system which complies with the standards.

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

11-10 The Department of Commerce does not ensure the funding it provides to sub-recipients is reported and audited in accordance with federal regulations.

Federal Awarding Agency:	U.S. Environmental Protection Agency U.S. Department of Energy U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	66.468	Capitalization Grants for Drinking Water State Revolving Funds
	66.468A	Capitalization Grants for Drinking Water State Revolving Funds – American Recovery and Reinvestment Act (ARRA)
	81.042	Weatherization Assistance for Low-Income Persons
	81.042A	Weatherization Assistance for Low-Income Persons – American Recovery and Reinvestment Act (ARRA)
	93.569	Community Services Block Grant
	93.710	Community Services Block Grant – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	Multiple	
Applicable Compliance Component:	Sub-recipient Monitoring Compliance	
Questioned Cost Amount:	None	

Background

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

The Department uses a database to track audits of sub-recipients. Each program is required to verify in the database that an audit was performed and to complete necessary follow up during site visits at the sub-recipients.

Description of Condition

The Department does not ensure sub-recipients receive an audit in accordance with federal regulations. The Department is not ensuring sub-recipients are reporting the federal program funds in their Schedule of Expenditures of Federal Awards as required. The Department is not ensuring timely and appropriate corrective action for all sub-recipient audit findings.

We reported similar issues with another program at the Department for fiscal year 2010.

Cause of Condition

The Department includes a clause in its award contract that states the sub-recipient is to obtain an audit if required and provide it to the Department. The Department relies on site visits to obtain any missing audits, but these visits do not occur annually, so audits may not be received in a timely manner, if at all. The Department did not review the audits to ensure the pass-through grants were included on Schedules of Expenditures of Federal Awards. The Department does not believe they are required to re-audit the sub-

recipients' audit reports. Program managers did not ensure corrective action plans were received and resolutions were documented for sub-recipient findings.

Effect of Condition

We randomly selected 38 sub-recipients for review and found:

- No evidence the Department verified five sub-recipients received the required audit.
- The Department did not ensure three sub-recipients reported pass through federal funds received in their Schedules of Expenditures of Federal Awards.
- The Department did not ensure four sub-recipients took timely and appropriate corrective action on audit findings.

Program	No Audit of Federal Funds		Pass through not reported on SEFA		Missing Corrective Action on Findings	
	ARRA	Non ARRA	ARRA	Non ARRA	ARRA	Non ARRA
Drinking Water	$ 0	$2,638,961	$ 0	$ 1,389,878	$ 0	$ 0
Weatherization	$151,173	$32,160	$ 0	$ 0	$412,417	$361,002
Community Services Block Grant	$208,061	$76,005	$596,655	$114,124	$950,960	$235,683

Recommendation

We recommend the Department ensure its sub-recipients receive audits as required and take appropriate and timely corrective action for those that receive audit findings. For sub-recipients that did not have an audit or report federal funds, we recommend the Department take appropriate action, up to and including recovery of any funds provided.

Department's Response

We partially concur with the finding. We agree five sub-recipients did not submit audit reports as required and we did not catch the oversight. We will contact those sub-recipients to verify compliance with A-133 and obtain audit copies. Sub-recipient contract terms and conditions identify the requirement that organizations receiving in excess of $500,000 in federal funds must have a Circular A-133 audit and submit copies to Commerce. We intend to increase periodic review of sub-recipients with federal expenditures provided from Commerce in excess of $500,000 by refining specific audit requirements and reporting functionality in our tracking systems to better follow-up on delinquent reports. Since it is possible for sub-recipients to receive less than $500,000 from Commerce plus additional funds from other sources to make them eligible for the A-133 audit report requirement, we intend to remind sub-recipients of this requirement however, we have no method to determine when this threshold is met beyond what Commerce provided. Commerce is satisfied that program funds expended during this period were appropriate and correct through the monthly invoice verification process, the required documentation review and on-site monitoring conducted for each sub-recipient.

Commerce does not agree that it is our responsibility to ensure sub-recipients are reporting all federal program funds in their Schedule of Expenditures of Federal Awards. We do not believe we are required to re-audit an A-133 audit prepared by the auditee's Certified Public Accountant. Generally accepted accounting principles and federal regulations enumerate many financial statement disclosure requirements for which the auditee and their auditor are responsible to comply with. If the State Auditor's Office has concerns about the quality of an audit report, there are procedures for notifying the State Board of Accountancy of those concerns. Commerce does not have the expertise to make those judgments and this is not a responsibility we will assume.

Commerce believes timely and appropriate corrective action was completed for the four sub-recipient audit findings. There are instances where we have made judgment decisions that accept the sub-recipient's original response to the audit finding and have not required any follow-up, which we feel is within our purview. We intend to refine specific corrective action and management decisions documentation and reporting functionality in our tracking systems to better centrally document timely and appropriate corrective action for sub-recipient audit findings.

Auditor's Concluding Remarks

We thank the Department for its response. Federal regulations (cited below) clearly state it is the Department's responsibility to ensure sub-recipients receive audits in accordance with OMB Circular A-133. During our audit, we looked at criteria to determine if the Department complied with A-133: Did the Department receive an audit report from its sub-recipients; did it look at the report to ensure the sub-recipients reported their federal funds received from the Department; and did the Department ensure timely corrective action was taken on sub-recipient audit findings.

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

Applicable Laws and Regulations

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

(d) Pass-through entity responsibilities. A pass-through entity shall perform the following for the Federal awards it makes: . . .
  (4) Ensure that subrecipients expending $300,000 *($500,000 for fiscal years ending after December 31, 2003)* or more in Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.
  (5) Issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.
  (6) Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.

U.S. Office of Management and Budget Circular A-133. *Audits of States, Local Governments, and Non-Profit Organizations*, Section .405, states in part:

(a) General. The management decision shall clearly state whether or not the audit finding is sustained, the reasons for the decision, and the expected auditee action to repay disallowed costs, make financial adjustments, or take other action. If the auditee has not completed corrective action, a timetable for follow-up should be given. Prior to issuing the management decision, the Federal agency or pass-through entity may request additional information or documentation from the auditee, including a request for auditor assurance related to the documentation, as a way of mitigating disallowed costs. The management decision should describe any appeal process available to the auditee

(c) Pass-through entity. As provided in **§___.400(d)(5)**, the pass-through entity shall be responsible for making the management decision for audit findings that relate to Federal awards it makes to subrecipients.

(d) Time requirements. The entity responsible for making the management decision shall do so within six months of receipt of the audit report. Corrective action should be initiated within six months after receipt of the audit report and proceed as rapidly as possible.

(e) Reference numbers. Management decisions shall include the reference numbers the auditor assigned to each audit finding in accordance with **§___.510(c)**.

U.S. Office of Management and Budget Circular A-133. *Audits of States, Local Governments, and Non-Profit Organizations*, Section .310, states in part:

> (b) Schedule of expenditures of Federal awards. The auditee shall also prepare a schedule of expenditures of Federal awards for the period covered by the auditee's financial statements…
>
> (2) For Federal awards received as a subrecipient, the name of the pass-through entity and identifying number assigned by the pass-through entity shall be included.

11-11 The Office of Superintendent of Public Instruction's internal controls over sub-recipient monitoring is not adequate to ensure only proper and allocable costs are charged to the Title I program.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.010 Title I, Part A 84.389 Title I, Part A, American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	Unknown
Applicable Compliance Component:	Sub-Recipient Monitoring
Questioned Cost Amount:	None

Background

The Office of Superintendent of Public Instruction administers the Title I program. The program is intended to improve the teaching and learning of children who are at risk of not meeting state academic standards and who reside in areas with high concentrations of children from low-income families.

The Office spent $257 million in Title IA funds in fiscal year 2011, $73 million of which was paid from the American Recovery and Reinvestment Act.

To ensure school districts receiving Title IA grants are spending funds for allowable purposes and complying with program requirements, the Office established a system of consolidated program reviews. This system includes on-site monitoring and desk reviews. The consolidated program review includes review of the following programs:

CFDA	Program	Federal Dollars Received by the Office	Federal Dollars Passed Through to Districts
84.010 and 84.389	Title I A	$257,073,145	$247,037,168
84.213	Title I B – Even Start	832,614	804,996
84.011	Title I, C – Migrant Education	15,738,310	15,255,034
84.013	Title I, D – Neglected and Delinquent	968,739	960,099
84.330	Title I, G – Advanced Placement	1,065,747	66,554
84.367	Title II, A – Highly Qualified Teacher and Principles	46,626,190	45,734,590
84.318 and 84.386	Title II, D – Enhancing Education through Technology	0.00	0.00
84.365	Title III – Limited English Proficient/Immigrant	15,611,911	14,939,087
84.186	Title IV, A – Safe and Drug-Free Schools	1,603,231	1,484,494
84.196 and 84.387	Title X – McKinney-Vento Homeless Education	0.00	0.00
84.048	Carl D. Perkins/Career Technical Education	0.00	0.00
94.004	Learn and Serve America	368,976	238,617
84.358	Reap Flexibility	1,125,664	1,078,153
Total Program Dollars Reviewed by CPR		$341,014,527	$327,598,792

In addition to the federal programs listed above, the Consolidated Program Review also includes a review of the state funded Learning Assistance Program and Highly Capable Program.

School districts claim Title I grant funding electronically from the Office monthly and are not required to submit supporting documentation at the time of the requests. Therefore it is critical that the Office obtain assurance that the districts are spending grant funds for allowable purposes and meeting federal regulations while conducting its on-site visits and desk reviews.

Description of Condition

We obtained a listing of all 27 desk reviews and 45 on-site reviews the Office conducted during state fiscal year 2011. We randomly selected a sample of seven desk reviews and nine on-site reviews. We evaluated the Office's sub-recipient monitoring for payroll.

Employee salaries and benefits typically make up the majority of costs claimed for reimbursement by school districts. School districts are required to maintain monthly time and effort records and semi-annual certifications to support payroll costs for which they seek reimbursement.

When conducting a consolidated program review, the Office requires districts to submit two or three samples of time and effort documentation for one month's salaries. These two or three samples are selected at the discretion of the district from teachers and administrators that could be funded under any of the programs reviewed as part of the consolidated review program. Only two or three samples are submitted, regardless of the size of the district and the dollar amount and number of grants it administers. Because some districts are being reviewed for more than three programs, not all programs at some districts are reviewed.

For the 72 reviews performed, the Office examined approximately 144-216 timesheets, depending if the review was of two or three samples. We requested from the Office the number of teachers and administrative staff being reviewed under programs covered by the consolidated program review. However, the Office was unable to provide this information. Since the review covers more than the Title IA program, and we could not determine the actual number of teachers covered by the review, we are using an estimated population of 60,000 teachers, this represents .02-.036 percent of all timesheets statewide. We believe this amount is not reasonable given the magnitude of federal grant funds used to pay school employee salaries and benefits.

Further, each district is permitted to decide which samples it will provide to the Office, which results in the Office's monitoring not being an effective control for evaluating districts' compliance with time and effort requirements.

Cause of Condition

The Office's monitoring process was not designed to ensure an adequate amount of payroll costs reimbursed to districts are reviewed to ensure the costs are proper and allocable to each federal program.

Effect of Condition and Questioned Costs

Because the amount of payroll expenditures reviewed is limited to two or three samples per district and the distrticts are allowed to select which employees are reviewed, the risk that the Office is reimbursing districts for costs that are unallowable increases.

Recommendation

We recommend the Office revise its method for obtaining time and effort records to a more random and objective system. Also, the Office should increase the amount of coverage it obtains when requesting time and effort samples from districts that administer multiple grants.

Office's Response

We appreciate the opportunity to respond to this finding. We do not concur, as this finding misrepresents the facts regarding our subrecipient monitoring system and we disagree with the auditor's professional judgment that this issue is a non-compliance condition or that this issue is material to the program.
It is our belief this audit finding does not meet the threshold required by auditing standards with regard to when a finding should be issued. Audit standards are clear that findings should be limited to those noncompliance conditions that have occurred or are likely to have occurred and noncompliance or internal control deficiencies that are ***significant or material*** *within the context of the audit objectives. We do not believe the auditor has established the condition is out of compliance or was in any way significant. Our belief is the auditor must be applying the requirements for auditing standards to our subrecipient monitoring process, with the understanding they are the same. This is simply not the case.*

We have provided evidence to your office that we are performing a significant amount of fiscal review during our monitoring efforts. Several times the auditor has stated the documentation submitted "is not good enough". We recognize that we can improve, and we plan to make changes to continue to improve our documentation. But, the federal government has not established standards for monitoring documentation – clearly making this a judgment call. We are open to suggestions about improvement – but believe the auditor is misstating the facts.

There are no minimum standards for sub-recipient monitoring, as quoted in a Department of Education training transcript we provided earlier to your office. Office of Management and Budget (OMB) Circular A-133 Compliance Supplement 2011, Part 3, Compliance Requirements, clearly states "Monitoring activities can take many forms".

This is very important because the fact is the auditor ***only*** *relied on the Consolidated Program Review (CPR) process, and only on his incorrect understanding of how the process is designed.*

Based on all of the subsequent documentation that we have provided to your office, we conclude the auditor failed to consider all of the technical assistance, compliance findings, and other monitoring performed by our office, based on the conclusions made in this finding. We have no requirement to select a sample of time and effort reports or other supporting documentation if we have determined there is low-risk the funds were expended inappropriately. When we determine a higher risk, we have evidence that additional documentation was reviewed.

There are several documents in our files that were completed and show evidence of a significant amount of review of payroll related expenditures completed on-site in addition to follow-up documentation requested for all payroll related non-compliance issues. These documents were available to the auditor and it was expressed by our office that additional material is reviewed on site if there is an issue. The sample the auditor selected contained 11 fiscal findings issued by our office on our subrecipients, including payroll expenditures with documentation supporting appropriate follow-up. We provided your office with two districts' monitoring files to support these statements. Our current procedures work well in identifying non-compliance conditions and ensuring our subrecipients are operating in accordance with grant requirements.

There is no mention of the 52 fiscal findings that were issued by our office in 31 of the 71 districts monitored, which is 44% of the population. These findings covered time and effort, allowable costs, program income, inventory of equipment, combining only allowable funds in schoolwide programs, contracts properly approved and monitored, bid requirements followed, and suspension and debarment. The majority, 25, were related to non-compliance with payroll related expenditures (time and effort). Some of those even required the district to move unallowable costs out of the federal programs. These findings required a significant amount of follow-up documentation for review including additional time and effort documentation. This is clear and convincing evidence that we are not simply checking off a box on a checklist. For the same time period and for the same 71 districts your office issued one time and effort finding in all of the programs included in the CPR process.

Your finding misstates the context of this situation by comparing the 60,000 teachers statewide to conclude only .02 percent of timesheets were reviewed. Our records indicate there are only 1198 teachers charged to all of the programs included in the CPR process statewide. Using your same calculation with the correct population and the actual number of documents that are reviewed, this would be 18 percent of statewide time and effort reviewed.

The auditor's recommendation that we utilize a random sample of timesheets is simply not required, and inappropriate due to the efficient risk based system already in place that meets or exceeds federal compliance. We are open to different methods, but we know that there are better ways to identify risk and to ensure districts know and understand time and effort requirements. Random samples are useful in audits if you want to extrapolate an error rate to a population – as you do in auditing – but they are very ineffective in monitoring. We utilize more than one method in determining compliance and to work with our subrecipients to stay in compliance but random sampling will not be one of them.

Based on all of the evidence provided, we contend that we are meeting or exceeding the standards for federal sub-recipient monitoring of use of funds. We have no intention of increasing unnecessary burden for our staff and districts that is not required. We take our responsibility to be accountable for public funds we administer very seriously and have developed a risk based system of monitoring districts to be efficient and effective with identifying proper use of those funds.

I know the auditor's office takes great pride in its risk based audit approach, and routinely performs desk reviews of its low-risk auditees. It is disappointing that your office does not approve of our use of a risk based approach to monitor subrecipients. Risk based auditing and monitoring is good public policy – it is efficient and effective – and we plan to continue to utilize this approach in the future.

In reviewing the facts presented in our response, I am hopeful your office will reconsider the issuance of this finding or make changes necessary to ensure that it is not a material misstatement of facts.

Auditor's Remarks

We thank the Office for its response.

To clarify, the State Auditor's Office is issuing this finding to report a material weakness in internal controls. While we are not reporting specific noncompliance, by reporting a material weakness in internal controls we are stating OSPI's processes are not sufficient to ensure noncompliance does not occur.

Payroll is the majority of federal grant expenditures that are reviewed during the consolidated review process. Therefore, examination of time and effort documentation is critical to ensuring grant funds are properly spent. Since more than 5 percent of grant funds are at risk, we are reporting this issue as a finding.

During the audit, OSPI consistently referred to the consolidated program review process as its way of monitoring sub-recipients.

As noted in our finding, we requested the number of teachers and administrators whose positions are wholly or partially funded with federal dollars that OSPI reviewed, but were told the Office could not provide that number. Additionally, the Office's response does not consider the number of administrative staff charged to the federal programs.

Our finding recommends the Office use an objective method to determine the samples to be tested. By allowing the districts themselves to choose the samples for testing, the Office reduces the likelihood that issues will be identified.

We reaffirm our finding and will review the status of the Office's corrective action plan 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 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. A pass-through entity shall perform the following for the Federal awards it makes:…
   (2) Advise subrecipients of requirements imposed on them by Federal laws, regulations, and the provisions of contracts or grant agreements as well as any supplemental requirements imposed by the pass-through entity.
   (3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

11-12 The University of Washington did not comply with the eligibility requirements of federal student financial aid programs.

Federal Awarding Agency:	U.S. Department of Education	
Pass-Through Entity:	None	
CFDA Number and Title:	84.063	Pell Grant (This program is part of the Student Financial Assistance Cluster – refer to the complete list of programs at the end of this finding.)
	84.063A	Pell Grant - American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	P063P110417	
Applicable Compliance Component:	Eligibility	
Questioned Cost Amount:	$10,645	

Federal Awarding Agency:	U.S. Department of Education	
Pass-Through Entity:	None	
CFDA Number and Title:	84.268	Federal Direct Student Loans (Direct Loan) (This program is part of the Student Financial Assistance Cluster – refer to the complete list of programs at the end of this finding.)
Federal Award Number:	P268K110417	
Applicable Compliance Component:	Eligibility	
Questioned Cost Amount:	$102,418	

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
	93.658A	Foster Care – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	The University has an interlocal agreement (no. 106598454) with state Department of Social and Health Services (DSHS). DSHS is the prime recipient with HHS.	
Applicable Compliance Component:	Eligibility	
Questioned Cost Amount:	$13,562	

Background

The University of Washington awards federal financial aid, such as PELL grants and direct loans, to students based on financial need and the number of credit hours in which they are enrolled. The U.S. Department of Education establishes the eligibility criteria. The University's School of Social Work also offers tuition assistance from the federal Child Welfare Training and Advancement Program. The U.S. Department of Health and Human Services oversees that program.

For the 2009-10 school year, the University disbursed $241.5 million in direct loans and $37.5 million in PELL Grants to students. For the 2010-11 school year, the School of Social Work awarded $1,313,433 in financial assistance from child welfare training program funds.

Description of Condition

The Assistant Dean of Student Affairs for the School of Social Work was responsible for establishing quarterly time schedules and approving independent study plans. He also was the instructor for the Social Work independent study courses. The School of Social Work is responsible for verifying that students meet graduation requirements. The Assistant Dean started in that position in 1997.

In March 2011, the Office of Student Financial Aid notified the Internal Audit Department that the School of Social Work Assistant Dean of Student Affairs may have inappropriately enrolled students in independent study courses for which they did not have to complete any work. The Internal Audit Department investigated. We reviewed its work, which found that primarily graduate students received credits for this independent study. The Assistant Dean believed that graduate students needed to maintain 10 credits for full-time status. Accordingly, he created a graduate-level independent study course, with himself as the instructor of record, and awarded the number of credits he thought students needed to keep their full-time status and to obtain financial aid. He did not develop independent study plans or require students to perform any studies to earn these credits as required by the University.

Although the School of Social Work Student Affairs Office does not apply these independent study credits toward graduation requirements, the University used these credits to determine eligibility for financial aid awards, resulting in overpayments of both Federal Student Aid program and Child Welfare Training and Advancement Program federal funds to students. Both programs require that schools award aid based on a student's enrollment status. Further, the federal financial aid program prohibits schools from awarding student aid for classes that do not count toward a degree or certificate.

Cause of Condition

No one monitored the activities of the Assistant Dean of School of Social Work, who had the authority to make decisions that ultimately affected students' financial aid status. The Assistant Dean misunderstood student financial aid requirements and misapplied academic policies related to independent study credits in order to affect students' enrollment status.

Effect of Condition and Questioned Costs

The School of Social Work inappropriately awarded 139 students 428 credits. Twenty-four of those students were ineligible for financial aid. Overpayments of financial aid from the Department of Education were $102,418 in direct loans and $10,645 in Pell Grants from 2004 to 2010. We are questioning these costs. The University reported the overpayment to the U.S. Department of Education, which is reviewing the issue to determine if repayment and fines are required.

Overpayments from the Department of Health and Human Services were $13,562 in child welfare training program funds over the seven years. We are also questioning these costs. The University returned the overpayment to the state Department of Social and Health Services, which sponsors this program.

Year	U.S. Department of Education Federal Aid	HHS CWTAP
2010	$ 23,144	$ 582
2009	19,790	1,128
2008	25,039	534
2007	25,439	0
2006	6,988	1,460
2005	5,575	7,205
2004	7,088	2,653
TOTAL	$113,063	$13,562

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 University strengthen and/or establish internal controls at the school level to ensure students enrolled in independent study courses meet the required academic standards, as these courses affect the students' ability to meet federal financial aid requirements.

We also recommend the University provide guidance and monitoring to ensure departments refer students to the Office of Student Financial Aid for assistance in determining eligibility for financial aid.

University's Response

We agree with the recommendations. The School of Social Work has strengthened their internal control structure. Duties have been segregated so that the Assistant Dean for Student Affairs, who had complete control of the independent study process, no longer approves independent study course proposals. The MSW (Masters of Social Work) and BASW (Bachelor of Social Work) Program Directors now approve all independent study course proposals. To ensure compliance with this policy, two steps are in place. First, on day 10 of each quarter, the files of all students enrolled in independent study courses are reviewed to ensure that the independent study course proposals are properly documented and approved. Second, periodic checks are conducted by the Associate Dean for Academic Affairs on a sample of students enrolled in independent study courses to ensure that proposals are properly documented and approved.

The University currently provides guidance to students regarding their eligibility for Student Financial Aid via a number of communication mechanisms, including secure websites with individual student eligibility information, written, verbal and email communication from financial aid counselors and printed publications and websites relating to general financial aid information. In the future, periodic alerts will be sent to undergraduate and graduate academic department advisors directing them to University policies regarding financial aid eligibility, typically at the beginning of the Fall Quarter. These alerts will also serve to remind them that they should direct students who have questions or concerns about financial aid to the Office of Student Financial Aid.

Auditor's Remarks

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

Applicable laws and Regulations

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

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

UW Scholastic Regulations, Chapter 110, Section 7a states:

> With appropriate departmental review and approval, faculty may offer a course or courses on a CR/NC basis. The standard for granting credit in CR/NC courses shall be the demonstration of competence in the material of the course to the instructor's satisfaction. Students demonstrating such competence shall have CR entered on the transcript; those who do not shall have NC entered on the transcript.

2010-2011 Federal Student Aid Handbook, Volume 1, Chapter 1 – School-Determined Requirements, Enrollment Status states in part:

> A student must be enrolled at least half time to receive aid from the Stafford and Plus loan programs… The Pell, TEACH Grant, and Campus-based programs don't require half-time enrollment [except for post baccalaureate Pell grants for teacher education and Perkins and FWS for students enrolled in a program for teaching credential, per internal note], but, the student's enrollment status does affect the amount of Pell a student receives.

> To be enrolled half time, a student must be taking at least half of the course load of a full-time student. Your school defines a full-time workload, but it must meet the minimum standards in the FSA regulations. The definition of full time for FSA purposes (below) can differ from the definition used for other purposes at your school, such as the definition used by the registrar's office.
>
> Minimum standards for full-time enrollment. … For undergraduates, full-time status must be at least:
>
> · 12 semester hours or 12 quarter hours per academic term in an educational program using a semester, trimester ,or quarter system[.] …
>
> If a student is enrolled in courses that do not count toward his degree, they cannot be used to determine enrollment status unless they are noncredit or remedial courses…. This means you cannot award the student aid for classes that do not count toward his degree or certificate.

DSHS 6036LF Custom Interlocal Agreement PIHE (8-22-07), Special Terms and Conditions, Section 6, states in part:

> Individual student financial assistance expenditure will be equivalent to resident tuition plus $500 per quarter for full-time students and pro-rated for part-time students as defined in this agreement. The "plus $500" assistance will be prorated for students carrying less than seven (7) credit hours/quarter or six (6) credit hours/quarter in the Tacoma evening program and Extended Learning Degree Programs, Evening and Weekend, so that the student financial assistance will equal tuition plus a proportion of the $500 add on.

Programs included in the 2011 Student Financial Assistance cluster:

- CFDA 84.375 Academic Competitiveness Grant (ACG)
- CFDA 84.268 Federal Direct Student Loans program (Direct Loan)
- CFDA 84.032 Federal Education Loans (FFEL)
- CFDA 84.007 Federal Supplemental Educational Opportunity Grant (FSEOG)
- CFDA 84.033 Federal Work-Study Program (FWS)
- CFDA 93.342 Health Professions Student Loans, Including Primary Care Loans and Loans For Disadvantage Students (HPSL/PCL/LDS)
- CFDA 84.408 Postsecondary Education Scholarships for Veteran's Dependents (Iraq and Afghanistan Service Grants (LASG))
- CFDA 93.364 Nursing Student Loans (LSL)
- CFDA 93.264 Nurse Faculty Loan Program (NFLP)
- CFDA 84.063 Federal Pell Grant Program (PELL)
- CFDA 84.037 Perkins Loan Cancellations
- CFDA 84.038 Federal Perkins Loan (FPL)
- CFDA 93.407 ARRA – Scholarships for Disadvantaged Students (ARRA-SDS)
- CFDA 93.408 ARRA – Nurse Faculty Loan Program (ARRA – NFLP)
- CFDA 84.376 National Science and Mathematics Access to Retain Talent (SMART) Grants (SMART Grants)
- CFDA 84.379 Teacher Education Assistance For College And Higher Education Grants (TEACH Grants)
- CFDA 93.925 Scholarships for Disadvantaged Students (SDS)

11-13 The Department of Social and Health Services is not complying with federal requirements for suspension and debarment for its federal Vocational Rehabilitation Program.

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

Background

The Department of Social and Health Services, Division of Vocational Rehabilitation, administers the federal Vocational Rehabilitation Program. The program's purposes are to design, assess, plan, develop, and provide vocational rehabilitation services for individuals with disabilities to help them prepare for and attain employment. The Department received $40.1 million in federal funding during fiscal year 2011, $2.3 million of which was provided through the American Recovery and Reinvestment Act.

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

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

Description of Condition

The Division contracts with vendors to provide services to its clients for activities allowed under the program. In some cases a formal Department master contract is used, in others a less formal vendor agreement, known as a "Authorization For Purchase" is used. The Division's client service tracking system automatically creates the authorization. The Department's master contracts contain suspension and debarment clauses, but the vendor agreements do not. We issued a finding during state fiscal year 2010 related to this condition.

During state fiscal year 2011 we selected a sample of 42 vendors paid during the audit period that would be subject to the suspension and debarment requirements. We found the Division did not verify that ten of these vendors were not suspended or debarred. Thirty-two of the vendors tested had a Department master contract containing a suspension and debarment clause; the remaining ten vendors were supported by an agreement without a suspension and debarment clause.

Cause of Condition

In response to our state fiscal year 2010 finding, the Division is revising the vendor agreements to include the required suspension and debarment clauses. However, the Division was not able to complete the changes during our current audit period.

Effect of Condition

Failure to comply with grant requirements could result in repayment of grant funding or loss of eligibility for future federal awards. We examined the status of the 14 vendors in the excluded parties list and found none were debarred or suspended, therefore we are not questioning any costs.

Recommendations

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

Department's Response

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

DVR purchases client services with a STARS Authorization for Purchase (AFP). DVR will update the Terms and Conditions for the AFP to include suspension and debarment language as recommended by the Department's Central Contract 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 Nonprofit Organizations*, Subpart C, section 300 -- Auditee responsibilities.

The auditee shall:

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

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

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

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

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

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

11-14 The Department of Services for the Blind is not complying with federal requirements for suspension and debarment for its federal Vocational Rehabilitation Program.

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

Background

The Department of Services for the Blind administers approximately 16 percent of the federal Vocational Rehabilitation Program funding received by the state. The program's purposes are to design, assess, plan, develop, and provide vocational rehabilitation services for sight-impaired individuals so that they may prepare for and become employed. The Department received $7.8 million in federal funding during fiscal year 2011, $1.1 million of which was provided through the American Recovery and Reinvestment Act.

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

(d) Checking the federal Excluded Parties List System
(e) Collecting a certification from the vendor or sub-recipient.
(f) Adding a clause or condition to the covered transaction with the vendor or sub-recipient.

Description of Condition

The Department contracts with vendors to provide services to it's clients for activities allowed under the program. The contracts do not contain a clause or condition concerning suspension and debarment. Further, the Department does not collect a separate certification from the vendors nor consult the federal Excluded Parties List System.

During state fiscal year 2011 we found 16 vendors paid during the audit period that would be subject to the suspension and debarment requirements. We found the Department did not verify these vendors were not suspended or debarred.

Cause of Condition

The Department was not aware it must ensure all vendors receiving more than $25,000 in Vocational Rehabilitation grant funds are not suspended or debarred.

Effect of Condition

Failure to comply with grant requirements could result in repayment of grant funding or loss of eligibility for future federal awards. We examined the status of the 16 vendors in the excluded parties list and found none were debarred or suspended, therefore we are not questioning any costs.

Recommendations

We recommend the Department ensure all vendors receiving more than $25,000 in Vocational Rehabilitation grant funds have not been suspended or debarred by using one of the methods identified in federal regulations. We recommend the Department provide adequate training to ensure all staff responsible for contracting with vendors understand federal suspension and debarment requirements.

Department's Response

The Department concurs with this finding and will take the following steps to ensure all vendors receiving more than $25,000 in vocational rehabilitation funds are not suspended or debarred:

1) *Expand its General Terms and Conditions [GT&Cs] to include debarment certification language;*
2) *Attach the expanded GT&Cs to all service delivery outcome plans and contracts;*
3) *Review monthly if a current vendor has received more than $25,000 in grant funds in the preceding twelve months. If so, staff will verify the vendor has signed the GT&Cs providing the necessary certification; and*
4) *Insure applicable staff implements these 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 Nonprofit Organizations*, Subpart C, section 300 -- Auditee responsibilities.

The auditee shall:

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

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

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

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

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

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

11-15 The Department of Services for the Blind did not comply with federal requirements regarding services charged to the Vocational Rehabilitation Program.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Vocational Rehabilitation Grants to States 84.390 Vocational Rehabilitation Grants to States – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	H126A100072; H390A090072
Applicable Compliance Component:	Allowable Costs
Questioned Cost Amount:	$20,676 Non ARRA $ 36 ARRA

Background

The Department of Services for the Blind administers approximately 16 percent of the federal Vocational Rehabilitation Program funding received by the state. The program's purposes are to design, assess, plan, develop, and provide vocational rehabilitation services for sight-impaired individuals so that they may prepare for and become employed. The Department received $7.8 million in federal funding during fiscal year 2011, $1.1 million of which was provided through the American Recovery and Reinvestment Act.

Services provided to individuals under this grant must be described in an Individualized Plan for Employment and necessary to assist an individual with a disability in preparing for, securing, retaining, or regaining an employment outcome.

Description of Condition

As part of our audit, we tested a random sample of 148 client service expenditures charged to the grant during the year. We found nine expenditures totaling $20,712 were not specifically described in the client's Individualized Plan for Employment.

Cause of Condition

Department staff responsible for updating the Individualized Plan for Employment did not fully understand the federal requirements.

Effect of Condition and Questioned Costs

Without an Individualized Plan for Employment that specifically lists services to be provided, federal grantors cannot be assured client services charged to the grant are valid. This could jeopardize future federal funding.

We are questioning costs of $20,712, the amount charged to the grant that was not supported in accordance with federal 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.

Recommendations

We recommend the Department ensure all services provided to a client are specifically listed in the Individualized Plan for Employment. We recommend the Department provide adequate training to ensure all staff responsible for updating Individualized Plans for Employment understand federal requirements.

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

Department's Response

The Department acknowledges the finding and plans to take the following steps to respond to the identified concerns:

1) *Submit to the Rehabilitation Services Administration a request for determination whether the tools and methods developed by DSB for documenting estimated individual plans for employment [IPE] goods and services costs, modification of cost estimates, service date ranges, extension of general timeliness guidelines and active client involvement in decision making meet necessary requirements.*

2) *If RSA finds a need for closer alignment of IPE content and accompanying detailed case narrative, DSB will focus staff training on updating standardized IPE responses, and making other necessary process adjustments.*

Auditor's Concluding Remarks

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

Applicable laws and Regulations

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

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

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

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

Rehabilitation Act of 1973, Section 103(a), (29 USC 723 (a)) states in part:

> Vocational rehabilitation services provided under this title are any services described in an individualized plan for employment necessary to assist an individual with a disability in preparing for, securing, retaining, or regaining and employment outcome that is consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual…

Code of Federal Regulations 34 CFR Section 361.45(a)(1) and (2) state in part:

(a) General requirements. The State plan must assure that

(1) An individualized plan for employment (IPE) meeting the requirements of this section and section 361.46 is developed and implemented in a timely manner for each individual determined to be eligible for vocational rehabilitation services…
(2) Services will be provided in accordance with the provisions of the IPE.

Washington Administrative Code 67-25-260 states in part:

(1) The individualized plan for employment is a written agreement that documents important decisions made between the customer and a vocational rehabilitation counselor concerning the customer's employment outcome including, responsibilities agreed upon by the department and the customer, and the vocational rehabilitation services to be provided.
(2) The customer must be actively involved in developing the individualized plan for employment including making meaningful and informed choices about the selection of the employment outcome, intermediate objectives, the vocational rehabilitation services provided, service providers, settings, and methods of procuring services.

11-16 The Department of Early Learning did not comply with time and effort requirements for its Special Education Grants for Infants and Families for the Early Support for Infants and Toddlers Program.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.181 Special Education – Grants for Infants and Families 84.393 Special Education – Grants for Infants and Families – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	H181A100128, H393A090027(ARRA)
Applicable Compliance Component:	Allowable Costs / Cost Principles
Questioned Cost Amount:	$96,711

Background

The Department of Early Learning administers the Early Support for Infants and Toddlers Program, which provides services to children from birth to age 3 who have disabilities and/or developmental delays.

In fiscal year 2011, the Department spent $12.5 million in federal funds on the program, approximately $4.17 million of which was provided by the American Recovery and Reinvestment Act.

Grants may be used to pay only for costs that are allowable and related to the grant's purpose. Federal regulations specify what documentation must be kept to support employee payroll charged to federal grants. If an employee works solely on one grant program or cost objective and charges all payroll related costs to that grant, the employee must certify this semiannually in writing. Employees can also support payroll costs by monthly personnel activity reports or equivalent documentation, such as timesheets. Such documents 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.

The Department requires salaried employees to certify their time semiannually and hourly employees to complete timesheets to meet federal time and effort requirements.

Description of Condition

We randomly selected 11 employees who worked solely on the grant for the fiscal year. Of the employees selected, two were hourly employees and the rest were salaried. We reviewed timesheets for the hourly employees and the semiannual time and effort certifications for the salaried employees. The Department could not locate one employee's time certifications.

Cause of Condition

The Department stated it had misplaced the missing certifications.

Effect of Condition

We identified $96,711 in direct payroll charges to the Grants for Infants and Families for the Early Support for Infants and Toddlers Program that did not have the required documents. We are questioning those costs as unallowable charges.

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

We question costs when we find a department 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 original certifications are completed and retained for individuals who work solely on the grant for the fiscal year.

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

Department's Response

The department acknowledges that two payroll certifications (for one employee) out of the entire ESIT program were not obtained. The department did contact the employee after this was discovered, who responded that 100% of his time was devoted to the work funded under the IDEA Part C federal grant. However, this retroactive certification was not allowed by the auditor.

This specific employee completed a certificate for every period while the program was at DSHS. However, when the program transferred to DEL, somehow the follow-through did not occur and his certificates were never received by the Fiscal Manager. This was a clear indication that the department needed to tighten up its process for ensuring a certificate is completed for all the ESIT staff.

Steps have already been taken to ensure this does not happen again, by ESIT Fiscal Program Manager (FPM) implementing the following procedures:

- *develop a certification tracking grid containing a list of ESIT Program and ESIT IT staff*
- *use the tracking grid as a checklist to ensure all certificates are obtained from all ESIT Program and ESIT IT staff*
- *scan all certificates and store/file on the FPM drive*
- *deliver original hard copy certificates to the Fiscal Office for recording/filing.*

We expect this will eliminate any future circumstances of missing certificates.

The department appreciates the thoughtful approach the auditor took on this audit. Although we never like to hear that an audit finding is being levied, we do appreciate the opportunity to improve our processes.

Auditor's Concluding Remarks

We thank the Department for its response. To clarify, our testing of payroll only included 11 employees who worked solely on the program, it did not include the entire ESIT Program.

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

Applicable Laws and Regulations

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

The auditee shall:

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

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

Appendix B, Section 8(h):

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

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

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

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

11-17 The Department of Health does not monitor sub-recipients of 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:	5U90TP017010-10; 3U90TP017010-10W1; 1H75TP000669-01; U3REP090208-01; U3REP090228-02; U3REP080103-01
Applicable Compliance Component:	Cash Management Controls; Sub-recipient Monitoring Controls / Compliance
Questioned Cost Amount:	$480,000 Public Health Emergency Preparedness $190,832 Hospital Preparedness

Background

The State Department of Health administers the Public Health Emergency Preparedness Program and the National Bioterrorism Hospital Preparedness Program. These programs are designed to enhance the ability of hospitals and health care systems to prepare for and respond to biological and other public health emergencies. The Department distributes money to hospitals, outpatient facilities, tribes, health centers, poison control centers, emergency management services and other healthcare partners. These entities oversee training, meetings, purchasing of supplies and equipment, and generate reports on the program.

The Department spent $23 million in Public Health Emergency Preparedness funds and $8.5 million in Hospital Preparedness Program funds in fiscal year 2011.

Cash Management

Federal regulation prohibits recipients from using federal money to accumulate excess cash reserves. Payments to sub-recipients must be for actual costs incurred or, in the case of cash advances, actual short-term needs. Sub-recipients must have documentation to support the expenditures.

Sub-recipient Monitoring

Pass-through entities are responsible for monitoring the sub-recipients' use of federal awards to ensure they comply with federal law and grant agreements. Pass-through entities also are responsible for ensuring sub-recipients spending $500,000 or more in federal awards during a fiscal year meet federal audit requirements. The Department is responsible for notifying sub-recipients of federal requirements.

We reported a finding for fiscal year 2010 stating the Department did not adequately monitor sub-recipients or collect or review supporting documentation for expenditures reimbursed to sub-recipients for either program.

Description of Condition

The Department has not addressed the lack of monitoring. It stated despite internal discussions on how to modify processes, it has made no changes. The Department contracts with a certified public accountant (CPA) for on-site monitoring of sub-recipients. We spoke with Department management and reviewed reports and determined this monitoring does not ensure expenditures of federal funds are supported or are for allowable costs.

We requested a random sample of the most recent monitoring reports for 21 Hospital Preparedness sub-recipients and 14 Public Health Emergency Preparedness sub-recipients. We determined that for 14 sub-recipients, the CPA was reviewing only one month of expenditures during a two-year period and was not

reviewing any expenditures from the second year. We also noted that for two sub-recipients who received more than $10 million in program funding, the CPA reviewed only half of one percent of program expenditures.

For the sub-recipient reimbursement requests we tested, the Department did not collect supporting documentation for either program. The recipients invoice the Department for a portion of the grant award monthly, quarterly, or annually, regardless of actual costs incurred. We found no documentation of actual costs included with the invoices.

We also reviewed the contract files and federal (A-133) audits for the selected sub-recipients. We determined:

- The Department did not notify any of the selected sub-recipients of the Catalog of Federal Domestic Assistance title, award name, award number, or the name of the grantor.
- The Department did not ensure all sub-recipients received audits in accordance with A-133 requirements. One sub-recipient told the Department it was not required to have an audit even though it received more than over $1 million in federal funding. Entities spending $500,000 or more in total federal funding are required to have an A-133 audit.
- The Department did not ensure federal funds provided to the sub-recipient were accurately reported on its Schedule of Expenditures of Federal Awards (SEFA). SEFA reporting was inaccurate for three sub-recipient audits for Hospital Preparedness and two for Public Health Emergency Preparedness.
- The Department does not follow up when sub-recipients do not respond to requests for federal award information and audit requirements.
- The Department does not adequately address sub-recipient noncompliance or recover questioned costs reported by federal audits or fiscal monitoring reports.

We noted that the monitoring reports and A-133 audits identified some instances of sub-recipient non-compliance, including unallowable expenditures, questioned costs, and unsupported billing rates and time and effort billing. Department management told us they have not recovered any questioned costs and are uncertain about who is supposed to determine whether costs are allowable. The Department sent letters to some sub-recipients to address the issues, but continue to pay them despite continued non-compliance.

Sub-recipient contracts include a statement of work that outlines the objectives and deliverables for the grant. Eleven of the sub-recipients we selected for Hospital Preparedness and 12 of the sub-recipients we selected for Public Health Emergency Preparedness had consolidated contracts, which are agreements covering two or more federal grants. The statement of work in the consolidated contracts did not specify which objectives were for each grant or the budgeted amounts allowed to be reimbursed for completing the objectives. Without specifying the activities that can be charged to each grant, the Department cannot determine if federal expenditures charged by the sub-recipient are allowable.

We also reviewed $1.17 million in Hospital Preparedness and $1.36 million in Public Health Emergency Preparedness sub-recipient payments. We selected 93 Hospital Preparedness expenditures and 64 Public Health Emergency Preparedness expenditures by random sampling and using auditor judgment. They were reimbursements based on requests submitted to the Department; thirty-eight Hospital Preparedness expenditures for medical equipment were supported with copies of invoices and receipts, but there was no additional support included for any of the remaining expenditures.

We found $190,832 in unallowable expenditures for Hospital Preparedness and $480,000 for Public Health Emergency Preparedness.

Cause of Condition

Department management felt its payment process and monitoring were adequate to ensure costs were allowable and supported. Department management relies on finished deliverables from the sub-recipients

as a basis for supporting costs. This is not sufficient to determine if the amount paid to the sub-recipient was allowable or based on actual costs.

The Department has no policies and procedures to ensure staff know how to comply with all federal compliance and monitoring requirements for sub-recipients.

Staff responsible for ensuring compliance with A-133 requirements stated they do not attempt to verify the amounts reported in the SEFA. Staff relies on the sub-recipients to report their award expenditures and A-133 audit requirements, and do not follow-up with sub-recipients when they do not respond to the Department's requests for this information.

Effect of Condition and Questioned Costs

The Department cannot be sure it is reimbursing only allowable and actual costs and that its sub-recipients are not making a profit from federal dollars. The Department also cannot be sure the sub-recipient is operating only on a reimbursement basis.

We found sub-recipients improperly charged $190,832 to the Hospital Preparedness Program and $480,000 to the Public Health Emergency Preparedness Program. We are questioning those costs as unallowable charges. The federal grantor could disallow these charges and require the Department to pay back the money.

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:

Ensure it pays sub-recipients in accordance with federal requirements and requires documentation to support those costs. The Department should only reimburse for actual costs so sub-recipients will not have excess cash on hand.

Ensure all sub-recipients required to receive A-133 audits have one and submit it to the Department for review. The Department should review the audit reports to ensure it properly reported program expenditures.

Ensure it collects and returns all improper payments to the federal government.

Department's Response

We partially concur with the SAO finding.

We agree with the finding in the following areas:

- *All A-133 reports that are required for our sub-recipient entities should be collected and reviewed by DOH. Where our sub-recipient entities do not comply with this requirement we will initiate appropriate sanctions consistent with the A-133 compliance supplement. We will clarify with our federal grantors concerning the acceptability of some forms of alternative documentation.*
- *We agree that follow up on issues identified through both the A-133 audits and sub-recipient monitoring could have been more timely and coordinated. However, we wish to emphasize that these efforts are in place.*
- *We will notify sub-recipients of grant information as described in the A-133 compliance supplement.*

- *We are also increasing the scope of the documentary review in our contracted monitoring visits, beginning with the calendar year 2012 fiscal monitoring visits.*

We have concerns in the following areas:

We wish to make clear that the Department of Health has had a multi program sub-recipient monitoring process in place since at least 2005. This same process has been reviewed by SAO in the intervening years up until 2009 without this level of concern being articulated. While we understand that the SAO position on the A-133 Compliance Supplement criteria has changed, we wish to emphasize the broad scope and budgetary impact that these changes could imply.

SAO initially concluded its fiscal year 2010 single audit in March of 2011, which was nine months into the subsequent fiscal year. This date is significant because the greater balance of sub-recipient monitoring for fiscal year 2011 had already taken place, and so too had the planning and contracting for the calendar year 2011 monitoring visits which have extended into fiscal year 2012. Changing this process involves a close coordination with our public health partners and it is not easily modified once set in motion.

In this finding SAO has concluded simultaneously that DOH does not monitor sub-recipients of the subject grants, and that the monitoring visits were sufficient to arrive at a determination of non-compliance on the part of certain sub-recipients. We are concerned that this conclusion is not consistent and points out that the DOH sub-recipient monitoring efforts were not wholly inadequate. While follow up on some of the issues identified in these fiscal monitoring visits may have been delayed, it is not absent, and DOH is actively involved in both the resolution of questioned costs and in reviewing sub-recipient corrective action.

We are also uncertain of the requirement as interpreted by SAO for the agency to be responsible for reconciling the statement of expenditures of federal awards (SEFA) as part of our A-133 audit review process. We will be consulting with our federal grantor on this and other issues connected with the audit and the associated questioned costs.

We will work with the Office of Financial Management to implement our corrective action plan, and will share this information with our SAO audit team.

Auditor's Concluding Remarks

We thank the Department for its response. In our finding we acknowledge the Department does perform some monitoring, which has resulted in identified issues of non-compliance. While we determined some monitoring is performed, we also determined this level of monitoring is not sufficient to ensure the Department's sub-recipients administer the Public Health and Hospital Preparedness awards in compliance with the laws, regulations, and the provisions of contracts or grant agreements. These two conclusions are not inconsistent as even an insufficient level of monitoring can sometimes identify instances of noncompliance.

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

Applicable Laws and Regulations

OMB Circular A-133 Compliance Supplement Subpart C--Auditees§___.300 Auditee responsibilities.

The auditee shall:

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

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

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

(a) Payment methods shall minimize the time elapsing between the transfer of funds from the United States Treasury and the issuance or redemption of checks, warrants, or payment by other means by the recipients. Payment methods of State agencies or instrumentalities shall be consistent with Treasury-State CMIA agreements or default procedures codified at 31 CFR part 205.
(b) Recipients are to be paid in advance, provided they maintain or demonstrate the willingness to maintain:
    (1) Written procedures that minimize the time elapsing between the transfer of funds and disbursement by the recipient, and
    (2) Financial management systems that meet the standards for fund control and accountability as established in § 215.21. Cash advances to a recipient organization shall be limited to the minimum amounts needed and be timed to be in accordance with the actual, immediate cash requirements of the recipient organization in carrying out the purpose of the approved program or project. The timing and amount of cash advances shall be as close as is administratively feasible to the actual disbursements by the recipient organization for direct program or project costs and the proportionate share of any allowable indirect costs.
(c) Whenever possible, advances shall be consolidated to cover anticipated cash needs for all awards made by the Federal awarding agency to the recipient.
(d) Reimbursement is the preferred method when the requirements in § 215.12(b) cannot be met.

Title 45, Code of Federal Regulations, Part 92

Section 92.22 - Allowable costs, states in part.
(a) Limitation on use of funds. Grant funds may be used only for:
    (1) The allowable costs of the grantees, subgrantees and cost-type contractors, including allowable costs in the form of payments to fixed-price contractors; and
    (2) Reasonable fees or profit to cost-type contractors but not any fee or profit (or other increment above allowable costs) to the grantee or subgrantee.

Section 92.21 – Payment, states in part

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

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

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

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

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

Appendix A, Section C.- Basic Guidelines:

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

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

Section C. Cash Management

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

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

Section M. Subrecipient Monitoring:

Compliance Requirements

A pass-through entity is responsible for:

- Award Identification – At the time of the subaward, identifying to the subrecipient the Federal award information (i.e., CFDA title and number; award name and number; if the award is research and development; and name of Federal awarding agency) and applicable compliance requirements.

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

- 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.

11-18 The Department of Health did not comply with federal 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:	5U90TP017010-10; 3U90TP017010-10W1; 1H75TP000669-01; U3REP090208-01; U3REP090228-02; U3REP080103-01
Applicable Compliance Component:	Reporting Controls / Compliance
Questioned Cost Amount:	None

Background

The Washington State Department of Health administers the Public Health Emergency Preparedness Program and the National Bioterrorism Hospital Preparedness Program. These federal grants enhance the ability of hospitals and health care systems to prepare for and respond to biological and other public health emergencies. The Department distributes money to hospitals, outpatient facilities, tribes, health centers, poison control centers, emergency management services and other healthcare partners. These entities oversee training, meetings, purchasing of supplies and equipment, and generate reports on the program. The Department spent $23 million in Public Health Emergency Preparedness funds and $8.5 million in Hospital Preparedness Program funds in fiscal year 2011.

As a condition of receiving these grants, the Department is required to submit cash draw reports, financial status reports and progress reports to the grantor. The quarterly cash draw report shows the cumulative amount of federal share of cash disbursed for each award and is due within 30 days after the end of the quarter. The financial status report shows program revenues and expenditures on an annual and semi-annual basis. Semi-annual reports must be submitted no later than 30 days after the end of each reporting period. Annual reports must be submitted within 90 days after the end of each reporting period and final reports must be submitted within 90 days after the project or grant period end date. Progress reports are due when specified by the grant. All reports must be supported by the Department's accounting system and reflect actual work performed.

Description of Condition

We reviewed all quarterly cash draws and financial status reports the Department submitted for both programs during fiscal year 2011. We also requested four progress reports for Hospital Preparedness and three progress reports for Public Health that were due during the year.

We found:

- None of the financial status reports for Public Health Emergency Preparedness had complete original supporting documentation from the accounting system. Because of this, we could not verify that all reported amounts were accurate.
- Two financial status reports for Public Health Emergency Preparedness did not correctly report the federal share of outlays. On one report, the federal share of outlays was overstated by $1,077,230. On the other report, the Department understated the federal share of outlays by $9,360.
- Two financial status reports for Hospital Preparedness included expenditures that were beyond the reporting period. These reports were overstated by a total of $131,447.
- All cash draw reports showed revenues drawn from the federal grantor instead of funds disbursed. Amounts for Hospital Preparedness and Public Health Emergency Preparedness were overstated by $514,181 and $1,014,462, respectively.

- Cash draw reports for Public Health Emergency Preparedness were overstated by an additional $2,744,345 due to expenditures being incorrectly calculated.
- The FSRs for Hospital Preparedness were submitted late, and corrections to two final reports were submitted 165 and 201 days after the original report was due.
- None of the progress reports for either program had any supporting documentation. Therefore, we could not verify that amounts and information reported were accurate.
- The Department has no policies and procedures for completing these reports and does not track or document the review process.
- The Department did not provide two of the progress reports for Hospital Preparedness to us. We were unable to determine if these reports were completed or submitted to the grantor as required.

Cause of Condition

Department management and grants staff did not have a full understanding of how to complete the reports correctly. Detailed instructions for completion of federal reports are available from grantors.

Department management did not adequately review reports and supporting documentation before approving and submitting them to the grantor.

Department management did not develop internal controls over the completion of progress reports. This includes not having written policies or procedures to provide guidance for Department staff.

Effect of Condition

Grantors rely on accurate reports to monitor the progress of programs and the use of federal dollars. By not submitting the reports with accurate data, the Department prevented the grantor from adequately monitoring the financial status and effectiveness of the program.

We could not test internal controls over the completion of progress reports.

Grant conditions allow the grantor to penalize the Department for noncompliance, suspending or terminating the award, and withholding future awards.

Recommendation

Department management should ensure all staff preparing and reviewing financial reports are aware of reporting requirements and have a full understanding of how to complete the reports. Department management should also thoroughly review all reports and supporting documentation before submitting them to the federal grantor.

The Department should establish and implement internal controls over progress reports sufficient to ensure the reports are accurate, complete, supported, reviewed and approved prior to being submitted to the federal grantor. The submitted report, supporting documentation and evidence of the review process should be retained and available for review.

Department's Response

We concur with the auditor's finding.

We wish to emphasize that there is a review process in place for our progress reports, though it has not been formalized in a procedure at this point. In addition, the Department feels that our overall process for financial status report filings includes supporting documentation from the agency's accounting systems. Although there were errors noted on some reports, many of these were identified by DOH Grants Management prior to the audit field work.

DOH Grants Management does review all Federal Financial Reports (FFRs) in coordination with the program, and provides supporting documentation before approving and submitting them to the grantor. We will review our procedures and controls governing reporting for these federal grants and draft a corrective action plan for submission to the Office of Financial Management. We will share this information with the State Auditor's Office.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

OMB Circular A-102 Common Rule, *Uniform Administrative Requirements For Grants And Cooperative Agreements To State And Local Governments,* 45 CFR 92. 20 states in part:

> Standards for financial management systems.
>
> (a) Fiscal control and accounting procedures of the state, as well as its subgrantees and cost-type contractors, must be sufficient to —
>
> (1) Permit preparation of reports required by this part and the statutes authorizing the grant, and
>
> (2) Permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of applicable statutes.

11-19 The Department of Health did not maintain the federally required documentation for $189,000 in payroll costs charged to 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:	5U90TP017010-10; 3U90TP017010-10W1; 1H75TP000669-01; U3REP090208-01; U3REP090228-02; U3REP080103-01
Applicable Compliance Component:	Allowable Costs / Cost Principles
Questioned Cost Amount:	$114,206.06 Public Health Emergency Preparedness $ 75,686.14 Hospital Preparedness

Background

The Washington State Department of Health administers the Public Health Emergency Preparedness Program and the National Bioterrorism Hospital Preparedness Program. These federal grants enhance the ability of hospitals and health care systems to prepare for and respond to biological and other public health emergencies.

The Department distributes money to hospitals, outpatient facilities, tribes, health centers, poison control centers, emergency management services and other healthcare partners. These entities oversee training, meetings, purchasing of supplies and equipment, and generate reports on the program. The Department spent $23 million in Public Health Emergency Preparedness funds and $8.5 million in Hospital Preparedness Program funds in fiscal year 2011.

Grant money may be used to pay only for costs that are allowable and related to the grant's purpose. Federal regulations specify the documentation that must be kept to support employee compensation charged to federal grants. If an employee works solely on the grant program and all related payroll costs are charged to that grant, minimal documentation is required: the employee must certify, semi-annually, in writing, that he or she worked solely on that program. In contrast, payroll costs of employees who work on multiple programs or cost objectives 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 for interim accounting purposes so long as the estimate of time worked is reconciled to actual work activity at least quarterly.

We reported a finding in our fiscal year 2010 audit, noting that the Department did not comply with regulations for employee compensation charged to federal grants. We questioned approximately $448,000 of payroll costs.

Description of Condition

During six months of the fiscal year 2011, the Department charged a portion of the payroll costs for five managers to multiple grants based on budgeted percentages. Although these managers worked on and were charged to multiple programs, they did not maintain timekeeping or other personnel activity reports as required prior to January 1, 2011.

The Department also charged payroll costs for five employees to the Public Health Emergency Preparedness grant based on certifications instead of the hours on their timesheets.

Cause of Condition

Department management misinterpreted federal requirements and believed the personnel activity reports were not required for the managers. The Department became aware of the misinterpretation in February 2011 and managers began keeping timesheets as of March 1, 2011.

Supervisors were submitting both time sheets and certifications for employees. Payroll charged the grant according to the certifications instead of the hours on the time sheets.

Effect of Condition and Questioned Costs

We identified $114,206.06 in direct payroll charges to the Public Health Emergency Preparedness Program grants and $75,686.14 in direct payroll charges to the National Bioterrorism Hospital Preparedness Program grants that were incorrectly charged and not supported in accordance with federal requirements. We are questioning those costs as unallowable charges for salaries and benefits. The federal grantor could disallow these charges and require the Department to pay back the money.

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.

Recommendations

We recommend the Department ensure all employee salaries and benefits charged to a federal grant meet the documentation requirements of federal regulations. We also recommend that Department management thoroughly review time sheets and certifications prior to approval to ensure charges to the grant are accurate and 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 State Auditor's Office finding. We wish to emphasize that the corrective action concerning the major issue in this finding was implemented as of March 2011 in response to the audit finding included in the Auditor's FY 2010 Single Audit Report. Also, we have addressed the issue, identified in the current FY 2011 audit, of the few employees who began keeping time sheets during the time period that was supposed to have been covered by quarterly certifications.

We will work with the Office of Financial Management to complete our corrective action plan, and will share this with the State Auditor's Office.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

The auditee shall:

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

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

Appendix B, Section 8(h):

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

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

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

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

(4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection 8.h.(5) of this appendix unless a statistical sampling system (see subsection 8.h.(6) of this appendix) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:

(a) More than one Federal award

(b) A Federal award and a non Federal award

(c) An indirect cost activity and a direct cost activity

(d) Two or more indirect activities which are allocated using different allocation bases, or

(e) An unallowable activity and a direct or indirect cost activity

(5) Personnel activity reports or equivalent documentation must meet the following standards:

(a) They must reflect an after the fact distribution of the actual activity of each employee.

(b) They must account for the total activity for which each employee is compensated

(c) They must be prepared at least monthly and must coincide with one or more pay periods, and

(d) They must be signed by the employee

(e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:

(i) The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;

(ii) At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and

(iii) The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

(6) Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort.
   (a) Substitute systems which use sampling methods (primarily for Temporary Assistance to Needy Families (TANF), Medicaid, and other public assistance programs) must meet acceptable statistical sampling standards including:
      (i) The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results except as provided in subsection 8.h.(6)(c) of this appendix;
      (ii) The entire time period involved must be covered by the sample; and
      (iii) The results must be statistically valid and applied to the period being sampled.
   (b) Allocating charges for the sampled employees' supervisors, clerical and support staffs, based on the results of the sampled employees, will be acceptable.
   (c) Less than full compliance with the statistical sampling standards noted in subsection 8.h.(6)(a) of this appendix may be accepted by the cognizant agency if it concludes that the amounts to be allocated to Federal awards will be minimal, or if it concludes that the system proposed by the governmental unit will result in lower costs to Federal awards than a system which complies with the standards.
(7) Salaries and wages of employees used in meeting cost sharing or matching requirements of Federal awards must be supported in the same manner as those claimed as allowable costs under Federal awards.

11-20 The Department of Health does not have sufficient internal controls to ensure federal requirements for matching and level of effort are met 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:	5U90TP017010-10; 3U90TP017010-10W1; 1H75TP000669-01; U3REP090208-01; U3REP090228-02; U3REP080103-01
Applicable Compliance Component:	Matching Controls; Level of Effort Controls / Compliance
Questioned Cost Amount:	None

Background

The State Department of Health administers the Public Health Emergency Preparedness Program and the National Bioterrorism Hospital Preparedness Program. These federal grants enhance the ability of hospitals and health care systems to prepare for and respond to biological and other public health emergencies.

The Department distributes money to hospitals, outpatient facilities, tribes, health centers, poison control centers, emergency management services and other healthcare partners. These entities oversee training, meetings, purchasing of supplies and equipment, and generate reports on the program. The Department spent $23 million in Public Health Emergency Preparedness funds and $8.5 million in Hospital Preparedness Program funds in fiscal year 2011.

Matching

For each program, the Department is required to spend $1 of state funds for every $10 dollars it spends in federal funds. These matching funds must be verifiable from the Department's records, not used as a match for any other federal program, necessary and reasonable to achieve program objectives, and allowable under the applicable cost principles.

Level of Effort

The Department also is required to spend, in state preparedness funds, an amount that is not less than the average of expenditures maintained for the preceding two-year period. These expenditures encompass all funds the state spent for health care preparedness.

Description of Condition

The Department does not have sufficient internal controls to ensure compliance with federal matching requirements. At the beginning of each grant year the Department calculates an estimated amount of matching dollars needed to meet the match requirements. The Department then ensures it has budgeted sufficient funding to meet the requirement. Once the estimated match requirement has been budgeted, the Department does not do further monitoring throughout the year.

The Department does not have internal controls to ensure compliance with federal level of effort requirements. Although the Department spends a significant amount of state funding on these two programs, including the amount spent to meet the matching requirements, it reported to the grantor that it spent $0 for its level of effort requirement. We did determine the Department met the required match.

Cause of Condition

Department management felt that because account codes and dedicated budgets were established at the beginning of the year to charge matching expenditures, regular monitoring and tracking was not necessary to ensure compliance.

The Department is not tracking level of effort spending in state preparedness funds and management considers the level of effort requirement to be $0. Program managers stated they believe that because the Legislature does not appropriate state funds specifically for these programs, no level of effort requirement is in place. Department managers told us they met with representatives from the Assistant Secretary for Preparedness and Response (ASPR) and the Centers for Disease Control (CDC) and the agencies agreed with its position. Department managers said this was a verbal agreement. We spoke to grant management officers for both organizations who told us they were not aware of any approval given to the Department not to maintain the level of effort as required.

Effect of Condition

By not properly tracking, documenting and reporting that the level of effort and matching requirements are being met, the Department is at risk of having to return grant funds. This also could jeopardize future federal funding to the state.

Recommendation

We recommend the Department develop and follow internal controls over matching dollars to ensure it complies with federal requirements.

The Department should work with its federal grantor to correctly interpret level of effort requirements, and should track all state preparedness dollars to ensure it spends at least the minimum required amount each year.

Department's Response

We partially concur with the Auditor's Office finding. We have implemented improved tracking that lists all match sources by their major index account codes, their corresponding allotments, and expenditures. This is now tracked quarterly for the first three quarters and monthly in the last quarter of the fiscal year.

However, we feel that the Auditor's Office has misinterpreted the relationship of the agency expenditures identified for the match requirement to the requirement in the grant for Maintenance of Funding (MOF). We will clarify our understanding of this with the federal grantor.

We also feel that the finding overstates the risk that our agency would have underfunded the match requirements and or not met the maintenance of funding requirements. Our budgetary process identified expenditures over and above the ten percent requirement for each of these grants.

We will also work with the federal grantor, and the Office of Financial Management to complete our corrective action plan. We will share this information with the State Auditor's Office.

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

FY10 Hospital Preparedness Program Guidance:

3.3 Other

3.3.1 Maintenance of Funding (MOF): Awardees must demonstrate that they intend to maintain expenditures for healthcare preparedness at a level that is not less than the average of such expenditures maintained by the entity for the preceding 2-year period. These expenditures encompass all funds spent by the State for healthcare preparedness. The awardee must 'certify with a sentence' that they have maintained the average level of expenditures required.

To be eligible for an award under this funding opportunity, the awardee must demonstrate, in the budget narrative, they intend to budget not less than the average of their FY08 and FY09 total spending for healthcare preparedness. For the purposes of calculating MOF for healthcare preparedness spending, the following applies:

1. State contributions only, not Federal dollars:
2. Surge Capacity investments to be considered:
3. Beds
4. Isolation
5. Decontamination
6. PPE
7. Pharmaceuticals
8. Mobile Medical Assets
9. Interoperable communications equipment and capability
10. Laboratory equipment, and trainings

Public Health Emergency Preparedness Budget Period 10 Extension Guidance

4) Maintaining State Funding (MSF)
Awardees are required to document MSF as part of their BP10 Extension funding applications. MSF is defined as ensuring that awardee expenditures for public health security are maintained at a level not less than the average of such expenditures for the previous two years. This definition includes:

- Appropriations specifically designed to support public health emergency preparedness as expended by the entity receiving the award; and
- Funds not specifically appropriated for public health emergency preparedness activities but which support public health emergency preparedness activities, such as personnel assigned to public health emergency preparedness responsibilities or supplies or equipment purchased for public health emergency preparedness from general funds or other lines within the operating budget of the entity receiving the award.

Appendix 4: Maintaining State Funding (MSF)

Background: Section 319C-1(i)(2) Maintaining State Funding

(A) In General. – An entity that receives an award under this section shall maintain expenditures for public health security at a level that is not less than the average level of such expenditures maintained by the entity for the preceding two-year period.

Administrative Requirement

MSF represents an applicant's historical level of contributions related to federal programmatic activities which have been made prior to the receipt of federal funds "expenditures (money spent)." The MSF is used as an indicator of nonfederal support for public health security before the infusion of federal funds. These expenditures are calculated by the awardee without reference to any federal funding that also may have contributed to such programmatic activities in the past. Awardees must stipulate the total dollar amount in their cooperative agreement applications.

Awardees must be able to account for MSF separate from accounting for federal funds and separate from accounting for any matching funds requirements; this accounting is subject to ongoing monitoring, oversight, and audit. MSF may not include any matching funds requirement.

OMB Circular A-133 Compliance Supplement Subpart C--Auditees§___.300 Auditee responsibilities.

The auditee shall:

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

11-21 The Department of Social and Health Services, Division of Child Support, did not comply with federal regulations on documentation for employee salaries and wages charged to the Child Support Enforcement Program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.563 Child Support Enforcement 93.563A Child Support Enforcement – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	G-1104WA4004
Applicable Compliance Component:	Allowable Costs
Questioned Cost Amount:	$65,432.56

Background

The Department of Social and Health Services, Division of Child Support, administers the federal Child Support Enforcement Program. The program is designed to ensure noncustodial parents pay spousal and child support and to establish paternity. The Department received $87.5 million in federal funding for this program in fiscal year 2011, $6.7 million through the American Recovery and Reinvestment Act.

Federal regulations specify how recipients are to document employee salaries and wages charged to the grant. Employees who work on multiple activities or cost objectives are to document time spent on each on monthly personnel activity reports or documentation such as time sheets. Time records are to reflect the actual hours employees work on each program and are used as a basis for requesting federal funds. Agencies may estimate these hours on an interim basis if they adjust for actual costs at least quarterly. An employee who works on only one federal activity needs to provide twice a year certifications signed by the employee or a supervisor.

Description of Condition

Headquarters staff create monthly certifications that Division supervisors check for accuracy and sign. If an employee does not work 100 percent on the grant, a time sheet is attached to the monthly certification and grant expenditures are reduced accordingly.

Approximately 47 percent of the salary and benefit expenditures charged to the grant occurred during the months of October 2010, December 2010 and March 2011. We reviewed all of the monthly certifications for these three months and found:

- Thirty-eight employees submitted 68 timesheets for work not related to the grant during the three months. Headquarters staff reduced the grant expenditures by $62,429.81 for 63 of these timesheets. The grant expenditures were not reduced for five of these timesheets totaling $709.86.

- The Department assigned two employees to work outside of the Division. We examined records for these two employees and found from January through June 2011, they did not work 100 percent on the grant. They did not submit timesheets and the Division did not reduce salaries and benefits charged to the grant. Total salaries and benefits improperly charged to the grant for the six month period were $64,722.70.

Headquarters staff also create semi-annual federal payroll certifications which are signed by the Division Director and submitted to the U.S. Department of Health and Human Services to meet federal time and effort requirements.

We reviewed the semi-annual federal payroll certifications submitted during fiscal year 2011 and found they incorrectly state all Division employees worked 100 percent on the grant.

Cause of Condition

Management was not aware:

- Semi-annual federal payroll certifications should not include employees who work less than 100 percent on the grant throughout the certification period.
- Employees who do not work 100 percent on the grant during any portion of the certification period must submit timesheets for every month of the certification period.

Effect of Condition and Questioned Costs

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

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

We are questioning salary and benefit costs of $65,432.56 charged to the grant that was not supported in accordance with federal regulations.

Recommendations

We recommend the Department:

- Revise its procedures and require employees who do not work 100 percent on grant activities to complete timesheets for every month of the certification period.
- Ensure salary and benefit expenditures not related to grant activities are not charged to it.
- Correct the semi-annual federal payroll certifications submitted to the U.S. Department of Health and Human Services.

Additionally, we recommend the Department consult with the U.S. Department of Health and Human Services to determine what, if any, questioned costs should be repaid.

Department's Response

The Department concurs with this finding. We do not concur with the questioned costs.

- *The audit report states that the salaries and benefits for two employees were improperly charged to the grant during a six month period totaling $64,722.70. Based on our review, the actual amount improperly charged to the grant during that same six month period was $2,609.64.*

We have taken additional steps to ensure that employee salaries and benefits charged to the grant are accurate and valid.

Effective October 2011, the following procedures were implemented to ensure only allowable salaries and benefits are charged to the grant:

- *All employees who do not work 100% on the grant will complete monthly time sheets, recording the actual hours worked on each program;*
- *Employees whose job duties change, or are reassigned, during the certification period will complete time sheets beginning the month the changes occur and each month thereafter;*
- *Fiscal staff will work with program staff to ensure that time sheets are completed and submitted for all affected employees;*
- *Cost coding was changed for those employees serving in developmental job assignments (DJA) outside of the child support program, removing them from the grant;*

- *Semi-annual certification will only include those employees who work 100% on the grant.*

We will consult with the US Department of Health and Human Services to determine if any of the questioned costs should be repaid.

Auditor's Concluding Remarks

The $64,722.70 in questioned costs represents 100% of the salaries/benefits paid to two employees on "Developmental Job Assignment" during the six month period examined. Time and effort certifications examined indicated these employees did not work 100% time on the grant, but no timesheets were completed or submitted by the employees during any of the six months to determine the exact amount of time spent on non-grant activities. We therefore question the entire $64,722.70. Subsequent conversations with the employees , or timesheets created after the fact are not acceptable. We re-affirm our finding.

We reaffirm the finding and thank the Department for its cooperation and assistance throughout the audit, and will follow up during our next audit.

Applicable laws and Regulations

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

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

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

> Appendix A, Section C:
> 1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:…
> b. Be allocable to Federal awards under the provisions of 2 CFR 225.
> 3. Allocable costs.
> a. A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received.
>
> Appendix B, Section 8(h):
> Support of salaries and wages. These standards regarding time distribution are in addition to the standards for payroll documentation…
> (3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi annually and will be signed by the employee or supervisory official having 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. . .

(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.

11-22 The Department of Commerce, Community Services and Housing Division, did not comply with period of availability requirements for its Community Services Block Grant program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.569 Community Services Block Grant 93.710 Community Services Block Grant – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	09B1WACOSR
Applicable Compliance Component:	Period of Availability
Questioned Cost Amount:	$147,422

Background

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

During fiscal year 2011, the Department spent almost $11.8 million on the Program, approximately thirty five percent of which was provided through the American Recovery and Reinvestment Act of 2009.

Description of Condition

Federal regulations allow the Department two years from the time of an award to spend the block grant money. It had to spend funds awarded for the 2009 grant by September 30, 2010. We tested a random sample of expenditures charged to the 2009 grant and found six expenditures totaling $147,422 were made after September 30, 2010. None were paid from Recovery Act funds.

In our fiscal year 2010 audit, we reported in a finding that the Department violated the period of availability requirements of the grant by charging the federal grant for expenditures incurred after the grant period had closed. We reported approximately $55,000 in questioned costs in that audit.

Cause of Condition

The payment documentation submitted to the Department is pre-coded with the account coding and Department program staff did not properly review the payment documentation to ensure costs were within the proper period of availability. Department fiscal staff did not properly review costs transferred from one grant year to another grant year to ensure they were within the proper period of availability.

Effect of Condition and Questioned Costs

We are questioning $147,422 to the grant after the grant's period of availability ended. When the Department does not adequately monitor expenditures to ensure only expenditures within the period of availability are paid for, grant conditions allow the grantor to penalize the Department for noncompliance by suspending or terminating the award or withholding future awards.

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 properly review payment costs to ensure only expenditures made during the proper period of availability are charged to grants.

We recommend the Department stop providing pre-coded payment documentation to sub-recipients.

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

Department's Response

We concur with the finding. Commerce program staff did not properly review the pre-coded payment documentation to ensure costs were within the proper period of availability. Sub-recipients used an out-of-date pre-coded payment document template with closed 2009 award year coding. Neither program staff nor fiscal staff verified nor corrected the old coding. As a result, $57,071.69 paid was not within the period of availability for 2009. Commerce fiscal staff did not properly review costs transferred from one grant year to another grant year to ensure costs were within the proper period of availability. Program staff inadvertently chose items outside the period of availability when requesting a transfer. Fiscal staff reviewing the work of newly trained fiscal staff did not properly verify backup documentation for the transfer. As a result, $90,350.46 transferred was not properly identified within the period of availability for the 2009 award year.

In February 2012, fiscal and program staff reviewed and corrected the $147,422.15 questioned 2009 grant year costs by transfer to the correct grant year per the period of availability. Appropriate costs within the period of availability for the 2009 grant were identified and subsequently transferred, resulting in zero net impact to the Community Services Block Grant 2009 award year.

Commerce concurs with the Auditors recommendations to properly review payment costs for proper period of availability and stop providing pre-coded payment documents to sub-recipients. Commerce has reiterated document review and approval expectations with program and fiscal staff. Payment document (invoice) templates with no pre-coding will be used in the future. Understanding a federal program may have awards with overlapping / concurrent periods of availability, Commerce added award tracking to the Commerce Contract Management System (CMS) in January 2012, including award first-in-first-out (FIFO) functionality to help reduce or eliminate cost transfers at award end between award years. Commerce intends to begin usage of this new functionality with the CSBG program. Additionally, Commerce intends to add stop edits to the CMS invoice payment functionality to notify an award end date is past, prior to allowing any payment.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit, and will follow up during our next audit

Applicable Laws and Regulations

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

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

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

13) If the grantee is on an accrual accounting system, services must be provided on or before September 30, 2010; and liquidated on or before December 29, 2010;
14) Grantees shall adhere to a provision of law under the Consolidated Appropriations Act of 2005 which requires that to the extent FY 2009 CSBG funds are distributed by a State to an eligible entity, and have not been expended by such eligible entity, they shall remain with

such eligible entity for carryover and expenditure into the next fiscal year. If FY 2009 funds are carried forward by such eligible entity into FY 2010, those funds must be fully expended and services provided on or before September 30, 2010.

11-23 The Department of Early Learning and the Department of Social and Health Services do not have adequate internal controls over direct payments to child care providers.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.575 Child Care Development Block Grant
	93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund
	93.713 Child Care and Development Block Grant – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	G-1101 WACCDF
Applicable Compliance Component:	Activities Allowed or Unallowed
Questioned Cost Amount:	None

Background

The state Department of Early Learning (DEL) administers the federal Child Care and Development grant to assist eligible working families in paying for child care. In fiscal year 2011, DEL paid approximately $108.5 million to child care centers and providers through the Working Connections Child Care Program.

The Department of Social and Health Services (DSHS) performs many functions related to the grant under an agreement with DEL. DSHS determines client eligibility, pays child care providers and monitors to ensure payments are allowable. Monitoring includes a monthly reconciliation of child care payments to providers and their attendance records, and performing a federally required Improper Payment Act audit every three years.

Description of Condition

Since fiscal year 2005, our audits have reported the Departments did not adequately monitor payments to child care providers. During our fiscal year 2010 audit we found DSHS stopped performing reconciliations between attendance records and child care payments.

We found DSHS again performed no reconciliations between attendance records and child care payments in fiscal year 2011.

Cause of Condition

DSHS stated it did not have adequate staff to do both the reconciliations and the Improper Payment Act audits.

Effect of Condition

The lack of internal controls over reconciling payments to source documentation results in a high risk that DSHS will not identify or recover overpayments to providers.

In September 2011, our office issued a report, "Audit of State Payments to Child Care Providers". It identified $2.6 million in overpayments to child care providers going back as far as five years and an additional $241,299 in questionable payments. The Departments are aware providers have claimed more than authorized and that overpayments have been made.

Recommendation

We recommend the Departments establish and follow detailed monitoring procedures for provider payments that include adequate reconciliations of provider attendance records to payments. When issues are found, the Departments should expand their review to determine if additional costs could be recovered.

Departments' Response

As reported in past audit reports, the Department of Early Learning (DEL) and the Department of Social and Health Services (DSHS) have taken steps to improve control over child care payments, such as increasing communications to the public on fraud-reporting options, and researching options for a new electronic attendance tracking system. The agencies have begun, or will implement additional measures as follows:

- *DEL added 5 new FTE's specifically in January 2012 to audit child care subsidy payments by comparing subsidy child care provider billings with attendance records. DEL auditors will expand the audit scope when they identify a child care provider that billed incorrectly. This is an on-going activity.*
- *The audits are randomly sampled and high billing providers for all three types of providers: centers, family homes and license exempt providers.*
- *DEL contracts to provide training on subsidy billing to licensed family home and license exempt providers according to the collective bargaining agreement with Service Employees International Union 925.*
- *DEL will contract to develop on-line subsidy billing training for child care center staff who do 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 Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Section 300, states in part:

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

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

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

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

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

Washington Administrative Code 170-296-0520 states in part:

(3) Daily attendance records, listing the dates and hours of attendance of each child must be kept up-to- date and maintained in the licensed space of the family home child care for five years.
(4) When a child is no longer enrolled, the date of the child's withdrawal must be recorded in the child's file. You must maintain the child's file for at least five years from the child's last date of attendance. After five years the file may be destroyed or returned to the parent. The child's file must be made available for review by the child's parents and us during this period.

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

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

11-24 The Department of Social and Health Services, Children's Administration, is not ensuring the eligibility of clients receiving Adoption Assistance payments.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.659 Adoption Assistance
	93.659A Adoption Assistance – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	Unknown
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	$ 33,624 Actual
	$542,261 Projected

Background

The federal Adoption Assistance program provides money to states for parents who adopt children with special needs. The Children's Administration of the Department of Social and Health Services administers the state program from six regional offices. The Department paid approximately $54 million in federal dollars for adoption assistance in fiscal year 2011, for support of almost 12,000 children.

In our audits of fiscal years 2009 and 2010, we reported the Department was not following controls designed to ensure the eligibility of clients receiving adoption assistance payments. In response, the Department stated it would train all adoption support staff on how to determine eligibility.

Description of Condition

To follow up on the concerns noted in prior audits, we randomly selected 58 payments made during fiscal year 2011 from one regional office for the support of children over 18 years of age. To be eligible, adopted children over 18 must be in school. Our prior audit found exceptions in these cases, particularly when associated with this region. We identified the adoptee related to each payment selected and reviewed case files to determine if they contained evidence that eligibility requirements were met and that payments were properly supported. Thirty of 58 did not include support showing the adopted children were still in school and entitled to receive adoption support assistance. Payments associated with these selections totaled $20,345.

In addition, we randomly selected 59 payments from all adoption support payments made during the fiscal year for review. We again reviewed case files to determine if they contained evidence to support the adoptees' eligibility. For these 59 payments, case files showed eligibility requirements were met and all payments were properly supported.

State law prohibits support payments for any adoptee once they reach age 21. We reviewed all adoption payments for fiscal year 2011 to determine if any were made for adoptees over the age of 21. We identified 12 adoptees over 21 who received a total of 26 payments during the year, totaling $13,279.

Cause of Condition

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

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

Effect of Condition and Questioned Costs

In our review of children over the age of 18 but not in school, we used a sampling method that allows us to project our results to the entire population of children over 18 for the region selected for testing. Known questioned costs for this category are $20,345. Our projected questioned costs are $528,982.

Unallowable payments made for adoptees over age 21 totaled $13,279.

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

Recommendation

We recommend the Department:

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

Department's Response

The Department concurs with the finding. Since the last audit in 2010 the Children's Administration, in addition to training staff and conducting quarterly spot checks of payments, has begun developing system controls in Famlink, the Department's child welfare and payment system, that suspend payments after age 18 and only allows them to resume after staff have manually confirmed that the adopted child warrants continuation of the monthly support payment and a separate fiduciary employee has been asked to continue them.

For all amounts identified as a questioned cost Children's Administration will review each individual payment and return any federal share associated with unauthorized payments. These amounts will also be communicated to our federal partners at the time they are returned.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit, and will follow up during our next audit.

Applicable Laws and Regulations

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

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

RCW 74.13.031 Duties of department — Child welfare services — Children's services advisory committee (as amended by 2011 c 160).

> (11) (a) <u>The department shall, w</u>ithin amounts appropriated for this specific purpose, have authority to provide continued foster care or group care to youth ages eighteen to twenty-one years who are:
>
> (i) Enrolled and participating in a postsecondary or vocational educational program;

(ii) Participating in a program or activity designed to promote or remove barriers to employment;
(iii) Engaged in employment for eighty hours or more per month; or
(iv) Incapable of engaging on any of the activities described in (a)(i) through (iii) of this subsection due to a medical condition that is supported by regularly updated information.

(b) A youth who remains eligible for placement services or benefits pursuant to department rules may continue to receive placement services and benefits until the youth reaches his or her twenty-first birthday.

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

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

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

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

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

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

Children's Administration Operations Manual
13100. Records Management And Security

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

CA will maintain these records in two formats:

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

Title IV-E Desk Guide:

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

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

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

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

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

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

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

4.G.2. Mental or Physical Disability

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

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

11-25 The Department of Health did not survey hospitals in accordance with state law, which could increase the risk of Medicaid clients receiving substandard care services.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Special Tests and Provisions	
Questioned Cost Amount:	None	

Background

Hospitals statewide received more than $1.3 billion in state and federal funds in fiscal year 2011 for services to Medicaid clients. Federal regulations require states to ensure hospitals meet prescribed health and safety standards to be eligible for federal reimbursement.

The state has 100 active hospitals in three categories: acute care/general hospitals, chemical dependency hospitals and psychiatric hospitals. State regulations require the Health Department or an accreditation agency such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to survey all hospitals every 18 months. The survey focuses on the hospital's administration and patient services. The survey also assesses compliance with federal health, safety and quality standards designed to ensure patients receive safe, quality care services.

Description of Condition

During fiscal year 2011, the Department of Health did not perform hospital surveys as required by state and federal regulations. Of the 100 hospitals, the Department evaluated 54. Of that group, 30 (55 percent) were not surveyed within the 18-month interval.

The table below summarizes what we found.

Time exceeding the 18-month survey period	Number of hospitals
One month	12
Two months	9
Three months	5
Four months or more	4
Total	30

Cause of Condition

The Department stated that in February 2011 they recognized they were falling further behind in the survey process and started looking at how they could "right size" the survey staff to allow for the completion of the surveys within the required time frames. Challenges to maintaining sufficient staffing levels included having some positions held vacant due to a hiring freeze; recruitment difficulties due to a recognized shortage of registered nurse candidates; several unavoidable long term staff absences; and redeployment of survey staff to other critical functions during this period.

Effect of Condition

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

Recommendation

We recommend the Department implement adequate procedures to ensure it conducts hospital surveys as required by law.

Department's Response

We have reviewed the State Auditor's report and concur with this finding. We appreciate the Auditor's work on this issue and the opportunity to respond.

Patient safety is our highest priority. We are, and have been, very concerned with not being able to inspect hospitals on average at least every eighteen months, as set forth in RCW 70.41.120. We believe that not being able to inspect these hospitals more timely may expose patients to risk of harm. The mission of the Department of Health has always been to provide patient safety to the citizens of this state. We are committed to immediately addressing and resolving the issues identified in the audit. The following is an outline of how we are addressing this challenge:

In February 2011 we recognized we were falling further behind in the survey process. We started looking at how to "right size" the staff to allow us to complete the inspections more timely. We identified numerous reasons we believed contributed to our hospital inspections unit not being right sized including having some positions held vacant due to a hiring freeze; recruitment difficulties due to a recognized shortage of registered nurse candidates; several unavoidable long term staff absences; and redeployment of survey staff to other critical functions during this period.

Our first step in response to this challenge was to dedicate our experienced hospital inspectors to performing hospital inspections exclusively as opposed to dividing their time on other regulated facility types. To this end, in May 2011, we formed a team of new inspection staff to perform the Ambulatory Surgery Centers inspections eliminating the need to assign hospital inspectors to this function. That team was able to assume this function during the last part of September.

We have identified the need to add additional inspectors in order to meet the hospital inspection frequency requirements of RCW 70.41.120. We are striving to increase the hospital team by two permanent inspectors. This will help address the hospital inspection backlog by providing greater capacity for conducting inspections even when there are extended staff absences, and will help compensate for the eight mandatory furlough days each nurse inspector must take in a year. We are exploring funding sources for these new positions as well as identifying a separate funding source to allow us to hire and train additional inspectors on a two year project basis. The purpose for the project positions would be to focus on completing the backlogged hospital inspections.

While the hospital inspections unit was able to hire several new nurse inspectors, we continue to experience difficulty in recruiting additional staff. There is a recognized shortage of registered nurses

within Washington State and in the United States as a whole. We are expanding our recruitment resources to try and reach a larger audience of potential candidates. These resources include outlets such as professional recruitment publications and large metropolitan newspapers.

The agency is also experiencing challenges in recruiting public health advisor inspectors which conduct the portion of an inspection that deals with environmental issues. Since a retirement in June 2011, we have been openly recruiting for one full time position and have received only one qualified candidate.

We are also evaluating strategies of how we conduct inspections to achieve greater efficiencies. This analysis includes an evaluation of the number of inspectors needed in relation to the size of the hospital, developing streamlined procedures for collecting information during an inspection, and reviewing our procedures for determining compliance/non-compliance with the regulations and protocols for inspecting care delivery within the hospital.

We began using checklists in approximately 2007 in our inspections, based on a recommendation from the State Auditor's Office. These checklists help to insure we are covering all areas required by law during our inspections. The checklists continue to grow in complexity as new legislation requires monitoring. One example is the Patient Safe Lifting Law that was passed in 2006 and requires us to a review of safe lifting practices during the inspection process.

While we have looked at potentiating reducing the scope of the inspection we are concerned that modifying the current protocols may increase the risk of harm to patients. We do believe, however, we may be able to reduce the amount of survey time spent on some paperwork review, such as human resource files, unless a particular problem is observed during the inspection. We will continue to look for greater efficiencies.

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

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

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

Title 42 of the Code of Federal Regulations, Section 430.10 states:

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

RCW 70.41.120 states in part:

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

RCW 70.41.122 states in part:

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

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

WAC 246-320-016 states in part:

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

(1) Surveys. The department will:
  (a) Conduct on-site surveys of each hospital on average at least every eighteen months or more often using the health and safety standards in this chapter and chapter 70.41 RCW;
  (b) Coordinate the on-site survey with other agencies, including local fire jurisdictions, state fire marshal, state pharmacy board, and report the survey findings to those agencies;
  (c) Notify the hospital in writing of the survey findings following each on-site survey;
  (d) Require each hospital to submit a corrective action plan addressing each deficient practice identified in the survey findings;
  (e) Notify the hospital when the hospital submitted plan of correction adequately addresses the survey findings; and
  (f) Accept on-site surveys conducted by the Joint Commission or American Osteopathic Association as meeting the eighteen-month survey requirement in accordance with RCW 70.41.122.

11-26 The Department of Social and Health Services paid Medicaid providers for services that were not provided to Medicaid beneficiaries.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed or Unallowed	
Questioned Cost Amount:	$45,624.90 Non-ARRA	
	$ 9,899.69 ARRA	

Background

Medicaid is a state and federal partnership that pays the health-care costs for qualifying low-income individuals. The state Medicaid program spent more than $7.5 billion in state and federal dollars during fiscal year 2011.

Federal regulations state an overpayment is the amount a Medicaid agency paid to a provider in excess of the amount allowable for the services provided. They classify most payments after the date of a Medicaid client's death as overpayments.

The Department receives quarterly data from the state Department of Health it uses to identify deceased Medicaid clients. Social and Health Services is to remove these clients from the program. It also runs its own data query to identify Medicaid services paid after a client's date of death. Once identified, the Department starts a process to recoup the payments.

Description of Condition

We analyzed Medicaid claims paid through the Department's Social Service Payment System (SSPS) from July 1, 2010 to June 30, 2011 and identified 311 Medicaid beneficiaries for whom payments for services were made after the dates of their deaths. The Department paid $514,424.35 for those services.

We reviewed detailed transactions and noted services had been provided to 229 of these clients prior to their death. We also noted the Department paid a total of $742.87 for allowable services such as monthly insurance premiums and monthly medical emergency response services in the month of beneficiaries' deaths. These expenditures are allowable because services are charged for a month.

The table below summarizes the results of our work:

Description	SSPS		
	Clients	Payments	Questioned Costs
Services provided before date of death. Payments allowable	229	$349,243.31	$0
Payments covered for the month of beneficiaries' deaths. Allowable	34	$742.87	$0
Payments for charges for services after date of death. Recoupment started.	32	$73,240.47	$0
Payments were for charges for services after date of death. Payments unallowable.	83	$91,197.70	$91,197.70
Total	311*	$514,424.35	$91,197.70

*Clients possible in more than one category. Related questioned costs are not duplicated.

The Department identified unallowable payments totaling $73,240.47 and started recoupment processes. The Department paid the providers a total of $91,197.70 for services that were never rendered to Medicaid beneficiaries.

Cause of Condition

The Department stated it was not able to prevent or detect all unallowable payments due to the lack of a timelier and more consistent way to inform field staff about deceased clients.

Effect of Condition and Questioned Costs

The Department paid $91,197.70 to providers for charges for services after Medicaid beneficiaries had died. We are questioning $55,524.59, which is the federal portion of the expenditures.

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

Recommendation

We recommend the Department:

- Continue to strengthen procedures to identify deceased Medicaid clients to prevent overpayments.
- Recover $91,197.70 in unallowable payments from providers.
- 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 will continue its work to strengthen processes that may provide a timelier and more consistent way to inform field staff about deceased clients. Currently field staff receive this information from a variety of sources, including relatives, death notices in the papers, ACES-Social Security Data Exchange matches, and other sources. There is no departmental or legal requirement to notify field offices. The availability and consistency of this information will improve with upgrades to our payment systems. At that time staff should have uniform access to the same data sources for information about client deaths.

In the interim, the Department has developed and is testing a new report that will soon be available to field staff. The Invalid Payments report identifies potentially invalid payments on a monthly basis. The report will enable field staff to discover and correct invalid payments in the month after payments are made and process any necessary vendor overpayments.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

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

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.

Title 42, Code of Federal Regulations, Part 433.304 defines an overpayment as following:

> *Overpayment* means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.

11-27 The Department of Social and Health Services, Office of Financial Recovery, did not have adequate controls to ensure the federal share of overpayments made to Medicaid providers is refunded to the federal government in an accurate and timely manner.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM, 5-1105WAARRA	
Applicable Compliance Component:	Allowable Costs / Cost Principles	
Questioned Cost Amount:	None	

Background

Most Medicaid expenditures are payments to providers of medical treatment, prescriptions, medical equipment, home health care, and other services. Providers submit payment claims to the Health Care Authority through ProviderOne, the Medicaid payment system.

Since October 1, 2008, more federal dollars have been available for these payments, known as the Federal Medical Assistance Percentage, due to the American Recovery and Reinvestment Act of 2009. This means the state has been receiving federal money to pay for more than 60 percent of Medicaid costs, up from the previous 50 percent.

The Health Care Authority and the Department of Social and Health Services conduct a number of audits designed to identify and recover overpayments. When they identify overpayments, the state has one year from the date of discovery to pay back to the federal government its share of overpayments, even if the state has not recovered the overpayment. The state does not have to refund the overpayment if the provider has filed for bankruptcy or has gone out of business.

The Department and the Authority are responsible for forwarding information to the Office of Financial Recovery when they identify overpayments. That Office is the official collection agency for Medicaid overpayments in the state. It tracks the overpayment recoupment process and works with the Office of Accounting Services to ensure the federal share of overpayments is refunded.

If overpayment information is not forwarded to the Office of Financial Recovery, the federal portion of the overpayment will not be refunded to the federal government.

The federal Medicaid program operates on a reimbursement basis, meaning the state pays program costs and then submits a claim to the federal government to recover the costs. Because of this, payments owed to the federal government are made by reducing the amount of the reimbursement requested.

The state had Medicaid expenditures of approximately $7.5 billion in fiscal year 2011, approximately $4.7 billion of which was federal dollars.

Description of Condition

In our audits for fiscal years 2005 through 2010, we reported findings relating to the Department's inadequate controls over overpayment refunding. To address our recommendations, it established policies requiring each Administration within the Department and the Authority to send all overpayments to the Financial Recovery Office. The policies also required the Office to send monthly reminder notices to each Administration and the Authority. However, the Financial Recovery Office and the Authority did not follow these policies.

Cause of Condition

The Financial Recovery Office stated that due to staffing reductions, in December 2010 it discontinued the reminder process.

Effect of Condition

Without adequate monitoring of overpayment reporting, the Department cannot ensure the federal share of overpayments is refunded to the federal government in an accurate and timely manner. We reviewed 11 overpayments identified by the Authority and noted that the Office of Financial Recovery did not know of two overpayments totaling $683,773.90 since HCA had not forwarded those overpayments to the Office, possibly delaying reimbursement to the federal government.

By not reporting overpayments in a timely manner, the Department and the Authority denied the grantor the use of funds that otherwise would have been available for the Medicaid program.

Recommendation

We recommend:

- The Department and the Authority follow policies to ensure all overpayments discovered are forwarded to the Financial Recovery Office and subsequently refunded to the federal government in a timely manner.
- The Office monitor overpayment reporting procedures to ensure the federal portion of the overpayment is refunded to the federal government in an accurate and timely manner.

Department's Response

The Department agrees with the finding regarding overpayment monitoring and reporting procedures. Effective October 2011, the Office of Financial Recovery (OFR) Chief resumed sending notifications to each DSHS Administration and partners (including the Health Care Authority) to submit all overpayments to OFR for collection and reimbursement to the federal government per DSHS Administrative policy 19.85.54 (currently in draft form). A second notification followed in January 2012, and will occur on a quarterly basis thereafter. Receiving overpayment referrals in a timely manner allows OFR to use standard processes to repay the federal government within the one year time limit.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

The auditee shall:

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

Section 1903(d)(2) of the Social Security Act (42 U.S.C. 1396b(d)(2)) states in part:

(C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 1 year in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 1-year period, whether or not recovery was made.

(D) (i) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) (A) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

Title 42, Code of Federal Regulations, Section 433.312 - Basic requirements for refunds states in part:

(b) Exception.

The agency is not required to refund the Federal share of an overpayment made to a provider when the State is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business in accordance with Sec. 433.318.

(c) Applicability.

(1) The requirements of this subpart apply to overpayments made to Medicaid providers that occur and are discovered in any quarter that begins on or after October 1, 1985.

(2) The date upon which an overpayment occurs is the date upon which a State, using its normal method of reimbursement for a particular class of provider (e.g., check, interfund transfer), makes the payment involving unallowable costs to a provider.

Title 42, Code of Federal Regulations, Section 433.320 - Procedures for refunds to CMS.

(a) Basic requirements.

(1) The agency must refund the Federal share of overpayments that are subject to recovery to CMS through a credit on its Quarterly Statement of Expenditures (Form CMS-64).

(2) The Federal share of overpayments subject to recovery must be credited on the Form CMS-64 report submitted for the quarter in which the 60-day period following discovery, established in accordance with Sec. 433.316, ends.

(3) A credit on the Form CMS-64 must be made whether or not the overpayment has been recovered by the State from the provider.

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

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

11-28 The Department of Social and Health Services did not ensure that all individuals who received Medicaid benefits had valid Social Security numbers.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
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	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Eligibility	
Questioned Cost Amount:	$25,498.50	Non ARRA
	$ 5,696.71	ARRA

Background

Medicaid is a state and federal partnership that provides coverage for certain low-income individuals who might otherwise go without medical care. The state Medicaid program spent more than $7.5 billion during fiscal year 2011, more than $4.7 billion of which was federal dollars.

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

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

Along with the use of SOLQ, every Social Security number entered in the Department's Automated Client Eligibility System is sent in an overnight batch to the Social Security Administration for verification. If it cannot verify a number, the Administration sends an electronic message to the Department's Community Service Office.

Description of Condition

We reviewed all Social Security numbers of Medicaid beneficiaries in the Department's Social Service Payment System (SSPS), and independently verified the numbers in the system by running a computerized cross-match with the Social Security Administration's database. We focused on three areas:

Invalid Social Security numbers

We initially identified 283 Social Security numbers which, according to the Social Security Administration's database, have never been issued and therefore are invalid. The Department determined 281 of these were due to data entry error. The other two clients did not have valid Social Security numbers.

Clients with no Social Security numbers

We found 165 clients that had no Social Security number in the system. The Department was able to provide valid numbers for 161 of those. The remaining four clients did not have valid Social Security numbers.

Social Security numbers belonging to deceased people

We used the Social Security Administration Death Master File and Medicaid claims data to identify payments for services provided to individuals using the Social Security number of a deceased person. We found one client in the system inappropriately using the Social Security number of a deceased person.

The table below summarizes the unresolved instances, and related Medicaid expenditures:

Description	Number of Clients	Payments	Federal share		State Share
			Non-ARRA	ARRA	
Invalid number	2	$150.00	$75.00	$15.17	$59.84
No number	4	$50,639.40	$25,348.32	$5,662.31	$19,628.77
Number belongs to deceased person	1	$150.00	$75.18	$19.23	$55.59
Total	**7**	**$50,939.40**	**$25,498.50**	**$5,696.71**	**$19,744.19**

The Department paid $50,939.40 for services to seven clients who did not have valid Social Security numbers.

Cause of Condition

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

Effect of Condition and Questioned Costs

When Medicaid benefits are paid for services to ineligible individuals, the money available for eligible clients is reduced. Payments for services for these seven clients were $50,939.40. We are questioning $31,195.21, 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 Department:

- Follow up on the seven clients for whom the Department could not provide evidence of correct Social Security numbers and re-determine their Medicaid eligibility.

- Ensure all staff involved in the verification process follow the Department's Social Security number verification procedures.

Department's Response

This finding involved the Economic Services Administration (ESA) and the Children's Administration (CA). Both administrations concur with this finding.

ESA agrees with the two Community Services Division (CSD) cases identified as exceptions. ESA will review these cases and take appropriate action as necessary.

Each year, for the last several years, ESA has successfully improved Social Security Number accuracy. This audit resulted in two case exceptions, representing combined payments of $300. Staff training, monthly Social Security Number monitoring and improved client eligibility system functionality contributed to these improvements. ESA will continue to pursue enhancements to verification procedures that promote Social Security Number accuracy.

The CA agrees four of the seven clients identified in this finding were served by CA and were found not to have had a valid SSN on file. Of these four, one had applied for an SSN in August of 2011, another left care within 10 days, and a third left care within three days. The final client missing a valid SSN was a Canadian citizen.

In 2011 the Department created a SharePoint list to help track youth in our care that do not have SSNs. HCA Foster Care Meds staffs update the list with the names of youth missing SSNs. Regional CA staffs go into the list and work with social workers to get the SSN information into the system.

For any federal funds claimed for these four clients, CA will return the federal share and communicate this to the Center for Medicaid Services.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

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

Title 42, Code of Federal Regulations, Section 435.910 (a) specifically states in part:

> The agency must require, as a condition of eligibility that each individual (including children) requesting Medicaid services furnish each of his or her own social security numbers . . . .

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

> The agency must verify each SSN of each applicant and recipient with SSA, as prescribed by the commissioner, to insure that each SSN furnished was issued to that individual and to determine whether any others were issued.

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

> If a Medicaid applicant cannot remember or has not been issued a Social Security numberthe agency must:
> (1) Assist the applicant in completing an application for an SSN;
> (2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and
> (3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

Title 42, Code of Federal Regulations, Section 435.916 (a) states in part:

> The agency must re-determine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months . . .

Title 42, Code of Federal Regulations, Section 435.920 (a-c) states:

> (a) In re-determining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN.
> (b) If the case record does not contain the required SSNs, the agency must require the recipient to furnish them and meet other requirements of 435.910.
> (c) For any recipient whose SSN was established as part of the case record without evidence required under the SSN regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with 435.910.

11-29 The Department of Social and Health Services does not have adequate internal controls to ensure Medicaid payments to in-home service providers are allowable and supported.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles	
Questioned Cost Amount:	$9,664.64 Non ARRA	
	$2,367.93 ARRA	

Background

The Department of Social and Health Services, Aging and Disability Services Administration, administers the Home and Community Based Services program for the state. Through the program, the state pays for home and community-based services for Medicaid beneficiaries needing long-term care. Individual or agency providers, often chosen by the Medicaid client, provide personal care and assistance allowing the client to avoid institutionalization.

The Department conducts an initial assessment of clients to determine the level of care needed. The Department authorizes the number of service hours required for that care, which forms the basis of the payment to the provider. After the initial assessment, ongoing supervision of client cases and provider services is transferred to one of 13 Area Agencies on Aging (AAA) located throughout the state.

Depending on their financial resources, clients may be required to pay a portion of the costs of services. The Department pays the remainder up to the authorized amount. The service provider is required to record hours worked on a timesheet, to be signed by the client and the provider and retained for six years.

During fiscal year 2011, the Department paid approximately $687 million for in-home services. These included direct payments to AAAs and payments to in-home service providers for services that had been authorized by the AAA.

Description of Condition

In our audits for fiscal years 2008, 2009, and 2010 we reported findings regarding the Department's lack of adequate controls to ensure payments are allowable and supported. In response to the findings, the Department notified providers they are responsible for maintaining accurate timesheets to support hours worked and for having the timesheets available for review by the Department.

The Department also revised its Case Management Program Training curriculum to emphasize the requirement for case managers to periodically review a sample of clients' time sheets and verify with sampled clients that authorized services have been provided.

We randomly selected a sample of 149 from 103,096 payments the Department made to individual providers for August 1, 2010 through March 31, 2011 to determine if the new controls worked as intended.

We continued to find significant weaknesses. Of the 149 payments sampled, 24 providers did not provide timesheets. Of those who did provide timesheets, 73 were incorrectly totaled, 40 were not completed when the work was performed, and 32 did not include provider and client signatures as required.

Cause of Condition

The Department did not ensure the AAAs adequately monitored provider services. According to the Department's contract with the AAAs, case managers are expected to inspect a sample of the timesheets when clients are reassessed for service needs.

Effect of Condition and Questioned 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.

Of the 149 payments reviewed, we found 114 payments were allowable and supported. For the remaining 35 we noted:

	Number of Exceptions	Questioned Costs
No timesheet provided	24	17,971.52
Amounts not supported by timesheet	11	1,350.28
Totals	35	19,321.80

The Department paid a total of $144,714.91 to individual providers in the transactions selected for audit. We identified $19,321.80 in payments that were not fully supported with timesheets.

Including Federal Medical Assistance funds from the American Recovery and Reinvestment Act, $12,032.57 of the payments was funded by federal dollars; state dollars paid the remaining $7,289.23.

Projecting our results to the entire Home and Community Based Services program payments we reviewed, we estimate the amount of unallowable payments to individuals could range from $8,426,346 to $18,311,912.

Recommendation

We recommend the Department:

- Monitor and enforce the provisions of its contracts with the AAAs to ensure payments to providers are legitimate and supported. The Department should also pursue the remedies available to it in the contract for instances of non-performance.

- Seek recovery of the funds paid to providers who were unable to adequately support payment claims.

- Consult with its grantor to determine if any questioned costs must be repaid to the federal government.

Department's Response

The department does not concur with this finding:

1.) The Department disagrees with the questioned costs for the remaining sampled times sheets. Individual providers submit a signed invoice through the mail or through the state's Interactive Voice Response System to the Department of Social and Health Services for payment. This serves as

verification and documentation that they have provided the services for which they are requesting payment. The state retains these invoices/records as the record that providers have attested to the number of service hours provided to the recipient.

2.) *The Department disagrees that there are significant weaknesses in its systems for ensuring that payments are allowable and supported. The Department currently has strong controls in place to ensure that recipients receive services for which Medicaid is being billed. The Department relies on the following controls that are currently in place:*

- *Case managers complete an assessment that results in an authorization of hours that cannot be exceeded by a provider invoice.*
- *Recipients receive a copy of the service summary that tells them the number of hours of service they are eligible to receive. Recipients are advised they can choose when those hours are provided and direct the individual provider when to provide them. Case Managers also advise recipients to contact them if they are not receiving the hours (or care) for which they are eligible.*
- *Recipients are expected to keep copies of timesheets for their individual providers. Case Managers periodically review these time sheets and verify with the recipient that authorized services have been provided. Case managers are instructed to document the review of time sheets and the discussion of service verification in a Service Episode Record.*
- *Timesheet auditing has been added to the annual Quality Assurance monitoring cycle.*
    - *In August 2011, all IPs delivering personal care services received a written reminder of their obligation to keep a record of the date/time that in-home services are provided to ADSA recipients and complete and retain copies of their timesheets.*
    - *In September 2011, ADSA audited a statistically valid sample of IP time sheets to ensure that services billed for were consistent with timesheet documentation submitted. In instances where the billed hours differed from timesheet records or timesheets were not provided, service receipt was verified with the recipient. Corrective actions were taken which included contract termination and processing overpayments.*

- *The Department, through its Payment Review Program, runs algorithms to detect possible fraudulent claims. Overpayments are initiated and referrals are made to the Medicaid Fraud Control Unit as indicated by findings.*
- *The Social Service Payment System will not process payments in excess of hours authorized. A provider is therefore unable to claim and be reimbursed for hours that exceed those authorized by the case manager.*
- *The Department has added service verification monitoring to the Quality Assurance monitoring cycle. Monitoring will be completed on a randomly-selected, statistically-valid sample of in-home providers. In October 2012, the Department will verify with the selected recipients that Medicaid billed services were received. Corrective action will be taken as necessary. Department actions may include processing of overpayments, procuring the needed services that were not provided, terminating contracts with the providers, and referrals to the Medicaid Fraud Control Unit for further action.*
- *In addition to service verification monitoring, time sheet monitoring will continue to be a component of the annual Quality Assurance monitoring cycle.*

Despite these strong controls, the Department understands the need to automate the system used for recording service hours provided. The Department is exploring additional electronic options to verify that clients received the services authorized.

Additionally, the Department would like to clarify and correct statements made in the Background section of the finding:

- *The initial assessment conducted by the Department determines the classification group into which the client is assigned. The Department then authorizes the number of service hours determined by the assessment.*

- *Direct payments for the provision of in-home personal care are made to Individual Providers and to Home Care Agencies. The Area Agencies on Aging (AAAs) authorize payments to Individual Providers and to Home Care Agencies. No direct payments are made to the AAAs for the provision of personal care.*

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. The major changes the Department described in its response to the finding took place after the audit period. We look forward to reviewing the improvements the Department implemented in our next audit.

Sample Unit

The sample unit was an individual payment for service rendered to a Medicaid beneficiary during the period from July 1, 2010 through March 31, 2011.

Estimation Methodology

We used the U.S. Department of Health and Human Services Office of Inspector General Office of Audit Services variable appraisal program in RAT-STATS to estimate the amount of unallowable payments the Department made to Individual Providers.

Sampling Results and Projections

The results of our review of the 149 Medicaid payments were as follows:

Payments In Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Improper payments	Value of Improper Payment (Federal Share)
103,096	$58,136,663.09	149	$85,424.05	$19,321.80	$12,032.57

Projection of Sampling Results

Precision at the 90-Percent Confidence Level	
	Variables Appraisal
Midpoint	$13,369,129
Lower Limit	$8,426,346
Upper Limit	$18,311,912

Extrapolating the results of our statistical sample to the entire Home and Community Based Services program payments we reviewed, we estimate the amount of possible unallowable payments to individual providers that would meet our primary exception criteria could range between the lower limit of our projected results ($8,426,346) and the upper limit ($18,311,912).

Applicable Laws and Regulations

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

> The auditee shall:
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the

provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

OMB Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments* (2 CFR 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:
   d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
   j. Be adequately documented.

Revised Code of Washington 74.39A.095 states in part:

(1) In carrying out case management responsibilities established under RCW 74.39A.090 for consumers who are receiving services under the medicaid personal care, community options programs entry system or chore services program through an individual provider, each area agency on aging shall provide oversight of the care being provided to consumers receiving services under this section to the extent of available funding. Case management responsibilities incorporate this oversight, and include, but are not limited to:
   (a) Verification that any individual provider who has not been referred to a consumer by the authority established under chapter 3, Laws of 2002 has met any training requirements established by the department;
   (b) Verification of a sample of worker time sheets;
   (c) Monitoring the consumer's plan of care to verify that it adequately meets the needs of the consumer, through activities such as home visits, telephone contacts, and responses to information received by the area agency on aging indicating that a consumer may be experiencing problems relating to his or her home care;
   (d) Reassessment and reauthorization of services;
   (e) Monitoring of individual provider performance. If, in the course of its case management activities, the area agency on aging identifies concerns regarding the care being provided by an individual provider who was referred by the authority, the area agency on aging must notify the authority regarding its concerns; and
   (f) Conducting criminal background checks or verifying that criminal background checks have been conducted for any individual provider who has not been referred to a consumer by the authority. . .

(2) The area agency on aging case manager shall work with each consumer to develop a plan of care under this section that identifies and ensures coordination of health and long-term care services that meet the consumer's needs. In developing the plan, they shall utilize, and modify as needed, any comprehensive community service plan developed by the department as provided in RCW 74.39A.040. The plan of care shall include, at a minimum:
   (a) The name and telephone number of the consumer's area agency on aging case manager, and a statement as to how the case manager can be contacted about any concerns related to the consumer's well-being or the adequacy of care provided;
   (b) The name and telephone numbers of the consumer's primary health care provider, and other health or long-term care providers with whom the consumer has frequent contacts;
   (c) A clear description of the roles and responsibilities of the area agency on aging case manager and the consumer receiving services under this section;
   (d) The duties and tasks to be performed by the area agency on aging case manager and the consumer receiving services under this section;
   (e) The type of in-home services authorized, and the number of hours of services to be provided;
   (f) The terms of compensation of the individual provider;

(g) A statement by the individual provider that he or she has the ability and willingness to carry out his or her responsibilities relative to the plan of care; and

(h) (i) Except as provided in (h)(ii) of this subsection, a clear statement indicating that a consumer

receiving services under this section has the right to waive any of the case management services offered by the area agency on aging under this section, and a clear indication of whether the consumer has, in fact, waived any of these services.

(ii) The consumer's right to waive case management services does not include the right to waive reassessment or reauthorization of services, or verification that services are being provided in accordance with the plan of care.

(3) Each area agency on aging shall retain a record of each waiver of services included in a plan of care under this section.

(4) Each consumer has the right to direct and participate in the development of their plan of care to the maximum practicable extent of their abilities and desires, and to be provided with the time and support necessary to facilitate that participation.

(5) A copy of the plan of care must be distributed to the consumer's primary care provider, individual provider, and other relevant providers with whom the consumer has frequent contact, as authorized by the consumer.

(6) The consumer's plan of care shall be an attachment to the contract between the department, or their designee, and the individual provider.

(7) If the department or area agency on aging case manager finds that an individual provider's inadequate performance or inability to deliver quality care is jeopardizing the health, safety, or well-being of a consumer receiving service under this section, the department or the area agency on aging may take action to terminate the contract between the department and the individual provider. If the department or the area agency on aging has a reasonable, good faith belief that the health, safety, or well-being of a consumer is in imminent jeopardy, the department or area agency on aging may summarily suspend the contract pending a fair hearing. The consumer may request a fair hearing to contest the planned action of the case manager, as provided in chapter 34.05 RCW. When the department or area agency on aging terminates or summarily suspends a contract under this subsection, it must provide oral and written notice of the action taken to the authority. The department may by rule adopt guidelines for implementing this subsection.

(8) The department or area agency on aging may reject a request by a consumer receiving services under this section to have a family member or other person serve as his or her individual provider if the case manager has a reasonable, good faith belief that the family member or other person will be unable to appropriately meet the care needs of the consumer. The consumer may request a fair hearing to contest the decision of the case manager, as provided in chapter 34.05 RCW. The department may by rule adopt guidelines for implementing this subsection.

Washington Administrative Code 388-71-0515 states in part:

An individual provider or home care agency provider must:

(1) Understand the client's plan of care that is signed by the client or legal representative and social worker/case manager, and translated or interpreted, as necessary, for the client and the provider;

(2) Provide the services as outlined on the client's plan of care, as defined in WAC 388-106-0010;

(3) Accommodate client's individual preferences and differences in providing care;

(4) Contact the client's representative and case manager when there are changes which affect the personal care and other tasks listed on the plan of care;

(5) Observe the client for change(s) in health, take appropriate action, and respond to emergencies;

(6) Notify the case manager immediately when the client enters a hospital, or moves to another setting;

(7) Notify the case manager immediately if the client dies;

(8) Notify the department or AAA immediately when unable to staff/serve the client; and

(9) Notify the department/AAA when the individual provider or home care agency will no longer provide services. Notification to the client/legal guardian must:
   (a) Give at least two weeks' notice, and
   (b) Be in writing.
(10) Complete and keep accurate time sheets that are accessible to the social worker/case manager; and
(11) Comply with all applicable laws and regulations...

Employment Reference Guide for Individual Providers (DSHS22-221(X) Page 8 states in part:

- Make a check in all the personal care tasks listed on the form that you performed as defined in the Care Plan during that month.
- After you have completed the form, have your employer review it for accuracy. If your employer agrees, he/she should sign their name under "CLIENT'S SIGNATURE".
- Use your timesheet to fill out your SSPS Service Invoice accurately.
- Keep one copy for your records (for two (2) years) and give one copy to your employer for his or her files.

The Long Term Care manual states in part (Chapter 3, Resources: Forms to review with Client during their Assessment):

Form/Brochure Title	Requirements
Acknowledgement of My Responsibilities as the Employer of My Individual Providers (DSHS 11-055 revised 8/2009)	Review with clients about their responsibilities when employing an Individual Provider. Between November 1, 2009 and October 31, 2010 the form must be distributed and reviewed during the Initial and Annual assessments with all clients who employ an IP. After October 31, 2010, the form must be distributed and reviewed with new clients who select an IP and with current clients who switch to an IP from a homecare agency or residential setting.
IP time sheets	Review with the client and the provider during the annual or Significant Change assessments.

11-30 The Department of Social and Health Services, Aging and Disability Services Administration, did not ensure the level of in-home care services is appropriate and clients are still eligible for assistance at least annually.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Utilization Control and Program Integrity	
Questioned Cost Amount:	$42,041.10 Non ARRA	
	$ 8,894.94 ARRA	

Background

The Department of Social and Health Services, Aging and Disability Services Administration, requires all clients who seek Medicaid assistance to meet eligibility criteria to receive services. Eligibility is determined in part through an assessment of the client's level of ability to perform daily living tasks.

The Department uses the Comprehensive Assessment Reporting Evaluation system to determine the type and level of services the client needs. The Department's Home and Community Services perform an initial evaluation; it contracts with case managers at one of the 13 Area Agency on Aging offices across the state for the annual re-evaluations.

The annual re-evaluation is designed to determine whether the level of care is appropriate and whether clients are still eligible for assistance. Evaluations are considered complete and the client is authorized to receive services once the client has reviewed the results of his or her assessment and has either verbally agreed to or given a signature of approval for the services.

If an assessment is not completed in a timely manner, the client is notified that the assessment must be completed in order to continue receiving benefits.

In fiscal year 2011, the Department provided approximately $504 million in funding for services to approximately 21,000 clients. Approximately $56 million of this came from the American Recovery and Reinvestment Act (ARRA).

Description of Condition

The Department did not monitor to ensure staff was completing evaluations in a timely manner. During our audit, we identified 56 clients whose assessments were more than 30 days late. Case managers are allowed 30 days after the end of the 12-month period to complete the evaluations.

Cause of Condition

Department personnel stated most late assessments occurred due to difficulties in establishing contact with clients and high workloads.

Effect of Condition and Questioned Costs

When services are provided without current authorization, expenditures are not allowable. Total payments made to the 56 clients whose assessments were not completed in a timely manner were $88,278.62. We are questioning $50,936.04, which is the federal portion of the expenditures.

The table below summarizes the assessments we identified in our review as being completed after the annual re-evaluation due date:

Duration of Time Exceeding Due Date	Number of Assessments	Questioned Costs	Federal Share	
			Non-ARRA	ARRA
1-3 months	47	$56,927.59	$26,738.08	$5,646.84
4-5 months	4	$9,280.01	$4,646.11	$1,087.58
6 months or greater	5	$22,071.02	$10,656.91	$2,160.52
Total	**56**	**$88,278.62**	**$42,041.10**	**$8,894.94**

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:

- Establish and follow internal controls to ensure the level of care assessment for clients receiving in-home care is performed at least once every twelve months.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Department's Response

The Department partially concurs with this finding and notes that 99.9% (57416 out of 57472) assessments were timely. While the Department agrees that a very small percentage (.001% or 56/57472) of assessments were actually late, the Department does not concur with the auditor's questioned costs. Each of the clients for whom payments were made remained eligible for Medicaid Services during the period that the assessment was out of date.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

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

Section 1915(c) Community Options Program Entry System (COPES) Waiver Version 06-95 states in part:

Appendix D-1

a. Evaluation Of Level Of Care
The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in the Executive Summary of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. Qualifications Of Individuals Performing Initial Evaluation
The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):
_____Discharge planning team
_____Physician (MD or DO)
X_____Registered nurse, licensed in the state
_____Licensed social worker
_____Qualified mental retardation professional, as defined in 42 CFR 483.430(a)
X_____Other (specify): Social Workers, Case Managers

Appendix D-2

a. Reevaluations Of Level Of Care
Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (specify):
_____Every 3 months
_____Every 6 months
X_____Every 12 months
X_____Other (specify): As indicated by a significant change in the client's condition or situation

b. Qualifications Of Persons Performing Reevaluations
Check one:
X_____The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.
_____The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for all individuals performing reevaluations of level of care (specify):
_____Physician (MD or DO)
_____Registered nurse, licensed in the state
_____Licensed social worker
_____Qualified mental retardation professional, as defined in 42 CFR 483.430(a)
_____Other (specify): _____

c. Procedures To Ensure Timely Reevaluations
The state will employ the following procedures to ensure timely reevaluations of level of care (check below):
_____"Tickler" file Edits in computer system
_____Component part of case management
X_____Other (specify):
Quality assurance monitoring staff from ADSA headquarters conducts annual reviews of case management services provided by the Home and Community Services Division (HCS), Area Agencies on Aging (AAA) and Managed Care Organizations (MCO). Each HCS region, AAA office and MCO is monitored. At the regional and local levels, HCS and AAA case management supervisors also conduct regular quality reviews of their case management staff.

42 C.F.R. 441.302 State assurances.

Unless the Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted:

(a) Health and Welfare —Assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include—
  (1) Adequate standards for all types of providers that provide services under the waiver;
  (2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and
  (3) Assurance that all facilities covered by section 1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

(b) Financial accountability— The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

(c) Evaluation of need. Assurance that the agency will provide for the following:
  (1) Initial evaluation. An evaluation of the need for the level of care provided in a hospital, a NF, or an ICF/MR when there is a reasonable indication that a recipient might need the services in the near future (that is, a month or less) unless he or she receives home or community-based services. For purposes of this section, "evaluation" means a review of an individual recipient's condition to determine—
    (i) If the recipient requires the level of care provided in a hospital as defined in §440.10 of this subchapter, a NF as defined in section 1919(a) of the Act, or an ICF/MR as defined by §440.150 of this subchapter; and
    (ii) That the recipient, but for the provision of waiver services, would otherwise be institutionalized in such a facility.
  (2) Periodic reevaluations. Reevaluations, at least annually, of each recipient receiving home or community-based services to determine if the recipient continues to need the level of care provided and would, but for the provision of waiver services, otherwise be institutionalized in one of the following institutions:
    (i) A hospital;
    (ii) A NF; or
    (iii) An ICF/MR.

(d) Alternatives —Assurance that when a recipient is determined to be likely to require the level of care provided in a hospital, NF, or ICF/MR, the recipient or his or her legal representative will be—
  (1) Informed of any feasible alternatives available under the waiver; and
  (2) Given the choice of either institutional or home and community-based services.

(e) Average per capita expenditures. Assurance that the average per capita fiscal year expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made in the fiscal year for the level of care provided in a hospital, NF, or ICF/MR under the State plan had the waiver not been granted.
  (1) These expenditures must be reasonably estimated and documented by the agency.
  (2) The estimate must be on an annual basis and must cover each year of the waiver period.

(f) Actual total expenditures. Assurance that the agency's actual total expenditures for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to recipients under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals, absent the waiver, in—
  (1) A hospital;
  (2) A NF; or
  (3) An ICF/MR.

(g) Institutionalization absent waiver. Assurance that, absent the waiver, recipients in the waiver would receive the appropriate type of Medicaid-funded institutional care (hospital, NF, or ICF/MR) that they require.
(h) Reporting. Assurance that annually, the agency will provide CMS with information on the waiver's impact. The information must be consistent with a data collection plan designed by CMS and must address the waiver's impact on—
  (1) The type, amount, and cost of services provided under the State plan; and
  (2) The health and welfare of recipients.
(i) Habilitation services. Assurance that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver, are—
  (1) Not otherwise available to the individual through a local educational agency under section 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730); and
  (2) Furnished as part of expanded habilitation services, if the State has requested and received CMS's approval under a waiver or an amendment to a waiver.
(j) Day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness. Assurance that FFP will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are—
  (1) Age 22 to 64;
  (2) Age 65 and older and the State has not included the optional Medicaid benefit cited in §440.140; or
  (3) Age 21 and under and the State has not included the optional Medicaid benefit cited in §440.160.

Washington Administrative Code (WAC) 388-106-0025

How do I apply for long-term care services?

To apply for long-term care services, you must request an assessment from the department and submit a Medicaid application.

WAC 388-106-0050

What is an assessment?
(1) An assessment is an in-person interview in your home or your place of residence that is conducted by the department to inventory and evaluate your ability to care for yourself. The department will assess you at least annually or more often when there are significant changes to your ability to care for yourself.
(2) Between assessments, the department may modify your current assessment without an in-person interview in your home or place of residence. The reasons that the department may modify your current assessment without conducting an in-person interview in your home or place of residence include but are not limited to the following:
  (a) Errors made by department staff in coding the information from your in-person interview;
  (b) New information requested by department staff at the time of your assessment and received after completion of the in-person interview (e.g. medical diagnosis);
  (c) Changes in the level of informal support available to you; or
  (d) Clarification of the coding selected.
(3) When the department modifies your current assessment, it will notify you using a Planned Action Notice of the modification regardless of whether the modification results in a change to your benefits. You will also receive a new service summary and assessment details.

WAC 388-106-0055

What is the purpose of an assessment?

The purpose of an assessment is to:
(1) Determine eligibility for long-term care programs;
(2) Identify your strengths, limitations, and preferences;
(3) Evaluate your living situation and environment;
(4) Evaluate your physical health, functional and cognitive abilities;
(5) Determine availability of informal supports and other nondepartment paid resources;
(6) Determine need for intervention;
(7) Determine need for case management activities;
(8) Determine your classification group that will set your payment rate for residential care or number of hours of in-home care;
(9) Determine need for referrals; and
(10) Develop a plan of care, as defined in WAC 388-106-0010.
(11) In the case of New Freedom consumer directed services, the purpose of an assessment is to determine functional eligibility and for the participant to develop the New Freedom spending plan, as defined in WAC 388-106-0010.

WAC 388-513-1315 states in part:

Eligibility for long-term care (institutional, waiver, and hospice) services.
This section describes how the department determines a client's eligibility for medical for clients residing in a medical institution, on a waiver, or receiving hospice services under the categorically needy (CN) or medically needy (MN) programs. Also described are the eligibility requirements for these services under the general assistance (GA) program in subsection (12) and the state funded nursing facility program described in subsection (11).
(1) To be eligible for long-term care (LTC) services described in this section, a client must:
  (a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a) through (f);
  (b) Attain institutional status as described in WAC 388-513-1320;
  (c) Meet functional eligibility described in chapter 388-106 WAC for waiver and nursing facility coverage;

DSHS Long-Term Care Manual Chapter 3 states in part:

Completing a CARE Assessment – Developing the Plan of Care

Background
Clients are able to choose from options for personal and healthcare services that are governed by eligibility criteria, payment source requirements, coverage options, and provider qualifications. Twenty-four hour, paid care is available only in residential or medical facility settings, so case managers must work with clients to maximize all available resources, both paid and unpaid, in order to develop a plan of care that addresses the health and safety needs of the client. The state identifies the essential tasks to be performed by formal providers in the care plan within program limits. How and when they are performed is determined by the client.

The state has an obligation to educate clients, family members, support systems, and other service providers, informing them that a plan of care is developed based on the resources available and that meeting all needs and providing all services is an expectation that neither the client, family, support system, or case manager may be able to achieve.

How do I get approval on the plan of care from the client?
Before authorizing services, you must obtain the client's approval on the plan of care.
How do I distribute the plan of care to the client/representative?

Distribute the Service Summary and CARE Results to the client along with a Planned Action Notice (PAN) found in CARE. Distribute Assessment Details if requested by the client/representative.

How and when do I distribute the plan of care to the provider(s)?

Mail or fax the Service Summary and Assessment Details prior to authorizing/reauthorizing services and document in the SER. Distribute the Service Summary and Assessment Details to:

- Individual providers;
- Agency providers;
- Nursing services staff, if applicable;
- Residential providers;
- The nursing facility, if the client is placed there on Medicaid funding only;
- Adult Day Services providers;
- Nurse delegators.

Document in the SER when you distributed the documents and to whom.

How do I authorize services?

Complete all authorizations in CARE once the client has approved the plan of care. For:

- Initial assessments, the begin date may not precede the date the assessment was moved to *Current* status.
- Significant Change assessments, if extending services for one year, terminate the current line or lines (for example, if participation is also authorized) and create a new line(s) on the same authorization. Do not change the begin date on a current line since changing the begin date creates a risk of canceling outstanding payments or prevents invoicing from occurring. If there are not enough lines left on the authorization, open a new authorization.
- Annual assessments, you may not extend services beyond one year from the last day of the month in which it was moved to *Current*. A face-to-face assessment must occur and the assessment must be moved to *Current* prior to reauthorization of services.

11-31 The Department of Social and Health Services, Aging and Disability Services Administration, charged approximately $36,000 to the Medicaid program for services provided to ineligible individuals.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed; Cost Principles; Reporting	
Questioned Cost Amount:	$18,101.36 Non ARRA	
	$ 4,630.08 ARRA	

Background

The Medicaid program pays for medical assistance for certain individuals and families with low income and resources. Federal and state laws, regulations and other requirements establish Medicaid eligibility. Generally, an individual must, among other things, not exceed state-established income and resource thresholds, meet citizenship requirements, submit a written application for Medicaid benefits, furnish his or her Social Security number and be eligible for the services received.

In Washington, the Medicaid program covers children up to age 19 in families whose income is up to 200 percent of the Federal Poverty Level.

Description of Condition

In our prior audit we found expenditures for personal care services provided to Children's Health Insurance Program (CHIP) beneficiaries were charged to the Medicaid program because the Department was not aware expenditures for services provided to CHIP beneficiaries should be fully charged to that program, instead of Medicaid. In August 2011 the Department created new service codes for payments made for CHIP beneficiaries.

Since the new service codes were not available during the current audit period, the Department temporarily charged CHIP expenditures to the Medicaid program with the intention of making yearend adjustments. In August 2011 the Department identified CHIP expenditures totaling $463,586.37 and refunded those expenditures to the Medicaid program. During our audit, however, we found CHIP expenditures that should have been refunded to the Medicaid program totaled $499,702, resulting in a difference of $36,116.05.

Cause of Condition

The Department inadvertently failed to account for July 2010 CHIP expenditures totaling $36,116.05.

Effect of Condition and Questioned Costs

The Department charged $36,116.05 to the Medicaid program for services provided to ineligible individuals. We are questioning $22,731.44, which is the federal portion of the expenditures.

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

Recommendation

We recommend the Department:

- Follow adequate procedures to ensure only eligible Medicaid expenditures are charged to the Medicaid program.
- Refund to the federal government $22,731.44 in unallowable costs charged to Medicaid.

Department's Response

The Department concurs with this finding.

We inadvertently failed to account for the July 2010 CHIP expenditure correction. This was corrected in December 2011, returning the funds to Medicaid and charging the enhanced CHIP funding.

Auditor's Concluding Remarks

We appreciate the cooperation and assistance provided by the Department throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

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

OMB Circular A-133 Compliance Supplement, Part 4 (March 2011)- Department of Health and Human Services (HHS), Medicaid Cluster, III. Compliance Requirements, states in part:

> To be allowable, Medicaid costs for medical services must be: (1) covered by the State plan and waivers; (2) for an allowable service rendered (including supported by medical records or other evidence indicating that the service was actually provided and consistent with the medical diagnosis); (3) properly coded; and (4) paid at the rate allowed by the State plan. Additionally, Medicaid costs must be net of applicable credits (e.g., insurance, recoveries from other third parties who are responsible for covering the Medicaid costs, and drug rebates), paid to eligible providers, and only provided on behalf of eligible individuals.

Title 42, Code of Federal Regulations, Section 435.1002 FFP for services, states:

> (a) Except for the limitations and conditions specified in §§435.1007, 35.1008, 435.1009, and 438.814 of this chapter, FFP is available in expenditures for Medicaid services for all recipients whose coverage is required or allowed under this part.

(b) FFP is available in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided except that, for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the recipient's liability. (See §§435.914 and 436.901 of this subchapter for regulations on retroactive eligibility for Medicaid.)

(c) FFP is available in expenditures for services covered under the plan that are furnished—
   (1) To children who are determined by a qualified entity to be presumptively eligible;
   (2) During a period of presumptive eligibility;
   (3) By a provider that is eligible for payment under the plan; and
   (4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

11-32 The Department of Social and Health Services does not have an adequate process to identify ineligible Medicaid expenditures for nonqualified aliens at the time of payment, resulting in $52,104 in questionable costs.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed or Unallowed	
Questioned Cost Amount:	$43,039.37 Non ARRA	
	$ 9,065.34 ARRA	

Background

State and federal dollars pay for the Medicaid program, which provides coverage for low-income individuals who otherwise might go without medical care. The state Medicaid program spent more than $7.5 billion during fiscal year 2011, more than $4.7 billion of which was federal dollars.

Under federal law, all U.S. citizens and certain legal immigrants who meet Medicaid's financial and non-financial eligibility criteria may receive Medicaid. Nonqualified aliens are not eligible to receive general Medicaid benefits, but may be eligible for care and services necessary in an emergency medical situation not related to an organ transplant.

Federal law requires the state to have an Alien Emergency Medical program for these emergency situations for nonqualified aliens who meet all Medicaid program requirements with the exception of immigration status. This program covers low-income families, children and adults who are aged, blind or disabled.

The program defines emergency medical conditions as the sudden onset of a medical condition (including labor and delivery) whose symptoms are acute and severe (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

With the passage of the American Recovery and Reinvestment Act (ARRA), the amount the federal government will pay for most Medicaid expenditures increased from approximately 50 percent to more than 60 percent of costs. The state can elect to pay for non-emergency services for nonqualified aliens. The federal government will not share the cost of those services.

Description of Condition

The Department charges payments for services provided to nonqualified aliens to Medicaid. Every quarter the Department reviews the services, identifies non-emergency related services and refunds the payments that were charged to the Medicaid program to the federal government.

In our current audit, we identified non-emergency services provided to 39 nonqualified aliens totaling $559,820.79. We reviewed detailed payments associated with those services and found the Department already refunded the federal portion of the payments totaling $473,772.58. The remaining payments totaling $86,048.21 for non-emergency services provided to 27 nonqualified aliens have not been refunded.

The table below summarizes our findings:

Service Description	Unallowable expenditures	Questioned Costs	Federal Share		State Share
			Non-ARRA	ARRA	
Long-term care	$559,738.99	$85,966.41	$42,998.47	$9,056.19	$33,911.75
Disability medical evaluation	$81.80	$81.80	$40.90	$9.15	$31.75
Total	**$559,820.79**	**$86,048.21**	**$43,039.37**	**$9,065.34**	**$33,943.50**

Cause of Condition

The Department developed new procedures which prevent payments for non-emergency services provided to nonqualified aliens from being charged to the Medicaid program. However, the process was not implemented during our audit period.

The Department reviewed and identified unallowable payments that were charged to the Medicaid program. However, the Department did not identify all unallowable payments because the review did not cover all nonqualified alien clients.

Effect of Condition and Questioned Costs

The Department paid $86,048.21 for services that are not eligible for federal reimbursement. We are questioning $52,104.71, which is the federal portion of the expenditures.

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

Recommendation

We recommend the Department:

- Establish and follow adequate procedures to ensure that Medicaid services provided to nonqualified aliens are restricted only to emergency services.
- Follow up on the non-emergency services provided to 27 nonqualified aliens identified in our audit and work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid funds must be reimbursed.

Department's Response

The Department concurs with this finding.

Medicaid funds were used to serve non-qualified alien clients. Procedures have been developed and new SSPS codes have been established to move these clients to state only funded programs. All questioned costs have been reimbursed.

Auditor's Concluding Remarks

We appreciate the cooperation and assistance provided by the Department throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

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

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

> Section 510 - Audit findings.
>
> (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
> (3) Known questioned costs which are greater than $10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

Title 42, Code of Federal Regulations, Part 435

> Section 435.139 Coverage for certain aliens states:
> The agency must provide services necessary for the treatment of an emergency medical condition, as defined in §440.255(c) of this chapter, to those aliens described in §435.406(c) of this subpart.

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

> (a) FFP for services. FFP is available for services provided to aliens described in this section which are necessary to treat an emergency medical condition as defined in paragraphs (b)(1) and (c) or services for pregnant women described in paragraph (b)(2).
> (b) Legalized aliens eligible only for emergency services and services for pregnant women. Aliens granted lawful temporary resident status, or lawful permanent resident status under sections 245A, 210 or 210A of the Immigration and Nationality Act, who are not in one of the exempt groups described in §§435.406(a)(3) and 436.406(a)(3) and who meet all other requirements for Medicaid will be eligible for the following services—
> (1) Emergency services required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
> (i) Placing the patient's health in serious jeopardy;
> (ii) Serious impairment to bodily functions; or
> (iii) Serious dysfunction of any bodily organ or part.
> (2) Services for pregnant women which are included in the approved State plan. These services include routine prenatal care, labor and delivery, and routine post-partum care. States, at their option, may provide additional plan services for the treatment of conditions which may complicate the pregnancy or delivery.

(c) Effective January 1, 1987, aliens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of law must receive the services necessary to treat the condition defined in paragraph (1) of this section if—
  (1) The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
    (i) Placing the patient's health in serious jeopardy;
    (ii) Serious impairment to bodily functions; or
    (iii) Serious dysfunction of any bodily organ or part, and
  (2) The alien otherwise meets the requirements in §§435.406(c) and 436.406(c) of this subpart.

Title 42, Code of Federal Regulations, Section 435.406, Citizenship and alienage states:

(a) The agency must provide Medicaid to otherwise eligible residents of the United States who are —
  (1) Citizens: (i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and
    (ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in §435.407.
    (iii) An individual for purposes of the declaration and citizenship documentation requirements discussed in paragraphs (a)(1)(i) and (a)(1)(ii) of this section includes both applicants and recipients under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in their expenditures, as though the expenditures were for medical assistance.
    (iv) Individuals must declare their citizenship and the State must document the individual's citizenship in the individual's eligibility file on initial applications and initial redeterminations effective July 1, 2006.
    (v) The following groups of individuals are exempt from the requirements in paragraph (a)(1)(ii) of this section:
      (A) Individuals receiving SSI benefits under title XVI of the Act.
      (B) Individuals entitled to or enrolled in any part of Medicare.
      (C) Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on the individual's disability (as defined in section 223(d) of the Act).
      (D) Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are recipients of foster care maintenance or adoption assistance payments under Title IV–E of the Act.
  (2) (i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified aliens), qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified aliens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or recipient is an alien in a satisfactory immigration status.
    (ii) The eligibility of qualified aliens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.
(b) The agency must provide payment for the services described in §440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified aliens subject to the 5-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria,

except non-qualified aliens need not present a social security number or document immigration status.

Washington Administrative Code (WAC) 182-500-0030, Medical definitions, states in part:

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy;
(2) Serious impairment to bodily functions; or
(3) Serious dysfunction of any bodily organ or part.

Washington Administrative Code (WAC) 388-438-0115 states:

(1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 388-438-0110 is eligible for the alien emergency medical program's scope of covered services described in this section if the person meets (a) and (b) below, or (c) below:
  (a) The department's health and recovery services administration determines that the primary condition requiring treatment meets the definition of an emergency medical condition as defined in WAC 388-500-0005, and the condition is confirmed through review of clinical records; and
  (b) The person's qualifying emergency medical condition is treated in one of the following hospital settings:
    (i) Inpatient;
    (ii) Outpatient surgery;
    (ii) 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 department's inpatient mental health designee (see subsection (5) of this section).
(2) If a person meets the criteria in subsection (1), the department will cover and pay for all related medically necessary health care services and professional services provided:
  (a) By a physician in his 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 department as described in subsection (3) of this section.
(3) The department will cover admissions to an LTAC facility or an inpatient PM&R unit if:
  (a) The original admission to the 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 388-550-2590 for LTAC and WAC 388-550-2561 for PM&R).
(4) The department does not cover any services, regardless of setting, once the person is discharged from the hospital after being treated for a qualifying emergency medical condition authorized by the department under this program. Exception: Pharmacy services, drugs,

devices, and drug-related supplies listed in WAC 388-530-2000, 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 department's inpatient mental health designee according to the requirements in WAC 388-550-2600.

(6) There is no precertification or prior authorization for eligibility under this program. 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 388-501-0060. This includes, but is not limited to:

  (a) Hospital services, care, surgeries, or inpatient admissions to treat any condition which is not considered by the department to be a qualifying emergency medical condition, including but not limited to:

    (i) Laboratory X ray, or other diagnostic procedures;

    (ii) Physical, occupational, speech therapy, or audiology services;

    (ii) Hospital clinic services; or

    (iii) 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 non durable medical supplies;

    (xv) Nonemergency medical transportation;

    (xvi) Interpreter services; and

    (xvii) Pharmacy services, except as described in subsection (4).

(9) The services listed in subsection (8) of this section are not 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 department for visits or services that do not meet the qualifying criteria described in this section. The department will identify and recover payment for claims paid in error.

11-33 The Department of Social and Health Services, Aging and Disability Services Administration, does not have adequate controls to ensure the accuracy of financial eligibility determinations for Medicaid clients receiving home and community based services.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Eligibility	
Questioned Cost Amount:	None	

Background

Medicaid is a jointly funded state and federal partnership providing medical care for low-income individuals and plays a critical role for people with long-term care needs. The Department of Social and Health Services, Aging and Disability Services Administration, administers the Home and Community Based Services waiver programs, which allow long-term care services to be delivered in community settings instead of institutions.

One of the programs is the Community Options Program Entry System (COPES). It provides aged or disabled individuals with the option to remain at home or in alternate living facilities instead of nursing facilities. The program offers services such as personal care, transportation, specialized medical equipment and supplies, and home-delivered meals.

Clients must be both financially and functionally eligible for the program to receive services. Home and Community Services (HCS) offices across the state determine initial eligibility. After the initial determination, local Area Agencies on Aging assess and monitor continuing functional eligibility while HCS offices determine ongoing financial eligibility.

The Department requires HCS offices to audit financial eligibility determinations on a regular basis. Financial supervisors or lead workers at HCS offices are charged with auditing the determinations made by financial workers to ensure they are obtaining all appropriate information and using it to make an accurate determination. Each region determines which cases to review.

During fiscal year 2011, the Department paid approximately $687 million for in-home services. These included direct payments to agencies on aging and payments to in-home service providers for services authorized by those agencies.

Description of Condition

We selected two out of 29 Home and Community Services offices, not visited previously to determine whether they performed regular audits to ensure the accuracy of financial eligibility determinations. We found one of them did not complete regular audits for the second half of fiscal year 2011. We judgmentally selected additional five Home and Community Services offices to ensure what we identified during our

field work is not an isolated incident. We found three had not completed formal audits for the second half of fiscal year 2011.

Cause of Condition

The four HCS offices identified did not complete formal audits to monitor the accuracy of financial eligibility determinations due to a lack of resources.

Effect of Condition

Without performing routine audits, the Department cannot ensure client eligibility determinations are complete and accurate.

Recommendation

We recommend the Department perform formal audits to ensure the accuracy of financial eligibility determinations.

Department's Response

The Department concurs with this finding.

Staff at Home and Community Services field offices and headquarters assisted the State Auditor's Office (SA0) in obtaining reports that led to this finding. As a result, we became aware that some offices had reduced or eliminated formal audits due to a lack of resources related to budget reductions that made it difficult or impossible to hire for vacancies. All offices had audit or pre-audit (audits occurring prior to disposition) requirements for certain types of complex long-term care eligibility scenarios. However, these were often not being entered in the audit system. Statewide discussions about our auditing practices occurred before the finding was received and a corrective action plan was agreed to on February 9th.

The department concurs with the SAO that formal audits must be required for every worker regardless of their experience level. We also find that the number of audits required must be consistent statewide. Regions will have autonomy to focus on particular kinds of audits based on error trends and client demographics but must include food assistance audits as well as long-term care services. Regions are free to do any additional auditing that is needed. We will run reports on a quarterly basis to ensure compliance. Please see the corrective action plan for additional details.

Auditor's Remarks

We appreciate the cooperation and assistance provided by the Department throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

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

Title 42, code of Federal Regulations, Section 435 states in part:

> §435.948 Requesting information.

(a) Except as provided in paragraphs (d), (e), and (f) of this section, the agency must request information from the sources specified in this paragraph for verifying Medicaid eligibility and the correct amount of medical assistance payments for each applicant (unless obviously ineligible on the face of his or her application) and recipient. The agency must request—

(1) State wage information maintained by the SWICA during the application period and at least on a quarterly basis;

(2) Information about net earnings from self-employment, wage and payment of retirement income, maintained by SSA and available under Section 6103(l)(7)(A) of the Internal Revenue Code of 1954, for applicants during the application period and for recipients for whom the information has not previously been requested;

(3) Information about benefit and other eligibility related information available from SSA under titles II and XVI of the Social Security Act for applicants during the application period and for recipients for whom the information has not previously been requested;

(4) Unearned income information from the Internal Revenue Service available under Section 6103(l)(7)(B) of the Internal Revenue Code of 1954, during the application period and at least yearly;

(5) Unemployment compensation information maintained by the agency administering State unemployment compensation laws (under the provisions of section 3304 of the Internal Revenue Code and section 303 of the Act) as follows:

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

(ii) For a recipient that reports a loss of employment, at the time the recipient reports that loss and for at least each of the three subsequent months.

(iii) For an applicant or a recipient who is found to be receiving unemployment compensation benefits, at least for each month until the benefits are reported to be exhausted.

(6) Any additional income, resource, or eligibility information relevant to determinations concerning eligibility or correct amount of medical assistance payments available from agencies in the State or other States administering the following programs as provided in the agency's State plan:

(i) AFDC;

(ii) Medicaid;

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

(iv) SWICA;

(v) Unemployment compensation;

(vi) Food stamps; and

(vii) Any State program administered under a plan approved under Title I (assistance to the aged), X (aid to the blind), XIV (aid to the permanently and totally disabled), or XVI (aid to the aged, blind, and disabled in Puerto Rico, Guam, and the Virgin Islands) of the Act.

(b) The agency must request information on applicants from the sources listed in paragraph (a)(1) through (a)(5) of this section at the first opportunity provided by these sources following the receipt of the application. If an applicant cannot provide an SSN at application, the agency must request the information at the next available opportunity after receiving the SSN.

(c) The agency must request the information required in paragraph (a) of this section by SSN, using each SSN furnished by the individual or received through verification.

(d) *Exception:* In cases where the individual is institutionalized, the agency needs to obtain and use information from SWICA only during the application period and on a yearly basis, and from unemployment compensation agencies only during the application period. An individual is institutionalized for purposes of this section when he or she is required to apply his or her income to the cost of medical care as required by §§435.725, 435.733, and 435.832.

(e) *Exception: Alternate sources*— (1) The Secretary may, upon application from a State agency, permit an agency to request and use income information from a source or sources alternative to those listed in paragraph (a) of this section. The agency must demonstrate to the Secretary that the alternative source(s) is as timely, complete and useful for verifying eligibility and benefit amounts. The Secretary will consult with the Secretary of Agriculture and the Secretary of Labor before determining whether an agency may use an alternate source.

(2) The agency must continue to meet the requirements of this section unless the Secretary has approved the request.

(f) *Exception:* If the agency administering the AFDC program, or SSA under section 1634 of the Act, determines the eligibility of an applicant or recipient, the requirements of this section do not apply to that applicant or recipient.

§435.1002 FFP for services.

(a) Except for the limitations and conditions specified in §§435.1007, 35.1008, 435.1009, and 438.814 of this chapter, FFP is available in expenditures for Medicaid services for all recipients whose coverage is required or allowed under this part.

(b) FFP is available in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided except that, for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the recipient's liability. (See §§435.914 and 436.901 of this subchapter for regulations on retroactive eligibility for Medicaid.)

(c) FFP is available in expenditures for services covered under the plan that are furnished—

(1) To children who are determined by a qualified entity to be presumptively eligible;

(2) During a period of presumptive eligibility;

(3) By a provider that is eligible for payment under the plan; and

(4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

§435.916 Periodic redeterminations of Medicaid eligibility.

(a) The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months, however—

(1) The agency may consider blindness as continuing until the review physician under §435.531 determines that a recipient's vision has improved beyond the definition of blindness contained in the plan; and

(2) The agency may consider disability as continuing until the review team under §435.541 determines that a recipient's disability no longer meets the definition of disability contained in the plan.

(b) *Procedures for reporting changes.* The agency must have procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility.

(c) *Agency action on information about changes.*

(1) The agency must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility.

(2) If the agency has information about anticipated changes in a recipient's circumstances, it must redetermine eligibility at the appropriate time based on those changes.

WAC 388-515-1507 What are the financial requirements for home and community based (HCB) services when you are eligible for a noninstitutional categorically needy (CN) medicaid program?

(1) You are eligible for medicaid under one of the following programs:

(a) Supplemental Security Income (SSI) eligibility described in WAC 388-474-0001. This includes SSI clients under 1619B status;

(b) SSI-related CN medicaid described in WAC 388-475-0100 (2)(a) and (b);

(c) SSI-related healthcare for workers with disabilities program (HWD) described in WAC 388-475-1000. If you are receiving HWD, you are responsible to pay your HWD premium as described in WAC 388-475-1250. This change is effective April 1, 2009;

(d) General assistance expedited medicaid disability (GAX) or general assistance based on aged/blind/disabled criteria described in WAC 388-505-0110(6) and are receiving CN medicaid.

(2) You do not have a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363 through 388-513-1366. This does not apply to PACE or hospice services.

(3) You do not have a home with equity in excess of the requirements described in WAC 388-513-1350.

(4) You do not have to meet the initial eligibility income test of having gross income at or below the special income level (SIL).

(5) You do not pay (participate) toward the cost of your personal care services.

(6) If you live in a department contracted facility listed in WAC 388-515-1506 (1)(g), you pay room and board up to the ADSA room and board standard. The ADSA room and board standard is based on the federal benefit rate (FBR) minus the current personal needs allowance (PNA) for HCS CN waivers in an alternate living facility.

(a) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH) you keep a PNA of sixty-two dollars and seventy-nine cents and use your income to pay up to the room and board standard.

(b) If subsection (6)(a) applies and you are receiving HWD described in WAC 388-475-1000, you are responsible to pay your HWD premium as described in WAC 388-475-1250, in addition to the room and board standard.

(7) If you are eligible for general assistance expedited medicaid disability (GAX) or general assistance based on aged/blind/disabled criteria described in WAC 388-505-0110(6), you do not participate in the cost of personal care and you may keep the following:

(a) When you live at home, you keep the cash grant amount authorized under the general assistance program;

(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and general assistance grant to the facility for the cost of room and board up to the ADSA room and board standard; or

(c) When you live in an assisted living facility or enhanced adult residential center, you are only eligible to receive a cash grant of thirty-eight dollars and eighty-four cents, which you keep for your PNA.

(8) Current resource and income standards are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(9) Current PNA and ADSA room and board standards are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAchartsubfile.shtml.

WAC 388-515-1508 How does the department determine if you are financially eligible for home and community based (HCB) services and hospice if you are not eligible for medicaid under a categorically needy (CN) program listed in WAC 388-515-1507(1)?

(1) If you are not eligible for medicaid under a categorically needy (CN) program listed in WAC 388-515-1507(1), the department must determine your eligibility using institutional medicaid rules. This section explains how you may qualify using institutional medicaid rules.

(2) You must meet the general eligibility requirements described in WAC 388-513-1315 and 388-515-1506.

(3) You must meet the following resource requirements:

(a) Resource limits described in WAC 388-513-1350.

(b) If you have resources over the standard allowed in WAC 388-513-1350, the department reduces resources over the standard by your unpaid medical expenses described in WAC 388-513-1350 (d), (e) and (f) if you verify these expenses.

(4) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR).

(5) The department follows the rules in WAC 388-515-1325, 388-513-1330, and 388-513-1340 to determine available income and income exclusions.

(6) Current resource and income standards (including the SIL and FBR) for long-term care are found at:
http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

11-34 The Department of Social and Health Services, Aging and Disability Services Administration, did not perform background checks for some in-home care individual providers in accordance with state law.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Provider Eligibility	
Questioned Cost Amount:	$368,404.41 Non ARRA	
	$ 81,221.28 ARRA	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for low-income individuals who otherwise might go without medical care. The Medicaid program is the major source of public funding for long-term care services. The Medicaid Home and Community Based Services program permits states to furnish long-term care services to Medicaid beneficiaries in home and community settings, avoiding institutionalization. These services, generally personal care and assistance, are provided in the client's home by individuals or agencies often chosen by the Medicaid client.

During fiscal year 2011, the Department paid approximately $94 million to more than 14,000 in-home service individual providers for their services to 127,000 Medicaid clients.

All individual providers must meet basic qualifications to provide services to Medicaid clients. They must be at least 18 years old, authorized to work in the United States and meet the minimum training requirement.

Individual providers also must successfully complete a background check every two years. If the provider has lived in Washington State less than three years, the Department is to conduct a nationwide background check.

Description of Condition

We reviewed all 14,715 providers who provided services in fiscal year 2011 to ensure they have cleared a background check as required by state regulation.

We found the Department did not conduct background checks for 129 providers in a timely manner. The chart below summarizes the results of our audit.

Cause of Condition

The Department has procedures to ensure individual providers meet the background check requirements, however in some cases providers did not comply with the regulations before they provide services to

Medicaid clients. The Department stated most late background checks related to typos in its background check monitoring database and untimely communication between the Department and providers.

Effect of Condition and Questioned Costs

A provider who does not meet the background check requirement is not eligible to provide services to Medicaid clients. Any payments to ineligible providers are unallowable.

The table below summarizes the results of our work, and related expenditures:

Duration of Time Exceeding Background Check Date	Number of Providers	Questioned Costs	Federal share	
			Non-ARRA	ARRA
One to three months	67	$151,871.85	$75,981.49	$16,751.46
Four to six months	33	$215,871.33	$108,000.43	$23,810.61
Seven to nine months	11	$114,084.66	$57,076.56	$12,583.54
More than10 months	18	$254,539.13	$127,345.93	$28,075.67
Total	129	$736,366.97	$368,404.41	$81,221.28

The Department paid a total of $736,366.97 to the 129 providers who did not complete a required background check at the time of the services. We are questioning $449,625.69, the federal portion of the unallowable costs[1].

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

Recommendation

We recommend the Department:

- Ensure all providers have cleared background checks prior to providing services to Medicaid clients.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Department's Response

The Department concurs with this finding and will work to ensure that each Area Agency on Aging (AAA) has a strong tracking system in place to ensure that all providers have current background checks and that authorizations are terminated when the provider is noncompliant with background check requirements.

The Department is providing the following clarification to the auditor's statements in the "Cause of Condition" section of this report:

- *The Department has policies for AAAs to ensure individual providers meet the background check requirements; however the policies will be strengthened to ensure full compliance with this requirement. In 128 of the 129 cases where background checks were not conducted timely, providers were due for their two year renewal background check, but had passed a previous background check. For many of these findings, AAAs made multiple attempts to obtain a background authorization form from the providers in order to run new background checks, and providers did not always respond timely to these requests.*

[1] The federal share is calculated by using 61.06 percent, which is an average of FMAP rates for fiscal year 2011.

- *Most of the late background check findings were specific to one Area Agency on Aging that was using a less reliable data source for determining due dates for background check renewals. The Department is working closely with the AAA to implement a new tracking system by March 15, 2012. The new system will ensure that all providers due for background checks will be identified and notified prior to the due date.*
- *In a few instances, the background checks were not conducted timely due to typos in the background check monitoring database.*

Through a Management Bulletin (MB) the Department will direct the field to:

- *Require that effective tracking systems and procedures are in place to ensure that all providers have current background checks.*
- *Require that payments be terminated for providers who are out of compliance in this area.*
- *Terminate contracts for those providers who repeatedly fail to comply with requests to have a current background check.*
- *Include language stating, 'failure to obtain the required background check will result in payment termination and may result in contract termination' in written reminders sent to providers.*

The MB will also advise Area Agencies on Aging (AAAs) of contract actions that may be taken by the Department if performance to this metric is deemed non-compliant.

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.

OMB Circular A-87: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

> 1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
>
> k. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
>
> l. Be allocable to Federal awards under the provisions of 2 CFR part 225.
>
> m. Be authorized or not prohibited under State or local laws or regulations.
>
> n. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
>
> o. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

RCW 74.39A.056 states:

> Criminal history checks on long-term care workers.

(1) All long-term care workers for the elderly or persons with disabilities hired after January 1, 2012, shall be screened through state and federal background checks in a uniform and timely manner to ensure that they do not have a criminal history that would disqualify them from working with vulnerable persons. These background checks 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.
(2) To allow the department of health to satisfy its certification responsibilities under chapter 18.88B RCW, the department shall share state and federal background check results with the department of health. Neither department may share the federal background check results with any other state agency or person.
(3) The department shall not pass on the cost of these criminal background checks to the workers or their employers.
(4) The department shall adopt rules to implement the provisions of this section by August 1, 2010.

WAC 388.71.0510 states:

How does a person become an individual provider?

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) Picture identification; and
    (b) A Social Security card; or
    (c) Authorization to work in the United States.
(3) Complete and submit to the social worker/case manager/designee the department's criminal conviction background inquiry application, unless the provider is also the parent of the adult DDD client and exempted, per chapter 74.15 RCW;
    (a) Preliminary results may require a thumb print for identification purposes;
    (b) An FBI fingerprint-based background check is required if the person has lived in the state of Washington less than three years.
(4) Sign a home and community-based service provider contract/agreement to provide services to a COPES, MNIW, or medicaid personal care client.

Aging and Disability Services Administration Long Term Care Manual Chapter 7A- In-home Provider Requirement states:

How often does a background check need to be completed on a provider?

Every two years, unless you have reasonable cause to believe that the provider has been arrested or convicted of a disqualifying crime. In this circumstance, you need to re-run another background check.

11-35 The Department of Social and Health Services, Aging and Disability Services Administration does not have adequate controls to ensure Medicaid recipients have received the services for which Medicaid is billed.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
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	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Utilization Control and Program Integrity	
Questioned Cost Amount:	None	

Background

Federal regulations require state Medicaid agencies to have a process to verify with Medicaid clients that they received the services billed to Medicaid by providers. This process is intended to identify potential fraud or abuse of the Medicaid program.

The Medicaid program is the major source of public funding for long-term care services. The Home and Community Based Services waiver program permits states to furnish long-term care services to Medicaid beneficiaries in home and community settings to avoid institutionalization. The client or agencies working on behalf of the client choose the service providers.

The Department of Social and Health Services, Aging and Disability Services Administration, administers long-term services and support and is responsible for instituting and following the recipient verification process.

In the past three audits, we reported findings regarding the Department's lack of adequate controls to ensure Medicaid payments to in-home service providers are allowable and supported.

The Division paid more than $579 million for in-home services during fiscal year 2011.

Description of Condition

During our current audit, we found no changes in the conditions we previously reported. The Administration does not have procedures to verify with home- and community-based service Medicaid clients whether services billed by providers were received.

Cause of Condition

The Department states it plans to use a feature available in its new Medicaid payment system, ProviderOne, that will automatically send selected clients an explanation of services billed by providers in order to verify those services were received. This system is scheduled to be operational in 2012. The Department does not believe putting an interim automated solution in place is prudent or cost-effective.

Effect of Condition

The lack of appropriate, required verification increases the risk of fraudulent provider claims being paid and not being detected in a timely manner, if at all.

Recommendation

We recommend the Department develop and follow a process for verifying directly with recipients that they have received the services for which Medicaid is being billed.

Department's Response

The department does not concur with the finding that the "Administration does not have procedures to verify with home and community-based service Medicaid recipients whether services billed by providers were received". The Department has strong controls in place currently to ensure that recipients receive services for which Medicaid is being billed. In addition to these controls, the Department has recently implemented additional controls and is also exploring additional electronic solutions to verify service receipt.

Current Controls:
The department relies on the following controls that are currently in place:

- *Case managers complete an assessment that results in an authorization of hours that cannot be exceeded by a provider invoice.*
- *Recipients receive a copy of the service summary that tells them the number of hours of service they are eligible to receive. Recipients are advised they can choose when those hours are provided and direct the individual provider when to provide them. Case Managers also advise recipients to contact them if they are not receiving the hours (or care) for which they are eligible.*
- *Recipients are expected to keep copies of timesheets for their individual providers. Case Managers periodically review these time sheets and verify with the recipient that authorized services have been provided. Case managers are instructed to document the review of time sheets and the discussion of service verification in a Service Episode Record.*
- *Timesheet auditing has been added to the annual Quality Assurance monitoring cycle.*
    - *In August 2011, all IPs delivering personal care services received a written reminder of their obligation to keep a record of the date/time that in-home services are provided to ADSA recipients and complete and retain copies of their timesheets.*
    - *In September 2011, ADSA audited a statistically valid sample of IP time sheets to ensure that services billed for were consistent with timesheet documentation submitted. In instances where the billed hours differed from timesheet records or timesheets were not provided, service receipt was verified with the recipient. Corrective actions were taken which included contract termination and processing overpayments.*
- *The Department, through its Payment Review Program, runs algorithms to detect possible fraudulent claims. Overpayments are initiated and referrals are made to the Medicaid Fraud Control Unit as indicated by findings.*
- *The Social Service Payment System will not process payments in excess of hours authorized. A provider is therefore unable to claim and be reimbursed for hours that exceed those authorized by the case manager.*

New Controls:
The Department has added service verification monitoring to the Quality Assurance monitoring cycle. Monitoring will be completed on a randomly-selected, statistically-valid sample of in-home

providers. In October 2012, the Department will verify with the selected recipients that Medicaid billed services were received. Based on the findings, correction action will be taken. Such action might include processing of overpayments, procuring the needed services that were not provided, terminating contracts with the providers, and referrals to the Medicaid Fraud Control Unit for further action.

In addition to service verification monitoring, time sheet monitoring will continue to be a component of the annual Quality Assurance monitoring cycle.

Additional Electronic Controls:
If the final budget does not include funding for ProviderOne Phase Two, the Department will continue to explore additional electronic options to verify that clients received the services authorized.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

The auditee shall:

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

Title 42, code of Federal Regulations, Section 455 states in part:

§455.1 Basis and scope.
This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control.

(a) Under the authority of sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act, Subpart A provides State plan requirements for the identification, investigation, and referral of suspected fraud and abuse cases. In addition, the subpart requires that the State—
   (1) Report fraud and abuse information to the Department; and
   (2) Have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients.
(b) Subpart B implements sections 1124, 1126, 1902(a)(36), 1903(i)(2), and 1903(n) of the Act. It requires that providers and fiscal agents must agree to disclose ownership and control information to the Medicaid State agency.
(c) Subpart C implements section 1936 of the Act. It establishes the Medicaid Integrity Program under which the Secretary will promote the integrity of the program by entering into contracts with eligible entities to carry out the activities of subpart C.

[51 FR 34787, Sept. 30, 1986, as amended at 72 FR 67655, Nov. 30, 2007]

§455.20 Recipient verification procedure.

(a) The agency must have a method for verifying with recipients whether services billed by providers were received.
(b) In States receiving Federal matching funds for a mechanized claims processing and information retrieval system under part 433, subpart C, of this subchapter, the agency must provide prompt written notice as required by §433.116 (e) and (f).

11-36 The Department of Social and Health Services, Aging and Disability Services Administration, does not have adequate controls in place to ensure all applicant-owned assets are counted when Medicaid eligibility is determined.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Eligibility	
Questioned Cost Amount:	None	

Background

The Medicaid program covers long-term care services for individuals who are unable to afford it. In order to ensure the availability of long-term care services for people who truly need them, the Federal Deficit Reduction Act of 2005 tightened Medicaid rules to make it more difficult for individuals with resources to pay for their own long-term care to inappropriately transfer assets for less than fair market value in order to qualify for coverage.

When an individual applies for Medicaid coverage for long-term care, the state conducts a review, or "look-back", to determine whether the individual (or his or her spouse) transferred assets to another person or party for less than fair market value to become eligible. The Act lengthened the "look-back period" to 60 months (five years) prior to the date of the application.

When an individual transfers assets at less than fair market value in order to qualify for Medicaid long-term care services, he or she is subject to a penalty that delays the date Medicaid long-term care services begin. Under the Act, the penalty period for transfers made on or after February 8, 2006, begins on either the date of the asset transfer or the date the individual is determined to be eligible for Medicaid coverage, whichever is later.

The Department of Social and Health Services, Aging and Disability Services Administration, administers long-term care services under Medicaid. In fiscal year 2011, the Department spent almost $1.5 billion on these services.

Description of Condition

In our past three audits we reported findings relating to the Department's inadequate controls over the look-back. In answer to our previous year's finding, the Department responded that it did not concur with the finding and believed relying on self-declaration by the client regarding asset transfers or sales within is sufficient.

During our current audit, we found no changes in the conditions reported in our previous three audits:

- The Department limits its review to the client's bank statements, which does not provide a reasonable picture of the applicant's financial situation over the five-year look-back period or to ensure the Department is able to identify all assets owned or transferred by applicants.

- The Department relies on a self-declaration from the client that he or she has not transferred or sold any assets within the past five years.

Cause of Condition

The Department does not agree that federal rules require review of financial activities for the previous five years, unless a client declares he or she made an asset transfer or sale, or if it finds inconsistent information in financial records or other problems with the application.

Effect of Condition

Lack of adequate procedures to identify the financial resources of applicants when Medicaid eligibility is determined increases the risk of ineligible individuals receiving long-term care through the Medicaid program.

Recommendation

We recommend the Department establish and follow internal controls that will reasonably ensure all assets applicants own during the look-back period are counted when Medicaid eligibility is determined.

Department's Response

The Department does not concur with this finding. Our reasons for not concurring are the same reasons provided in response to prior audits. However, we do have new information about real estate and vehicles owned or transferred by clients during the five year look-back period.

The "Description of Condition" by the SAO states that the Department limits its review to bank statements and self-declaration, and finds this method to be sufficient. The description leaves out other things we are doing in order to evaluate resources held or transferred such as contacting assessors' offices. More importantly, it fails to acknowledge that the Department has not had systems in place to obtain most or all of the client's financial history in a manner that is cost-effective and would meet other federal requirements for standards of promptness and an application process that is simple and is in the best interest of the majority of applicants and recipients. We have pointed out these facts each year.

The Department recently executed a contract with LexisNexis for a trial of their database software that provides records of property and vehicles owned or transferred during the last five years and beyond. We analyzed the file for 1535 current recipients and found that properties and transfers we know about were found. In addition, we found a small number of properties and transfers we did not know about and apparently were not reported. We plan to purchase at least one license for each HCSO in the near future and screen each new applicant with the product prior to the initial interview. While the trial does not indicate that we have a large number of cases with unreported properties or transfers, it will only take a couple of cases for this type of cost avoidance to cover our costs.

Should a similar tool become available that offers a history of transactions at banks and other financial institutions we will evaluate it and purchase licenses if it is a good product that is cost-effective.

In the meantime, all of our previous reasons for non-concurrence are still applicable:

- *Requiring clients to provide five years of bank statements would only pertain to bank accounts that are declared. No system is in place to identify undeclared bank accounts and other types of undeclared transfers which is the primary reason for reliance on self-declaration.*
- *Most clients do not have proof of all financial activities that occurred during the last five years, which would be all of their financial statements from banks and other financial institutions. This is a very onerous request to make of clients, most of whom have not transferred assets in order to qualify. The process that the client or Department would have to go through to provide that much history would be lengthy and expensive, and would not meet the federal requirement in 42CFR*

435.902 that an agency's policies and procedures for determining eligibility must be conducted in a manner consistent with simplicity of administration and is in the best interests of applicants and recipients.

- *The Department would have to pay banks to provide archived statements that the clients no longer have per WAC 388-490-0005(7). The length of time it would take to request and then review a minimum of 60 bank statements, with the possibility of hundreds more if there are multiple accounts at different banks, would make it impossible to meet our standard of promptness for Medicaid applications with existing staff. Many additional FTEs would be required. Requiring all clients to provide 60 months of bank statements would not be cost-effective.*
- *Unless transfers were made with the intent of qualifying for long-term care benefits the Department cannot impose a transfer penalty. RCW 74.08.080(2)(g) states that the burden is on the department to prove by a preponderance of the evidence that the person knowingly and willingly assigned or transferred the resource at less than fair market value for the purpose of qualifying…for medical assistance". Applicants who have or had enough resources to consider transferring assets are usually applying for public assistance for the first time. If transfers occurred between 2 – 5 years prior to applying, what we find is that those persons were usually unaware of Medicaid policies at that time because they were in reasonably good health, were not contemplating future long-term care needs, and were simply helping family members. If they were transferring assets to qualify that long ago it is often difficult to prove. Specific planning for future Medicaid eligibility usually occurs within a few months of the application.*
- *The Department is committed to ensuring that Medicaid clients are financially eligible for the program benefits that they receive and will continue to pursue and verify any asset transfers that it becomes aware of through the written application, the subsequent interview, or discovered through other means. Applicants complete the DSHS Application for Benefits. This form specifically asks if the applicant or applicant's spouse has sold, traded, given away, or transferred a resource in the last five years, and if so, what and when. The application states that the person signing it is declaring an understanding that they can be criminally prosecuted for making a false statement or failing to report something. The signature certifies and declares under penalty of perjury under the laws of the State of Washington that the information given is true and correct. In addition, the Department is taking the following actions:*

    - *Staff will routinely check online county assessor systems to see if clients have transferred property within the county they reside in.* ***(purchase of LexisNexis software will make this step obsolete)***
    - *If the bank statements from the last three or six months contain payments or credits that present red flags we will look as far into this as necessary to resolve the issue.*
    - *If the client declares a transfer, staff will request and obtain verification and thoroughly evaluate that transfer to ensure that it is consistent with Medicaid rules.*
    - *If the interview is inconsistent with the application, staff will evaluate and probe inconsistencies as necessary.*
    - *If staff learn of possible transfers through other means they always follow-up and verify.*

The Department submitted policies and procedures to Maria Garza, our regional representative at Region 10 CMS, in June 2009. We asked them to review them and comment on whether they meet federal guidelines. We received CMS' email response December 22, 2009. The following is a direct quote from the CMS email:

> *"While we understand your dilemma with the State Auditor's Office on the matter of documenting 5-years of bank statement to ensure all assets of applicants during the look-back period are countable when Medicaid eligibility is determined. The CMS cannot specifically comment on the state process for conducting the 5-year look back for transfer of assets which could impact a state's flexibility in documenting and verifying these transfers. This continues to be an operational matter, states have flexibility to implement this provision according to the general "rules of reason" and to give workers procedural guidance as to how to explore or document past financial transactions that might have been asset transfers. CMS affirms the initial guidance on flexibility given to states to implement policies that provide for looking back 5 years.*

The 5-year look back period only changes for transfer made after February 8, 2006, the effective date of the law. States are actively engaged in the pursuit of the asset verification systems which will provide for external verification of the reported financial information made by applicants, until then states must have sufficient procedures to capture and verify the reported client information.

If you require any additional information please let me know.

Maria"

The Department believes this response validates our position that asking for bank statements for the entire look-back period is not required. The Department believes the methods described above meet the "rules of reason" test referred to by CMS in their email.

Auditor's Remarks

We thank the Department for its response and commitment to continuing discussions on this issue. We expect the Department to have internal controls that will reasonably ensure all assets applicants own during the look-back period are countable when Medicaid eligibility is determined. The current internal controls the Department has cannot provide a reasonable picture of the applicant's financial situation over the five year look-back period.

We look forward to reviewing the new controls the Department plans to implement during our next audit.

Applicable Laws and Regulations

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

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

Title 42, United States Code, section 1396p, as amended by the Deficit Reduction Act of 2005, states in part:

> (c)(1)(B)(i) The look-back date specified in this subparagraph is a date that is … (…in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005, 60 months) before the date specific in clause (ii).
>
> (c)(1)(D)(ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

Revised Code of Washington 74.08.335, Transfers of property to qualify for assistance, states:

> Temporary assistance for needy families and disability lifeline benefits shall not be granted to any person who has made an assignment or transfer of property for the purpose of rendering himself or herself eligible for the assistance. There is a rebuttable presumption that a person who has transferred or transfers any real or personal property or any interest in property within two years of the date of application for the assistance without receiving adequate monetary consideration

therefore, did so for the purpose of rendering himself or herself eligible for the assistance. Any person who transfers property for the purpose of rendering himself or herself eligible for assistance, or any person who after becoming a recipient transfers any property or any interest in property without the consent of the secretary, shall be ineligible for assistance for a period of time during which the reasonable value of the property so transferred would have been adequate to meet the person's needs under normal conditions of living: PROVIDED, That the secretary is hereby authorized to allow exceptions in cases where undue hardship would result from a denial of assistance.

Revised Code of Washington 74.39A.160, Transfer of assets — Penalties, states:

(1) A person who receives an asset from an applicant for or recipient of long-term care services for less than fair market value shall be subject to a civil fine payable to the department if:
   (a) The applicant for or recipient of long-term care services transferred the asset for the purpose of qualifying for state or federal coverage for long-term care services and the person who received the asset was aware, or should have been aware, of this purpose;
   (b) Such transfer establishes a period of ineligibility for such service under state or federal laws or regulations; and
   (c) The department provides coverage for such services during the period of ineligibility because the failure to provide such coverage would result in an undue hardship for the applicant or recipient.
(2) The civil fine imposed under this section shall be imposed in a judicial proceeding initiated by the department and shall equal (a) up to one hundred fifty percent of the amount the department expends for the care of the applicant or recipient during the period of ineligibility attributable to the amount transferred to the person subject to the civil fine plus (b) the department's court costs and legal fees.
(3) Transfers subject to a civil fine under this section shall be considered null and void and a fraudulent conveyance as to the department. The department shall have the right to petition a court to set aside such transfers and require all assets transferred returned to the applicant or recipient.

11-37 The Health Care Authority and the Department of Social and Health Services do not have adequate controls to correctly report all Medicaid expenditures that are eligible for additional Children Health Insurance Program (CHIP) funds.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.720 State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775 State Medicaid Fraud Controls
	93.776 Hurricane Katrina Relief Program
	93.777 State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA
Applicable Compliance Component:	Activities Allowed; Cost Principles; Reporting
Questioned Cost Amount:	None

Background

In Washington, Medicaid and the Children's Health Insurance Program (CHIP) provide medical assistance for children through age 18 who reside in certain low-income households. Both are jointly financed by the state and federal government.

The state is required to pay CHIP and Medicaid expenditures and may seek reimbursement from the federal government for eligible costs. The state is reimbursed for approximately 65 percent of its CHIP expenditures and 50 percent of Medicaid expenditures. The American Recovery and Reinvestment Act of 2009 increased the Medicaid reimbursement rate to approximately 62 percent.

Medicaid expenditures for children who reside in households with income between 133 percent and 200 percent of the Federal Poverty Level are eligible for CHIP funding. When states identify eligible Medicaid expenditures, they may claim the higher CHIP reimbursement rate. If the Medicaid costs already have been claimed and reimbursed, the state still can claim the difference between the Medicaid and CHIP rates.

The federal government awards states an annual CHIP allotment. States must return any unused amounts. The total CHIP allotment for the state for the last five years was approximately $418 million; the state spent and was reimbursed approximately $155 million, has returned the excess $199 million.

The table below summarizes the CHIP allotment, claimed amounts and returned amounts for the last five federal fiscal years:

FFY	CHIP Allotment	Claimed Amount	Returned
FFY2006	$ 64,705,479	$ 41,485,854	$ 23,219,625
FFY2007	$ 79,883,308	$ 35,411,865	$ 44,471,443
FFY2008	$ 79,883,308	$ 36,071,047	$ 43,812,261
FFY2009	$ 94,285,111	$ 6,642,932	$ 87,642,179
FFY2010	$ 99,438,161	$ 35,579,863	[1]

1. As of June 30, 2011. The returned amount of FFY2010 allotment will be determined when the allotment is closed.

Description of Condition

Federal regulations say the same income criteria used to determine eligibility for Medicaid clients should be used to identify Medicaid expenditures eligible for the additional CHIP funds. The Department uses net income to determine eligibility for the Medicaid program.

In our audit for fiscal year 2010, we recommended the Department use correct income criteria in determining Medicaid children who are eligible for additional CHIP money. During the current audit, we found the Department still incorrectly used gross income, rather than net income, to determine CHIP funds eligible Medicaid clients.

We also noted the Department did not have adequate procedures to account for all Medicaid expenditures that might qualify for additional CHIP funds.

Cause of Condition

The Department is working on developing a system. However, due to the complexity of extracting necessary information from its eligibility database, gross income was still used to identify eligible Medicaid expenditures during the audit period.

Prior to 2009, states could use only up to 20 percent of their CHIP allotment for additional reimbursements for eligible Medicaid expenditures. The Department had been able to identify enough eligible Medicaid expenditures in the Medicaid payment system to claim that 20 percent. In 2009, a change in federal regulation eliminated the 20 percent limit on these types of costs. The Department continued to look only to limited Medicaid claim data to identify costs eligible for transfer to CHIP, instead of searching the entire Medicaid data base for potentially eligible claims.

Effect of Condition

Since the Department used incorrect criteria to identify Medicaid expenditures for additional CHIP funds, it cannot ensure those costs were eligible for transfer and the higher reimbursement rate.

Because the Department did not identify all eligible Medicaid costs, it did not claim all available CHIP funds available to the state. During our audit we noted that the Department did not account for managed care premium payments for Medicaid children in the amount of $517 million incurred in 2010 when it claimed additional CHIP funds. A portion of those payments are eligible for additional CHIP funds. Because accurate client eligibility data was not available, we were unable to determine the exact amount of eligible payments.

Recommendation

We recommend the Department:

- Ensure correct income criterion is used in determining Medicaid children who are eligible for additional CHIP funds.
- Develop systems to ensure all current and future Medicaid costs eligible are identified and claimed from CHIP to the extent possible.
- Review CHIP funds claimed and work with the U.S. Department of Health and Human Services to determine if any costs charged to CHIP funds must be refunded.

Department's Response

The Health Care Authority agrees with the finding and is taking the following corrective actions:

1. *The agency will develop a report using data from its Medicaid Management Information System to identify claims by Recipient Aid Category (RAC) and Federal Poverty Level (FPL) based on net income.*

2. *In November 2011, the agency retroactively transferred all eligible Managed Care claims to CHIP. The agency is currently working with the Washington State Department of Social and Health Services' Aging and Disability Services Administration (ADSA) to ensure all eligible Medicaid claims for clients are transferred to CHIP.*

3. *The Health Care Authority now monitors CHIP funds on a monthly basis, and an internal staff workgroup conducts an additional review using an Excel tracking spreadsheet with data from Agency Financial Reporting System (AFRS) to ensure accuracy and proper use of funds.*

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.

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)[67], a qualifying State (as defined in paragraph (2)) may elect to use not more than 20 percent of any allotment under section 2104 for fiscal year 1998, 1999, 2000, 2001, or 2004, 2005, 2006, 2007, or 2008[68] (insofar as it is available under subsections (e) and (g) of such section) for payments under title XIX in accordance with subparagraph (B), instead of for expenditures under this title.

(B) Payments to states.—

(i) In general.—In the case of a qualifying State that has elected the option described in subparagraph (A), subject to the availability of funds under such subparagraph with respect to the State, the Secretary shall pay the State an amount each quarter equal to the additional amount that would have been paid to the State under title XIX with respect to expenditures described in clause (ii) if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)).

(ii) Expenditures described.—For purposes of this subparagraph, the expenditures described in this clause are expenditures, made after the date of the enactment of this subsection and during the period in which funds are available to the qualifying State for use under subparagraph (A), for medical assistance under title XIX to individuals who have not attained age 19 and whose family income exceeds 150 percent of the poverty line.

(iii) No impact on determination of budget neutrality for waivers.—In the case of a qualifying State that uses amounts paid under this subsection for expenditures described in clause (ii) that are incurred under a waiver approved for the State,

any budget neutrality determinations with respect to such waiver shall be determined without regard to such amounts paid.

(2) Qualifying state.—In this subsection, the term "qualifying State" means a State that, on and after April 15, 1997, has an income eligibility standard that is at least 184 percent of the poverty line with respect to any 1 or more categories of children (other than infants) who are eligible for medical assistance under section 1902(a)(10)(A) or, in the case of a State that has a statewide waiver in effect under section 1115 with respect to title XIX that was first implemented on August 1, 1994, or July 1, 1995, has an income eligibility standard under such waiver for children that is at least 185 percent of the poverty line, or, in the case of a State that has a statewide waiver in effect under section 1115 with respect to title XIX that was first implemented on January 1, 1994, has an income eligibility standard under such waiver for children who lack health insurance that is at least 185 percent of the poverty line, or, in the case of a State that had a statewide waiver in effect under section 1115 with respect to title XIX that was first implemented on October 1, 1993, had an income eligibility standard under such waiver for children that was at least 185 percent of the poverty line and on and after July 1, 1998, has an income eligibility standard for children under section 1902(a)(10)(A) or a statewide waiver in effect under section 1115 with respect to title XIX that is at least 185 percent of the poverty line.

(3) Construction.—Nothing in paragraphs (1) and (2) shall be construed as modifying the requirements applicable to States implementing State child health plans under this title.

(4) [69] Option for allotments for fiscal years 2009 through 2013.—

(A) Payment of enhanced portion of matching rate for certain expenditures.—In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State's allotment made under section 2104 for any of fiscal years 2009 through 2013 (insofar as the allotment is available to the State under subsections (e) and (m) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under title XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)).

(B) Expenditures described.—For purposes of subparagraph (A), the expenditures described in this subparagraph are expenditures made after the date of the enactment of this paragraph and during the period in which funds are available to the qualifying State for use under subparagraph (A), for the provision of medical assistance to individuals residing in the State who are eligible for medical assistance under the State plan under title XIX or under a waiver of such plan and who have not attained age 19 (or, if a State has so elected under the State plan under title XIX, age 20 or 21), and whose family income equals or exceeds 133 percent of the poverty line but does not exceed the Medicaid applicable income level.

11-38 The Health Care Authority does not comply with state law and the federal Deficit Reduction Act of 2005, increasing the likelihood that the state is paying claims that should have been paid by liable third parties.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles	
Questioned Cost Amount:	None	

Background

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

The federal Deficit Reduction Act of 2005 requires health insurers to provide states with eligibility and coverage information that will enable Medicaid agencies to determine whether recipients have third-party coverage. The Act directs states, as a condition of receiving Medicaid money, to have laws requiring health insurers doing business in that state to provide the eligibility and coverage information upon the request of the state.

To comply with this requirement, the state Legislature passed a law (RCW 74.09A) in 2007 that requires the Authority to provide Medicaid client eligibility and coverage information to insurers doing business in the state. The insurers are required to use that information to identify Medicaid clients with third-party coverage and to provide those results to the Authority. The law requires this process to be performed no less than twice per year. The law, if followed, would provide a comprehensive identification of potential third-party payers.

In our past three audits, 2008 through 2010, we reported findings regarding the Authority's noncompliance with the state law. In other audits performed by our Office, we identified 567 claims with Medicaid payments totaling $22,592 that were duplicates of workers' compensation insurance payments made the by Department of Labor and Industries.

The state had Medicaid expenditures of approximately $7.5 billion in fiscal year 2011, more than $4.7 billion of which was federal dollars.

Description of Condition

The Authority has not performed the semi-annual data share with insurers as required by state law.

Cause of Condition

The Authority believes it is meeting the requirements of state law and federal regulation by making data available to all insurers without exchanging eligibility and coverage data.

Effect of Condition

When Medicaid-eligible individuals with third-party liability coverage are not identified, Medicaid is no longer the payer of last resort and the Authority is paying claims that should have been paid by liable third parties.

Recommendation

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

Department's Response

The agency continues to disagree with this finding.

The agency maintains that it is in compliance with the Deficit Reduction Act of 2005 (DRA) and applicable state law. The Department meets this standard by making data available to all insurers to use for Third Party Liability (TPL) reporting and by matching data directly with those insurers most likely to provide third party coverage to Medicaid recipients.

The agency is taking the following steps to enhance its recovery effort:

- *Submitted a system change request to incorporate a tool that the federal Centers for Medicare and Medicaid Services (CMS) has identified for DRA data exchange requirements. This activity could not be pursued until CMS issued its guidance in June 2010. The agency will implement the change request based on prioritization against all other system change requests in their order of importance.*

- *The agency's position on compliance was further corroborated by an independent review conducted by Health Management Systems (HMS) in March 2010. That review stated, "HMS's review of the DSHS confirms a strong Medicaid TPL program…" This report also noted areas of industry best practices that the agency could explore to enhance its cost avoidance and recovery. As a result of this review, the agency entered into a contract with HMS to strengthen and improve our efforts in the area of TPL recoveries as HMS provides for enhanced data-matching to better identify a client's medical insurance coverage. The contracted activities include: conducting electronic data exchanges with health insurers, and verifying and updating the insurance eligibility of Medicaid recipients for billing liable third parties on behalf of HCA.*

Although the agency has been in compliance with the DRA since it was passed into law in April 2007, the above actions demonstrate how HCA continues to improve ways to share Medicaid information with health insurers so the state is <u>not</u> paying for claims that should have been paid by a liable third party.

Auditor's Remarks

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

Applicable Laws and Regulations

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

The auditee shall:

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

Title 42, United States Code, Part 1396a(a)(25).states:

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 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) to pay for care and services available under the plan, including—
  (i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and
  (ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396*o* of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396*o* of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396*o* of this title), exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall--
  (i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and
  (ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall--

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)], a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this subchapter for such State, or any other State;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

(i) provide, with respect to individuals who are eligible (and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with section 1396a(e)(13)(D) of this title) for, or are provided, medical assistance under the State plan under this subchapter (and, at State option, child health assistance under subchapter XXI), upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if—

(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

Revised Code of Washington (RCW) 74.09A.005 states:

The legislature finds that:

(1) Simplification in the administration of payment of health benefits is important for the state, providers, and health insurers;

(2) The state, providers, and health insurers should take advantage of all opportunities to streamline operations through automation and the use of common computer standards;
(3) It is in the best interests of the state, providers, and health insurers to identify all third parties that are obligated to cover the cost of health care coverage of joint beneficiaries; and
(4) Health insurers, as a condition of doing business in Washington, must increase their effort to share information with the department and accept the department's timely claims consistent with 42 U.S.C. 1396a(a)(25).

Therefore, the legislature declares that to improve the coordination of benefits between the department of social and health services and health insurers to ensure that medical insurance benefits are properly utilized, a transfer of information between the department and health insurers should be instituted, and the process for submitting requests for information and claims should be simplified.

RCW 74.09A.020 states:

Computerized information — Provision to health insurers.

(1) The department shall provide routine and periodic computerized information to health insurers regarding client eligibility and coverage information. Health insurers shall use this information to identify joint beneficiaries. Identification of joint beneficiaries shall be transmitted to the department. The department shall use this information to improve accuracy and currency of health insurance coverage and promote improved coordination of benefits.
(2) To the maximum extent possible, necessary data elements and a compatible database shall be developed by affected health insurers and the department. The department shall establish a representative group of health insurers and state agency representatives to develop necessary technical and file specifications to promote a standardized database. The database shall include elements essential to the department and its population's health insurance coverage information.
(3) If the state and health insurers enter into other agreements regarding the use of common computer standards, the database identified in this section shall be replaced by the new common computer standards.
(4) The information provided will be of sufficient detail to promote reliable and accurate benefit coordination and identification of individuals who are also eligible for department programs.
(5) The frequency of updates will be mutually agreed to by each health insurer and the department based on frequency of change and operational limitations. In no event shall the computerized data be provided less than semiannually.
(6) (6) The health insurers and the department shall safeguard and properly use the information to protect records as provided by law, including but not limited to chapters 42.48, 74.09, 74.04, 70.02, and 42.56 RCW, and 42 U.S.C. Sec. 1396a and 42 C.F.R. Sec. 43 et seq. The purpose of this exchange of information is to improve coordination and administration of benefits and ensure that medical insurance benefits are properly utilized.
(7) The department shall target implementation of this section to those health insurers with the highest probability of joint beneficiaries.

Washington Administrative Code 182-501-0200 states:

(1) The department requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.
(2) The department pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:

(a) Prenatal care;
(b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or
(c) Preventive pediatric services as covered under the EPSDT program.

(3) The department pays for medical services and seeks reimbursement from any liable third party when both of the following apply:
(a) The provider submits to the department documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and
(b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:
(i) Is not complying with an existing court order; or
(ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill the department or the client for a covered service when a third party pays a provider the same amount as or more than the department rate.

(5) When the provider receives payment from the third party after receiving reimbursement from the department, the provider must refund to the department the amount of the:
(a) Third-party payment when the payment is less than the department's maximum allowable rate; or
(b) The department payment when the third-party payment is equal to or greater than the department's maximum allowable rate.

(6) The department is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills the department, except as described under subsections (2) and (3) of this section.

(7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:
(a) Receives direct third-party reimbursement for such services; or
(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.

(8) The department considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.

(9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.

(10) For third-party liability on personal injury litigation claims, the department is responsible for providing medical services as described under WAC 388-501-0100.

11-39 The Health Care Authority did not investigate information on potential Medicaid fraud or abuse in accordance with federal law, risking the loss of Medicaid resources.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Utilization Control and Program Integrity	
Questioned Cost Amount:	None	

Background

Federal regulations require state Medicaid agencies to have a process to verify with Medicaid clients whether they received services billed by providers. This process is intended to improve program integrity and to identify potential fraud or abuse of the Medicaid program.

The Health Care Authority is responsible for this process, including selecting claims for verification from all eligible claims paid within the last 45 days, sending Medical Services Verification surveys to clients and following up when questions regarding the legitimacy of a claim arise. Federal regulations do not require 100 percent verification; a sampling method may be used. Under federal rule, certain types of claims are exempt from this process.

The Authority sends clients a survey asking if they received the listed services. Authority staff review returned surveys and identify responses that require follow up. Regulations require follow up for surveys in which clients indicate they did not receive the service and/or paid for the service listed.

If follow-through identifies credible suspicions of fraud or abuse, the Authority is to forward that information to the State Attorney General's Office Medicaid Fraud Control Unit. The Centers for Medicare and Medicaid Services (CMS), which is the federal agency that oversees Medicaid, estimated that improper Medicaid payments were $21.9 billion across the nation in fiscal year 2011.

The state had Medicaid expenditures of approximately $7.5 billion in fiscal year 2011, more than $4.7 billion of which was federal dollars.

Description of Condition

During fiscal year 2011, the Authority sent more than 34,662 surveys to clients. Over 11,600 (34 percent) were returned to the Authority. When it receives a negative response, the Authority must conduct a preliminary investigation to determine if it has sufficient basis to warrant a full investigation.

Medical Services Verification (MSV)	1st quarter	2nd quarter	3rd quarter	4th quarter	Total
MSVs sent	9,492	8,841	7,554	8,775	34,662
MSVs received	2,644	2,990	2,416	3,626	11,676
MSVs with negative response	59	113	75	173	420
MSVs received (%)	28%	34%	32%	41%	34%
MSVs with negative response (%)	2%	4%	3%	5%	4%

We found that for July 2010 through January 2011, the Authority followed up on all negative responses to determine if further investigation was necessary. It has not performed any follow-through since January 2011.

Cause of Condition

The Authority made the medical services verification process a low priority as it considers the process to have limited value. The Authority also stated it does not have adequate staffing to perform timely follow-through.

Effect of Condition

Due to the lack of timely follow-through on returned surveys, Medicaid fraud may go undetected and take away Medicaid resources that would otherwise be directed to the truly needy citizens of Washington.

We recommend the Department:

We recommend the Authority conduct a preliminary investigation on all returned surveys to determine whether there is sufficient basis to warrant a full investigation.

Department's Response

The agency does not agree with the finding that there is a "lack of timely follow-through on returned surveys" as there are no federal timeline requirements for Medical Services Verification reviews.

The Health Care Authority prioritizes its program integrity/SUR resources in areas that have proven to yield a higher return on investment. Data analytics have proven in the past to better identify suspicious provider patterns. Past investigations have been targeted on cases that have the highest potential to lead to a fraud or audit referral.

The SAO asked the Health Care Authority to review 10 surveys that SAO believed merited a full investigation. Agency staff determined that several of the claims contained inaccurate information stemming from inaccurate information and conversation data linked to the implementation of ProviderOne, the agency's new Medicaid Management Information System. Of the 10, only one was ultimately found to be worthy of a full investigation.

In its corrective action plan, the Health Care Authority will:

- *Conduct initial review on all returned surveys received between January 1, 2011, through June 30, 2011, to determine whether further review and prioritization of individual cases are warranted for detection Medicaid fraud.*

- *The Surveillance and Utilization Review unit will triage returned Medical Services Verification surveys in the future and follow up as resources are available.*

Auditor's Concluding Remarks

We thank the Authority for its response. When the Authority receives surveys in which clients indicate they did not receive the listed service, federal regulations require the Authority to conduct *a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. The Authority did not review negative responses it received since January 2011.*

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

Applicable Laws and Regulations

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

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

Title 42, Code of Federal Regulations, Section 455 states in part:

> §455.1 Basis and scope.
> This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control.
> (a) Under the authority of sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act, Subpart A provides State plan requirements for the identification, investigation, and referral of suspected fraud and abuse cases. In addition, the subpart requires that the State—
> (1) Report fraud and abuse information to the Department; and
> (2) Have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients.
> (b) Subpart B implements sections 1124, 1126, 1902(a)(36), 1903(i)(2), and 1903(n) of the Act. It requires that providers and fiscal agents must agree to disclose ownership and control information to the Medicaid State agency.
> (c) Subpart C implements section 1936 of the Act. It establishes the Medicaid Integrity Program under which the Secretary will promote the integrity of the program by entering into contracts with eligible entities to carry out the activities of subpart C.
> §455.13 Methods for identification, investigation, and referral.
> The Medicaid agency must have—
> (a) Methods and criteria for identifying suspected fraud cases;
> (b) Methods for investigating these cases that—
> (1) Do not infringe on the legal rights of persons involved; and
> (2) Afford due process of law; and
> (c) Procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials.
> §455.14 Preliminary investigation.
> 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.
> §455.15 Full investigation.
> 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 recipient has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.
(c) If there is reason to believe that a recipient has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

§455.20 Recipient verification procedure.
(a) The agency must have a method for verifying with recipients whether services billed by providers were received.
(b) In States receiving Federal matching funds for a mechanized claims processing and information retrieval system under part 433, subpart C, of this subchapter, the agency must provide prompt written notice as required by §433.116 (e) and (f).

Title 42, Code of Federal Regulations, Section 433.116 states in part:
FFP for operation of mechanized claims processing and information retrieval systems.
(a) Subject to 42 CFR 433.113(c), 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 (h) 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.)

11-40 The Health Care Authority's internal controls are insufficient to ensure payment rates for its Healthy Options managed care program are accurate.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles	
Questioned Cost Amount:	None	

Background

From July 2010 through June 2011, the state paid more than $1.34 billion to managed care organizations, an increase of more than $161 million over the previous year. During this period, the number of Medicaid clients enrolled in managed care programs increased by more than 14,000 and the average premium paid by the state increased by more than $13 per person. These payments include funds made available through the American Recovery and Reinvestment Act of 2009.

The Health Care Authority pays managed healthcare providers a uniform, pre-determined, per-patient monthly rate regardless of the number of times a patient is seen each month or the services provided. This is known as a capitation rate. Different managed health care plans may have different rates. Providers are required to submit information regarding the patient visit to the Authority, including the cost of the services and demographic, diagnostic and geographic data.

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

In a report in August 2010, the U.S. Government Accountability Office stated the accuracy and completeness of data used to set managed care rates is a critical component to ensure rates are appropriate. In fiscal years 2003 through 2010, we reported concerns regarding the Administration's lack of review of the accuracy of data received from providers that is used to determine the rates in this state.

Description of Condition

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

Cause of Condition

The Authority does not agree with the finding and believes its controls are sufficient to ensure data used in the rate-setting process is accurate and complete. Specifically, the Authority cites:

- The actuary's comparisons of data to managed healthcare providers' financial statements and prior year data, and a limited review of individual services provided by managed healthcare facilities.

- Fraud and abuse controls at the healthcare providers to prevent fraud.
- That it has had no findings regarding rate-setting in two Centers for Medicare and Medicaid Services (CMS) reviews.
- CMS approved its rates.

The controls the Authority cites are not specifically designed to verify the accuracy and completeness of the data, and therefore cannot be relied on to achieve that objective. A lack of identified fraud or findings by CMS does not reasonably ensure data integrity.

Effect of Condition

The Authority is increasing the risk that rates paid to providers are inaccurate.

Recommendation

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

Department's Response

The Health Care Authority continues to disagree with this audit finding.

There are sufficient controls in-place to assure that managed care rates are set based on the verified managed care organizations (MCO) actual costs of care. Actuarially certified, proprietary cost information is submitted directly to the agency's actuary. The actuary verifies the information submitted by comparing it to audited financial statements submitted to the Office of the Insurance Commissioner and encounter data submitted to the agency. As part of the verification, the actuary has the MCOs complete a reconciliation of cost information with encounter data. The actuary also does analysis of prior years, compares MCOs to each other and resolves outliers that arise from its verification and analyses with the MCOs.

The MCOs each have fraud and abuse controls. The controls provide reasonable assurance that the data used in rate-setting is accurate and complete. This assertion is supported by the fact that the agency has had no findings regarding rate setting in the Centers for Medicare and Medicaid Services (CMS) reviews and has had its rates consistently approved by CMS with their full understanding of our rate setting methodology.

Auditor's Remarks

We thank the Authority for its response. Without reviewing the accuracy and completeness of data used to set managed care rates, the Authority cannot ensure the rates are appropriate. We re-affirm our finding and will follow up during our next audit.

Applicable Laws and Regulations

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

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

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

> The Medicaid agency must implement a statewide surveillance and utilization control program that –
>
> 1. a. Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments

Title 42 CFR 438.6 Contract requirements, states in part:

(c) Payments under risk contracts —
- (1) Terminology. As used in this paragraph, the following terms have the indicated meanings:
  - (i) Actuarially sound capitation rates means capitation rates that—
    - (A) Have been developed in accordance with generally accepted actuarial principles and practices;
    - (B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and
    - (C) Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board. . .
- (3) Requirements for actuarially sound rates. In setting actuarially sound capitation rates, the State must apply the following elements, or explain why they are not applicable:
  - (i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population. . .
- (4) Documentation. The State must provide the following documentation:
  - (i) The actuarial certification of the capitation rates.
  - (ii) An assurance (in accordance with paragraph (c)(3) of this section) that all payment rates are—
    - (A) Based only upon services covered under the State plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).
    - (B) Provided under the contract to Medicaid-eligible individuals.

11-41 The Health Care Authority does not perform a retrospective drug use review of pharmaceutical claims data to identify patterns of fraud or abuse as required by federal law.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Utilization Control and Program Integrity	
Questioned Cost Amount:	None	

Background

Medicaid is a state and federal partnership that provides coverage for certain low–income individuals who might otherwise go without medical care. This coverage includes prescription drugs. The Authority paid more than $434 million to pharmacies for services to Medicaid clients in fiscal year 2011.

The Authority's point-of-sale system processes pharmaceutical claims for Medicaid client prescriptions. It runs each request for payment through a series of criteria, known as edits, within the system. The Authority pays the claims if they successfully pass all edits.

Federal laws require state Medicaid programs to have a retrospective drug use review program to identify patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary use. Medicaid administrators such as the Authority must do these reviews at least quarterly to examine the activities of physicians, pharmacists and Medicaid recipients. Federal law requires this examination to include an analysis of physicians' prescribing practices, drug use by patients and, where appropriate, dispensing practices of pharmacies.

A U.S Government Accountability Office report dated September, 2009, *Medicaid Fraud and Abuse Related to Controlled Substances*, stated it found tens of thousands of Medicaid beneficiaries and providers involved in potential fraudulent purchases of controlled substances, abusive purchases of controlled substances, or both, in Medicaid programs in California, Illinois, New York, North Carolina, and Texas.

In our audits for fiscal years 2008, 2009, and 2010, we reported concerns regarding the Authority's noncompliance with federal law that requires a retrospective drug use review of pharmaceutical claims date at least quarterly.

Description of Condition

During our audit, we found no changes in the conditions that we reported in our previous audits. The Authority does not perform a retrospective drug use review of pharmaceutical claims data at least quarterly as required by federal regulation.

Cause of Condition

The Authority believes its review of the medical appropriateness of prescribing and dispensing drugs is sufficient to fulfill the fraud and abuse-related requirements of federal law. It has not provided us any information on how often or how it does that analysis.

Effect of Condition

Because the Authority is not analyzing pharmaceutical claim data and other records to identify patterns of fraud, abuse, or misuse of Medicaid funds, it is increasing the risk these situations could occur and not be detected in a timely manner, if at all.

Recommendation

We recommend the Authority comply with federal law regarding quarterly analysis of pharmaceutical claims data to identify patterns of fraud, abuse, and misuse of pharmaceuticals paid for with Medicaid funds.

Department's Response

The agency disagrees with this finding.

The Auditor asserts that the Health Care Authority does not perform a retrospective drug use review of pharmaceutical claims data to identify patterns of fraud or abuse as required by federal law.

In fact, the Health Care Authority performs ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs, as required by 42 CFR § 456.709.

The agency agrees that federal regulation, specifically 42 CFR § 456.709, requires the Health Care Authority to have a retrospective drug use review program through which it conducts ongoing periodic examinations, at least quarterly, of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, inappropriate or medically unnecessary care. The Auditor's finding is in error because it fails to cite to or apply 42 CFR § 456.714 which operates to limit 42 CFR § 456.709.

42 CFR § 456.714 acknowledges that the retrospective drug use review requirements in 42 CFR § 456.709 are duplicative of the Surveillance and Utilization Review requirements provided for in 42 CFR Part 456, subpart A and 42 CFR Part 455. The regulation then expressly permits the Health Care Authority "to limit review activities to those that focus on what constitutes appropriate and medically necessary care to avoid duplication . . .." This is precisely what the Health Care Authority has done. The agency operates a robust Surveillance and Utilization Review program. The Health Care Authority, in full compliance with federal law, focuses its retrospective drug use review activities on ensuring appropriate and medically necessary care.

The Auditor states that "[t]he Authority believes its review of the medical appropriateness of prescribing and dispensing drugs is sufficient to fulfill the fraud and abuse-related requirements of federal law." This is incorrect. Again, it is the Health Care Authority's Surveillance and Utilization Review program that fulfills the fraud and abuse-related requirements of federal law. In accordance with federal law the agency's retrospective drug use review program focuses on what constitutes appropriate and medically necessary care and does not duplicate the fraud and abuse activities under the Surveillance and Utilization Review program. Other business units within the agency perform analysis in the remaining areas of concern to the Auditor, per 42 CFR § 456.714 allowing states to limit the review activity of DUR staff to avoid duplication of activities related to fraud and abuse.

The Auditor states that "[the Authority] has not provided us any information on how often or how it does that analysis." The Auditor also states that "the Authority is not analyzing pharmaceutical claim data and other records to identify patterns of fraud, abuse, or misuse of Medicaid funds ...." Both of these statements are incorrect.

See below for a complete description of the Health Care Authority's extensive fraud and abuse detection programs:

Potential for Fraud and Abuse by Pharmacies
Office of Program Integrity

The Office of Program Integrity uses pharmacy claims data to identify potential Medicaid fraud, waste or abuse. The same office also has the responsibility for escalating, reporting, and making referrals to the Attorney General's Medicaid Fraud Control Unit as warranted for either pharmacies or prescribing providers.

- *The Payment Review Program (PRP) runs data analysis algorithms against pharmacy claims data to identify potential overpayments. Algorithms look at things such as "near duplicate" claims; possible misuse of expedited prior authorization; and drug quantities that may be billed inappropriately for the National Drug Code (NDC) or refilled too soon. Fifteen different forms of fraud and abuse algorithms are run regularly throughout the year.*

- *Surveillance and Utilization Review (SURS) staff performs provider reviews on pharmacies based on either data analysis findings or constituent/intra-agency referrals. SURS staff reviews can produce referrals to audit, provider education, referrals to Quality Management Team (QMT) or overpayment identification. SURS staff also uses the iSURS tool, within ProviderOne, which peer groups pharmacy providers based on their claims data. Several pharmacies are in the process of review each month.*

- *The Medical Audit unit conducts desk and on-site audits of pharmacy providers. They also conduct third-party liability audits against paid pharmacy claims.*

Potential for Fraud and Abuse by Clients
Patient Review and Coordination (PRC)

The PRC program restricts identified clients to specific health care providers and services including one primary prescriber, one narcotic prescriber, and one pharmacy. These restrictions reduce the client's ability to potentially abuse the Medicaid benefit and obtain inappropriate and excessive pharmacy services.

Clients are identified for possible placement into the PRC program through pharmacy claim algorithms for high numbers of narcotic prescription from at least four different prescribers in a three-month period. Through data analysis and clinical review, clients are removed from the set if there is evidence of medical necessity for their prescription use. If no evidence of medical necessity is identified, the client is enrolled in the PRC program with all associated restrictions. Legal authorities may be notified whenever fraud (such as forging prescriptions) is identified on the part of a Medicaid recipient.

Aberrant prescribing patterns by providers are sometimes identified in these client reviews through prescription records, high numbers of clients seeing the same narcotic prescriber, or multiple PRC clients requesting the same 'lock-in' prescriber. When provider problems are identified, they are referred to QMT, and providers with an open QMT cannot serve as a client's" lock-in" prescriber.

Potential for Fraud and Abuse by Prescribers
Office of Program Integrity

An agency contractor (OptumInsight) provides data analysis for the agency's "Generics First Provider Feedback Reports." These reports compare prescribing providers to their peers in prescribing generic over brand drugs for certain drug classes, including Schedule II drugs such as long acting opioids and Attentio Deficit Hyperactivity Disorder (ADHD) medications. Data is analyzed by the Office of the Chief Medical Officer, who follows up with prescribers who show ongoing aberrance in their prescribing practices. If this analysis reveals potential fraud, referrals are made back to the Office of Program Integrity and the Quality Management Team (QMT).

Quality Management Team

QMT staff investigates complaints or information about quality of care issues or concerns, evaluates that information, and documents all cases in the Optum/Ingenix® Fraud and Abuse Detection System (FADS) case tracking database. QMT makes evidence-based decisions using medical/dental claims and encounter data, prescribing data, medical/dental record review, and clinical resources. If the provider under review has prescriptive authority, a full analysis of claims data for prescriptions written by the provider is conducted. Approximately 280 cases were reviewed in FFY 2011.

Severe cases are presented at the Medical Dental Advisory Committee (MDAC) meetings. The agency's Chief Medical Officer makes the final determination on all cases presented at MDAC meetings. Determinations may include termination of the provider's Medicaid contract or referral to the Office of Program Integrity for audit.

Auditor's Concluding Remarks

We thank the Authority for its response. The Authority is responsible for performing a pharmaceutical claims data analysis to identify patterns of fraud and abuse. Authority management can determine which division will best fulfill that responsibility. For the last four years, the State Auditor's office has asked for any evidence of how often and how the Authority performs a retrospective drug use review of pharmaceutical claims data to identify patterns of fraud or abuse as required by federal and state law. The Authority has not supplied us with any evidence of that analysis.

We look forward to reviewing the evidence the Authority described during our next audit.

Applicable Laws and Regulations

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

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

Title 42, Code of Federal Regulations, Section 456.703 states in part:

> (a) *General.* Except as provided in paragraphs (b) and (c) of this section, in order for FFP to be paid or made available under section 1903 of the Act for covered outpatient drugs, the State must have in operation, by not later than January 1, 1993, a DUR program consisting of prospective drug review, retrospective drug use review, and an educational program that meets the requirements of this subpart. The goal of the State's DUR program must be to ensure appropriate drug therapy, while permitting sufficient professional prerogatives to allow for individualized drug therapy.

Title 42, Code of Federal Regulations, Section 456.709 states:

(a) General. The State plan must provide for a retrospective DUR program for ongoing periodic examination (no less frequently than quarterly) of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs. This examination must involve pattern analysis, using predetermined standards, of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies. This program must be provided through the State's mechanized drug claims processing and information retrieval systems approved by CMS (that is, the Medicaid Management Information System (MMIS)) or an electronic drug claims processing system that is integrated with MMIS. States that do not have MMIS systems may use existing systems provided that the results of the examination of drug claims as described in this section are integrated within their existing system.

(b) Use of predetermined standards. Retrospective DUR includes, but is not limited to, using predetermined standards to monitor for the following:
   (1) Therapeutic appropriateness, that is, drug prescribing and dispensing that is in conformity with the predetermined standards.
   (2) Overutilization and underutilization, as defined in Sec. 456.702.
   (3) Appropriate use of generic products, that is, use of such products in conformity with State product selection laws.
   (4) Therapeutic duplication as described in Sec. 456.705(b)(1).
   (5) Drug-disease contraindication as described in Sec. 456.705(b)(2).
   (6) Drug-drug interaction as described in Sec. 456.705(b)(3).
   (7) Incorrect drug dosage as described in Sec. 456.705(b)(4).
   (8) Incorrect duration of drug treatment as described in Sec. 456.705(b)(5).
   (9) Clinical abuse or misuse as described in Sec. 456.705(b)(7).

Title 42 Code of Federal Regulations 455.2 states in part:

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Title 42 Code of Federal Regulations 455.14 Preliminary investigation states:

If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

Title 42 Code of Federal Regulations 455.15 Full investigation states:

If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must take the following action, as appropriate:

(a) If a provider is suspected of fraud or abuse, the agency must—
   (1) In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit under the terms of its agreement with the unit entered into under Sec.1002.309 of this title; or
   (2) In States with no certified Medicaid fraud control unit, or in cases where no referral to the State Medicaid fraud control unit is required under paragraph (a)(1) of this section, conduct a full investigation or refer the case to the appropriate law enforcement agency.

(b) If there is reason to believe that a recipient has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.

(c) If there is reason to believe that a recipient has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

Title 42 Code of Federal Regulations 455.16 Resolution of full investigation states:

A full investigation must continue until—
(a) Appropriate legal action is initiated;
(b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or
(c) The matter is resolved between the agency and the provider or recipient. This resolution may include but is not limited to—
  (1) Sending a warning letter to the provider or recipient, giving notice that continuation of the activity in question will result in further action;
  (2) Suspending or terminating the provider from participation in the Medicaid program;
  (3) Seeking recovery of payments made to the provider; or
  (4) Imposing other sanctions provided under the State plan.

Washington Administrative Code (WAC) 388-530-4050 [recodifed as WAC 182-530-4050] Drug use and claims review states:

(1) The department's drug use review (DUR) consists of:
  (a) A prospective drug use review (Pro-DUR) that requires all pharmacy providers to:
    (i) Obtain patient histories of allergies, idiosyncrasies, or chronic condition(s) which may relate to drug utilization;
    (ii) Screen for potential drug therapy problems; and
    (iii) Counsel the patient in accordance with existing state pharmacy laws and federal regulations
  (b) A retrospective drug use review (Retro-DUR), in which the department provides for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and individuals receiving benefits.
(2) The department reviews a periodic sampling of claims to determine if drugs are appropriately dispensed and billed. If a review of the sample finds that a provider is inappropriately dispensing or billing for drugs, the department may implement corrective action that includes, but is not limited to:
  (a) Educating the provider regarding the problem practice(s);
  (b) Requiring the provider to maintain specific documentation in addition to the normal documentation requirements regarding the provider's dispensing or billing actions;
  (c) Recouping the payment for the drug(s); and/or
  (d) Terminating the provider's core provider agreement (CPA).

11-42 The Health Care Authority did not adequately monitor sub-recipients to ensure Medicaid expenditures are allowable and supported.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Sub-recipient Monitoring	
Questioned Cost Amount:	None	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for low-income individuals who otherwise might go without medical care. The Health Care Authority (HCA) administers the Medicaid program in Washington State. It contracts with governmental entities across the state, such as school districts and local health jurisdictions, to conduct activities to support program goals. As part of the Medicaid Administrative Match (MAM) program, HCA reimburses these entities for the activities.

School districts and local health jurisdictions participate in time studies to determine amounts they will charge to Medicaid. School districts perform a five-day time study each quarter. Local health jurisdictions base their time studies on surveys that obtain information about employee activities at particular moments in time. Each location completes a time study to allocate their costs. The time study produces rates that determine the amount of participating employee salaries charged to Medicaid. The Centers for Medicare and Medicaid Services (CMS) approves the time study methodology used by sub-recipients.

The state Medicaid program paid more than $68 million in federal funding to sub-recipients during fiscal year 2011, $37 million of which went directly to participants of the MAM program. Sixty-four school districts and 16 local health jurisdictions spent the majority of the funds, $13.7 million and $21.6 million respectively.

Description of Condition

The Authority has not performed on-site fiscal monitoring of school districts and local health jurisdictions since the MAM program began. The accuracy of claims depends on the accuracy of the expenditures reported and time study results. Audits performed by our Office at school districts have found some submit inaccurate payroll costs for reimbursement. Without verifying the allowability and accuracy of the expenditures the Authority cannot ensure claims are allowable and supported.

Cause of Condition

The Authority has never performed on-site fiscal monitoring. It did not consider verification of the expenditures charged through time studies as a necessary monitoring activity.

Effect of Condition

The Authority risks reimbursing sub-recipients for expenditures that may be for unsupported and unallowable activities.

Recommendation

We recommend the Authority perform fiscal monitoring of school districts and local health jurisdictions to ensure costs reimbursed within the MAM program are supported and allowable.

Department's Response

The agency agrees with the finding.

To improve oversight, the Medicaid Administrative Match program plans to add a fiscal component to all monitoring activities of school districts and local health jurisdictions.

The improved monitoring activity will include:

> *Sampling time study participant transactions will be performed using the programs approved monitoring cycle. Those results will be reviewed and compared to actual salary and benefits claimed.*

Auditor's Remarks

We appreciate the cooperation and assistance provided by the Authority throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

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

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

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

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

h. Support of salaries and wages. These standards regarding time distribution are in addition to the standards for payroll documentation.
(4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection 8.h.(5) unless a statistical sampling system (see subsection 8.h.(6)) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:
(a) More than one Federal award,
(b) A Federal award and a non Federal award,
(c) An indirect cost activity and a direct cost activity,
(d) Two or more indirect activities which are allocated using different allocation bases, or
(e) An unallowable activity and a direct or indirect cost activity.

(5) Personnel activity reports or equivalent documentation must meet the following standards:
(a) They must reflect an after the fact distribution of the actual activity of each employee,
(b) They must account for the total activity for which each employee is compensated,
(c) They must be prepared at least monthly and must coincide with one or more pay periods, and
(d) They must be signed by the employee.
(e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:
(i) The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;
(ii) At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and
(iii) The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.
(6) Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort.
(a) Substitute systems which use sampling methods (primarily for Temporary Assistance to Needy Families (TANF), Medicaid, and other public assistance programs) must meet acceptable statistical sampling standards including:

(i) The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results except as provided in subsection 8.h.(c);
(ii) The entire time period involved must be covered by the sample; and
(iii) The results must be statistically valid and applied to the period being sampled.

(b) Allocating charges for the sampled employees' supervisors, clerical and support staffs, based on the results of the sampled employees, will be acceptable.

(c) Less than full compliance with the statistical sampling standards noted in subsection (a) may be accepted by the cognizant agency if it concludes that the amounts to be allocated to Federal awards will be minimal, or if it concludes that the system proposed by the governmental unit will result in lower costs to Federal awards than a system which complies with the standards.

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

OMB Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments* (2 CFR 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:
   d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
   j. Be adequately documented.

11-43 The Health Care Authority does not have adequate controls to ensure Medicaid is the payer of last resort.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles	
Questioned Cost Amount:	None	

Background

Medicaid is the "payer of last resort", meaning those who administer it are to identify and bill other payment sources prior to submitting claims to Medicaid. Third-party liability refers to the legal obligation of third-party resources, usually insurance companies, to pay medical and pharmaceutical claims of Medicaid recipients prior to Medicaid coverage.

Pharmacies submit claims for Medicaid client prescriptions through an electronic point-of-sale system, which processes requests for payment through a series of criteria, known as edits, within the system. The Authority pays claims if they successfully pass all edits.

Pharmacies that submit claims to Medicaid must document potential third-party payers. If a provider submits a claim on behalf of a client who has other insurance without accurately entering the third-party resource, the point-of-sale system will deny the claim. However, the pharmacy may use manual override codes to override the system edits intended to identify and deny these claims. Override codes are recognized nationally as part of electronic claims processing standards. They were established for uses such as processing payment for a drug the client's insurance does not cover, but which is covered by Medicaid.

The Authority paid more than $415 million to pharmacies for services to Medicaid clients in fiscal year 2011. Of that, more than $13.4 million was paid for claims using override codes.

Description of Condition

Pharmacies can enter either accurate third-party information or override codes to bypass the system. Due to this significant, inherent control weakness, claims for pharmaceutical payments are susceptible to errors or abuse. The Medicaid program could pay claims that should have been paid in whole or in part by third parties.

To compensate, the Authority established a post-payment audit program to identify and recover payments made to providers who inappropriately billed Medicaid. We analyzed post payment audits the Authority performed in fiscal years 2008 through 2010. The total pharmacy claims paid using override codes during that period were approximately $55 million and the Authority audited 5 percent of those claims, or $2.5 million. The Authority audits identified an average of 51 percent of payments audited, or approximately $1.3 million to be inappropriate. This is an indication other coverage codes are being misused to bypass controls within the point-of-sale system.

In our audits for fiscal years 2006 through 2010, we recommended the Authority either strengthen controls over the entry of claims into its payment system or increase post-payment audits as long as it is cost-effective. The Authority has requested a change in procedure which would require pharmacies to enter the date of third party liability confirmation into the point-of-sale system. However, this has not been done.

Cause of Condition

The Authority stated it has compensating controls in place to provide reasonable assurance that improper payments will be recovered through its post-payment audit process.

The Authority stated it does not have sufficient resources to expand post-payment audit staffing.

Effect of Condition

Without adequate internal controls over override codes, claims for pharmaceutical payments are susceptible to errors or abuse. The Medicaid program could pay claims that should have been paid in whole or in part by third parties.

Recommendation

We recommend the Authority:

- Strengthen controls over the entry of claims into its payment system to ensure third-party payers are properly billed as the primary source of payment, or
- Increase its post payment audit coverage to ensure improper payments are identified and recovered.

Department's Response

The agency disagrees with this finding.

The Office of Program Integrity currently has two full-time auditors dedicated to reviewing pharmacy third party liability claims for inappropriate use of override codes. It may be that additional system enhancements could strengthen controls over the use of overrides. The agency will continue to communicate with and educate pharmacy providers on the proper use of third party liability override codes.

In addition, the agency has strengthened and improved our efforts in the area of Third-Party Liability (TPL) recoveries by contracting with Health Management Systems (HMS) to augment recovery efforts. This is done by performing enhanced data-matching available through HMS to better identify a client's medical insurance coverage. The contracted activities include: conducting electronic data exchanges with health insurers, and verifying and updating the insurance eligibility of Medicaid recipients for billing liable third parties on behalf of HCA.

With the enhanced data matching, the agency has mitigated the potential loss of recoveries and the inappropriate use of override codes. This is a much more cost effective way to enforce TPL controls.

Auditor's Remarks

We thank the Authority for its response. We look forward to reviewing the improvements the Authority implements during our next audit.

Applicable Laws and Regulations

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

The auditee shall:

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

Title 42 Code of Federal Regulations, Section 433.139 (b) (1) states:

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

Title 42 Code of Federal Regulations, Section 433.140 FFP and repayment of Federal share, states in part.

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

(b) FFP is available at the 50 percent rate for the agency's expenditures in carrying out the requirements of this subpart.

Washington Administrative Code 182-501-0200 states:

Third-party resources.

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

(2) The department pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:
  (a) Prenatal care;
  (b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or
  (c) Preventive pediatric services as covered under the EPSDT program.

(3) The department pays for medical services and seeks reimbursement from any liable third party when both of the following apply:
  (a) The provider submits to the department documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and
  (b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:
    (i) Is not complying with an existing court order; or
    (ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill the department or the client for a covered service when a third party pays a provider the same amount as or more than the department rate.

(5) When the provider receives payment from the third party after receiving reimbursement from the department, the provider must refund to the department the amount of the:
   (a) Third-party payment when the payment is less than the department's maximum allowable rate; or
   (b) The department payment when the third-party payment is equal to or greater than the department's maximum allowable rate.
(6) The department is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills the department, except as described under subsections (2) and (3) of this section.
(7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:
   (a) Receives direct third-party reimbursement for such services; or
   (b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.
(8) The department considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.
(9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.
(10) For third-party liability on personal injury litigation claims, the department is responsible for providing medical services as described under WAC 388-501-0100.

11-44 The Health Care Authority improperly claimed $111,108.98 in federal reimbursement for the Medicaid program.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Eligibility; Activities Allowed or Unallowed; Allowable Costs / Cost Principles	
Questioned Cost Amount:	$91,038.03 Non ARRA	
	$20,070.95 ARRA	

Background

Medicaid is a state and federal partnership that provides medical assistance to certain low-income individuals and individuals with disabilities. The state administers its Medicaid program in accordance with a state plan approved by Centers for Medicare and Medicaid. Although the state has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable federal requirements.

The state Medicaid program spent more than $7.5 billion during fiscal year 2011, more than $4.7 billion of which was federal dollars. Approximately $750 million of this came from the American Recovery and Reinvestment Act.

Federal and state laws and regulations establish Medicaid eligibility requirements. To be eligible, an individual must, among other things, meet citizenship requirements; furnish his or her Social Security number; be eligible for the specific services received; and not exceed income and financial resource levels established in state regulation.

Federal regulations and the state plan define allowable services. For the period under audit, the Health Care Authority administered Medicaid and was responsible for ensuring services were allowable and supported.

When the state provides services to ineligible individuals, or the services are unallowable and/or unsupported, the service cannot be claimed for federal reimbursement.

Description of Condition

During our audit, we noted the Authority claimed the following unallowable expenditures for federal reimbursement:

Medicaid payments for ineligible individuals

We reviewed all Social Security numbers of Medicaid beneficiaries in the Authority's new Medicaid Management Information System named ProviderOne and independently verified those numbers with the Social Security Administration's database.

We found 101 individuals who did not have a valid Social Security number. The table below summarizes the results of our work:

Description	Number of clients	Payments	Federal share[1]	
			Non-ARRA	ARRA
Invalid Social Security number	24	$20,294.99	$10,153.58	$2,238.54
No Social Security number	64	$68,425.44	$34,233.25	$7,547.33
Number belongs to deceased person	13	$ 4,956.72	$ 2,479.85	$ 546.73
Total	**101**	**$93,677.15**	**$46,866.68**	**$10,332.60**

Medicaid payments for unallowable services

Nonqualified aliens are not eligible to receive general Medicaid benefits, but may be eligible for care and services necessary in an emergency medical situation. Non-emergency services provided to nonqualified aliens are not allowable.

We found 299 non-emergency services provided to 45 nonqualified aliens. The table below summarizes the results of our work:

Description	Number of transactions	Payments	Federal share[1]	
			Non-ARRA	ARRA
Non emergency services provided to nonqualified aliens.	299	$27,985.96	$14,001.38	$3,086.85

Medicaid payments for unsupported services

Federal regulations state an overpayment is the amount a Medicaid agency paid to a provider in excess of the amount allowable for services furnished. Therefore, most payments to providers after the date of a Medicaid client's death are classified as overpayments.

We found 202 services provided after a client's death. The table below summarizes the results of our work:

Description	Number of claims	Payments	Federal share[1]	
			Non-ARRA	ARRA
Services provided after date of death.	202	$60,303.76	$30,169.97	$6,651.50

In total, we identified $181,966.87 unallowable expenditures. We are questioning $111,108.98, which is the federal portion of the expenditures.

Cause of Condition

The Authority has Social Security number verification procedures and has made improvements in its training and monitoring. The Authority has also reviewed unallowable Medicaid payments for services provided to nonqualified aliens and payments for services provided after a client's death. However, it is still not preventing or catching all unallowable payments.

[1] The federal share is calculated by using an average of FMAP rates for fiscal year 2011.

Effect of Condition and Questioned Costs

The Authority paid $181,966.87 to providers for services for ineligible individuals or unallowable activities. We are questioning $111,108.98, 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:

- Follow up on 101 clients who did not have a valid Social Security number and re-determine their Medicaid eligibility.
- Strengthen procedures to ensure that Medicaid services provided to nonqualified aliens are restricted to emergency services.
- Strengthen 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

The agency agrees with this finding. The Health Care Authority concurs that 152 clients apparently received some benefits in error, and the agency will review those claims to determine the reason for the erroneous payments and the cost. While the payments cited by the State Auditor's Office are a relatively small amount of the funds handled by the Health Care Authority, the agency's target continues to be 100 percent accuracy in payments.

- *Health Care Authority will review all the payments cited by the State Auditor's Office to deceased persons or other ineligible people and will identify and correct any payments made in error after the person's date of death or made to someone other than the rightful holder of the Social Security Number in question. Past findings involving Social Security Number matching have often proven to be explainable – a widow continuing to cite a spouse's Social Security Number, for example.*
- *Health Care Authority will arrange repayment of any federal funds received in error, in the manner previous repayments have been completed, after the agency has completed the reviews mentioned in this response. The agency expects that review to take approximately four weeks, or until April 1, 2012.*
- *Health Care Authority continues to strengthen procedures to improve accuracy of all payments and claims that are paid for unallowable services. HCA does provide some programs for nonqualified and undocumented aliens that utilize multiple funding streams to pay for services that are not allowed by federal matching dollars. A portion of the 111 transaction errors found by the SAO was for clients in programs that have these multiple funding streams. In this way, necessary non-Medicaid allowable services can be provided by other funds, such as state dollars or Title XXI funds, that do allow those services for the aliens in question.*

- *The agency will review all transactions listed by the SAO to capture and correct any errors in these payments. Health Care Authority administers medical assistance for more than 1.2 million Washington state residents. As the State Auditor's Office reported, in fiscal year 2011, HCA spent more than $7.5 billion, of which more than $4.7 billion was in federal matching funds. One hundred percent accuracy remains the goal for all HCA transactions and eligibility determinations.*

Auditor's Concluding Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

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

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

> Section 510 - Audit findings.
>
> (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
> (3) Known questioned costs which are greater than $10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

OMB Circular A-87: *Cost Principles for State, Local and Indian Tribal Governments* (2 CFR 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:
> p. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
> q. Be allocable to Federal awards under the provisions of 2 CFR part 225.
> r. Be authorized or not prohibited under State or local laws or regulations.
> s. 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.
> t. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
> u. 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.
> v. Except as otherwise provided for in 2 CFR part 225, be determined in accordance with generally accepted accounting principles.
> w. 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.
> x. Be the net of all applicable credits.
> y. Be adequately documented.

Title 42, Code of Federal Regulations, Part 433.304 defines an overpayment as following:

> *Overpayment* means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.

Title 42, Code of Federal Regulations, Section 435.910 (a) specifically states in part:

> The agency must require, as a condition of eligibility that each individual (including children) requesting Medicaid services furnish each of his or her own social security numbers . . . .

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

> The agency must verify each SSN of each applicant and recipient with SSA, as prescribed by the commissioner, to insure that each SSN furnished was issued to that individual and to determine whether any others were issued.

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

> If a Medicaid applicant cannot remember or has not been issued a Social Security number the agency must:
> (1) Assist the applicant in completing an application for an SSN;
> (2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and
> (3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

Title 42, Code of Federal Regulations, Section 435.916 (a) states in part:

> The agency must re-determine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months . . .

Title 42, Code of Federal Regulations, Section 435.920 (a-c) states:

(a) In re-determining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN.
(b) If the case record does not contain the required SSNs, the agency must require the recipient to furnish them and meet other requirements of 435.910.
(c) For any recipient whose SSN was established as part of the case record without evidence required under the SSN regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with 435.910.

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

(a) FFP for services. FFP is available for services provided to aliens described in this section which are necessary to treat an emergency medical condition as defined in paragraphs (b)(1) and (c) or services for pregnant women described in paragraph (b)(2).
(b) Legalized aliens eligible only for emergency services and services for pregnant women. Aliens granted lawful temporary resident status, or lawful permanent resident status under sections 245A, 210 or 210A of the Immigration and Nationality Act, who are not in one of the exempt groups described in §§435.406(a)(3) and 436.406(a)(3) and who meet all other requirements for Medicaid will be eligible for the following services—
    (1) Emergency services required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

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

(2) Services for pregnant women which are included in the approved State plan. These services include routine prenatal care, labor and delivery, and routine post-partum care. States, at their option, may provide additional plan services for the treatment of conditions which may complicate the pregnancy or delivery.

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

(1) The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
(i) Placing the patient's health in serious jeopardy;
(ii) Serious impairment to bodily functions; or
(iii) Serious dysfunction of any bodily organ or part, and

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

Title 42, Code of Federal Regulations, Section 435.406, Citizenship and alienage states:

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

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

(2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified aliens), qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified aliens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration

required by section 1137(d) of the Act that the applicant or recipient is an alien in a satisfactory immigration status.

(ii) The eligibility of qualified aliens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.

(b) The agency must provide payment for the services described in §440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified aliens subject to the 5-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria, except non-qualified aliens need not present a social security number or document immigration status.

Washington Administrative Code (WAC) 182-500-0030, Medical definitions, states in part:

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

*Placing the patient's health in serious jeopardy;
*Serious impairment to bodily functions; or
*Serious dysfunction of any bodily organ or part.

Washington Administrative Code (WAC) 388-438-0115 states:

(1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 388-438-0110 is eligible for the alien emergency medical program's scope of covered services described in this section if the person meets (a) and (b) below, or (c) below:
   (a) The department's health and recovery services administration determines that the primary condition requiring treatment meets the definition of an emergency medical condition as defined in WAC 388-500-0005, and the condition is confirmed through review of clinical records; and
   (b) The person's qualifying emergency medical condition is treated in one of the following hospital settings:
      (i) Inpatient;
      (ii) Outpatient surgery;
      (iii) Emergency room services, which must include an evaluation and management (E&M) visit by a physician; or
   (c) Involuntary Treatment Act (ITA) and voluntary inpatient admissions to a hospital psychiatric setting that are authorized by the department's inpatient mental health designee (see subsection (5) of this section).
(2) If a person meets the criteria in subsection (1), the department will cover and pay for all related medically necessary health care services and professional services provided:
   (a) By a physician in his 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;
      (iv) 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 department as described in subsection (3) of this section.
(3) The department will cover admissions to an LTAC facility or an inpatient PM&R unit if:

(a) The original admission to the 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 388-550-2590 for LTAC and WAC 388-550-2561 for PM&R).

(4) The department does not cover any services, regardless of setting, once the person is discharged from the hospital after being treated for a qualifying emergency medical condition authorized by the department under this program. Exception: Pharmacy services, drugs, devices, and drug-related supplies listed in WAC 388-530-2000, 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 department's inpatient mental health designee according to the requirements in WAC 388-550-2600.

(6) There is no precertification or prior authorization for eligibility under this program. 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 388-501-0060. This includes, but is not limited to:
(a) Hospital services, care, surgeries, or inpatient admissions to treat any condition which is not considered by the department to be a qualifying emergency medical condition, including but not limited to:
(i) Laboratory X ray, or other diagnostic procedures;
(ii) Physical, occupational, speech therapy, or audiology services;
(iii) Hospital clinic services; or
(iv) Emergency room visits, surgery, or hospital admissions.
(b) Any services provided during a hospital admission or visit (meeting the criteria described in subsection (1) of this section), which are not related to 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;
(vi) Personal care services;
(vii) Physical, respiratory, occupational, and speech therapy services;
(vii) Waiver services;
(viii) Nursing facility services;
(ix) Home health services;
(x) Hospice services;

(xi) Vision services;
(xii) Hearing services;
(xiii) Dental services;
(xiv) Durable and non durable medical supplies;
(xv) Nonemergency medical transportation;
(xvi) Interpreter services; and
(xvii) Pharmacy services, except as described in subsection (4).

(9) The services listed in subsection (8) of this section are not 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 department for visits or services that do not meet the qualifying criteria described in this section. The department will identify and recover payment for claims paid in error.

11-45 The Health Care Authority does not have adequate controls to ensure controlled substances prescribed for Medicaid clients are authorized and allowable.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Allowable Costs / Cost Principles	
Questioned Cost Amount:	$26,051.78	

Background

The federal Drug Enforcement Administration (DEA) classifies all controlled substances as scheduled drugs ranging from level 1-5; the number represents the potential risk of abuse the drug poses to the client. Schedule 1 drugs, such as heroin, are illegal. The rest are considered legitimate for medical use and range from morphine (schedule 2), to cough syrup with codeine (schedule 5).

Federal regulations require individuals who prescribe controlled substances to register with the DEA. These individuals must have an active medical license in the state in which they practice. This registration allows the DEA to track all prescribers of controlled substances in a national database and to monitor all prescriptions. The DEA assigns all registrants an identification number. All Medicaid providers are also required to have a National Provider Identifier (NPI) number issued by the U.S. Department of Health and Human Services, regardless of whether they prescribe scheduled drugs.

Pharmacies submit claims for Medicaid client prescriptions through an electronic point-of-sale system that in real time processes requests for payment through a series of criteria (edits) within the system. Prescribers can use either their DEA numbers or NPI numbers as identification; the system will accept either, even when processing a scheduled drug claim. Claims are paid if the prescriber passes all edits.

Federal grant regulations require the Authority to have controls that provide reasonable assurance that Medicaid expenditures are allowable. These expenditures must be supported, authorized and allowable under federal, state laws or regulations. Controlled substances are allowable expenditures for Medicaid only when prescribed by prescribers with valid DEA numbers.

In a report issued in September 2009, the U.S. Government Accountability Office found tens of thousands of Medicaid beneficiaries and providers involved in potential fraudulent purchases of controlled substances, abusive purchases of controlled substances, or both, in five states: California, Illinois, New York, North Carolina, and Texas[1]. Investigations by GAO also uncovered other issues, such as doctors writing controlled substance prescriptions without having required DEA authorization.

[1] GAO 09-957

The Authority paid more than $41 million in claims for schedule two through five drugs between July 1, 2010 and June 30, 2011.

Description of Condition

In our past three audits we reported the Authority's controls over payments for schedule 2-5 prescription drug claims were inadequate. The Authority has procedures to ensure a prescriber of schedule 2 drugs has a DEA number, but the procedures do not verify whether the DEA number is valid. For schedule 3-5 drugs the Authority does not have any procedure to ensure prescribers have valid DEA numbers.

Claims for these medications are paid without assurance that the prescriber has proper DEA authorization.

Cause of Condition

The Authority stated it needs a complete source of data that provides the necessary NPI to DEA crosswalk to fully implement an efficient edit for all scheduled drugs. The data was not available during our audit.

Effect of Condition and Questioned Costs

We reviewed schedule 2-5 prescription drug claims with DEA numbers processed through the point-of-sale system and verified the validity of those DEA numbers with DEA databases available from the National Technical Information Service (NTIS), an agency of the Department of Commerce. We identified 214 prescribers who did not have valid DEA numbers at the time of the transaction. Those prescribers prescribed 1,428 scheduled drugs, as shown in the table below:

Schedule	Transactions with invalid DEA number	
	Transactions	Expenditures
Schedule 2	470	$ 27,704.82
Schedule 3	446	$ 5,265.81
Schedule 4	480	$ 4,041.53
Schedule 5	32	$ 5,656.99
Total	1,428	$ 42,669.15

The Authority paid $42,669.15 for these claims. We are questioning $ 26,051.78, which is the federal portion of the expenditures.

Without adequate controls to validate prescriber's DEA number for scheduled drugs, the Authority is unable to ensure all expenditures related to the claims are properly authorized and allowable.

Recommendation

We recommend the Authority:

- Ensure prescribers of controlled substances have valid DEA numbers that demonstrate they are authorized to provide this service in accordance with federal requirements.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Department's Response

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

There are no federal or state statutes that require a payer (e.g., the Health Care Authority) to validate the Drug Enforcement Administration (DEA) number of a prescriber. Therefore, the agency disagrees that the lack of an edit that validates DEA for Schedule 2-5 drugs constitutes inadequate internal controls or that the lack of such validation renders the payment unallowable.

The Health Care Authority believes that responsibility for compliance with controlled substance requirements lies with the prescribing provider and the dispensing pharmacies. The Controlled Substance Act (21 USC Sec. 821) and the State Uniform Controlled Substance Act (Chapter 69.50 RCW) do not regulate payment for controlled substances, and there are no provisions in either that could be interpreted as a requirement relating to payment of claims for controlled substances. Title 21 CFR Section 1306.04 clearly states that the prescribing practitioner is responsible for assuring that the prescription conforms in all essential respects to the law and regulation:

> *(a) A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription."*

This finding indicates that "the Authority has procedures to ensure a prescriber of schedule 2 drugs has a DEA number, but the procedures do not verify whether the DEA number is valid." That statement is incorrect. The agency's Pharmacy Point of Sale (POS) system maintains a prescriber network of known NPI/DEA associations, and it is updated by state staff as new associations become known. System functionality includes manual updates to a "blocked prescriber list" that identifies prescriber DEAs prevented from prescribing Schedule II drugs. Claims for Schedule 2 drugs are validated against the DEAs on the prescriber network. The problem identified by SAO is not a lack of validation. Rather, the DEA regular file update is received into the POS on a monthly basis, resulting in a lag in the DEA effective dates and a discrepancy with the DEA file that SAO used to conduct the audit. As noted in previous years, there continues to be no complete external file that accurately and completely associates NPI to DEA.

In addition to the POS edit that validates the DEA for Schedule II drugs, the Health Care Authority has a set of robust Program Integrity activities -- including pharmacy utilization review, pharmacy rules-based algorithms that identify improper payments, and data mining activities that identify patterns outside the norm. In the absence of any requirement to validate the DEA number for controlled substances, the agency believes this set of Program Integrity activities provides adequate controls to ensure that controlled substances are authorized and allowable.

Auditor's Concluding Remarks

We thank the Authority for its response.

The Authority is responsible for ensuring services provided to Medicaid clients are allowable. In order for a controlled substance prescription to be an allowable Medicaid service, it must be prescribed by a provider with a valid DEA number.

We will review this area during our next audit.

Applicable Laws and Regulations

Circular No. A-133, Subpart C, §_.300 Auditee responsibilities. states in part:

The auditee shall:

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

OMB Circular A-87: *Cost Principles for State, Local and Indian Tribal Governments* (2 CFR 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.

Title 21, Code of Federal Regulations, Section 1301 states in part:

§1301.11 Persons required to register; requirement of modification of registration authorizing activity as an online pharmacy.

(a) Every person who manufactures, distributes, dispenses, imports, or exports any controlled substance or who proposes to engage in the manufacture, distribution, dispensing, importation or exportation of any controlled substance shall obtain a registration unless exempted by law or pursuant to §§1301.22 through 1301.26. Except as provided in paragraph (b) of this section, only persons actually engaged in such activities are required to obtain a registration; related or affiliated persons who are not engaged in such activities are not required to be registered. (For example, a stockholder or parent corporation of a corporation manufacturing controlled substances is not required to obtain a registration.)

(b) As provided in sections 303(f) and 401(h) of the Act (21 U.S.C. 823(f) and 841(h)), it is unlawful for any person who falls within the definition of "online pharmacy" (as set forth in section 102(52) of the Act (21 U.S.C.802(52)) and §1300.04(h) of this chapter) to deliver, distribute, or dispense a controlled substance by means of the Internet if such person is not validly registered with a modification of such registration authorizing such activity (unless such person is exempt from such modified registration requirement under the Act or this chapter). The Act further provides that the Administrator may only issue such modification of registration to a person who is registered as a pharmacy under section 303(f) of the Act (21 U.S.C. 823(f)). Accordingly, any pharmacy registered pursuant to §1301.13 of this part that falls within the definition of an online pharmacy and proposes to dispense controlled substances by means of the Internet must obtain a

modification of its registration authorizing such activity following the submission of an application in accordance with §1301.19 of this part. This requirement does not apply to a registered pharmacy that does not fall within the definition of an online pharmacy set forth in §1300.04(h). Under the Act, persons other than registered pharmacies are not eligible to obtain such a modification of registration but remain liable under section 401(h) of the Act (21 U.S.C. 841(h)) if they deliver, distribute, or dispense a controlled substance while acting as an online pharmacy without being validly registered with a modification authorizing such activity.

Title 21, Code of Federal Regulations, Section 1306 states in part:

§1306.03 Persons entitled to issue prescriptions.

(a) A prescription for a controlled substance may be issued only by an individual practitioner who is:
  (1) Authorized to prescribe controlled substances by the jurisdiction in which he is licensed to practice his profession and
  (2) Either registered or exempted from registration pursuant to §§1301.22(c) and 1301.23 of this chapter.

(b) A prescription issued by an individual practitioner may be communicated to a pharmacist by an employee or agent of the individual practitioner.

§1306.21 Requirement of prescription.

(a) A pharmacist may dispense directly a controlled substance listed in Schedule III, IV, or V that is a prescription drug as determined under section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)) only pursuant to either a paper prescription signed by a practitioner, a facsimile of a signed paper prescription transmitted by the practitioner or the practitioner's agent to the pharmacy, an electronic prescription that meets the requirements of this part and part 1311 of this chapter, or an oral prescription made by an individual practitioner and promptly reduced to writing by the pharmacist containing all information required in §1306.05, except for the signature of the practitioner.

(b) An individual practitioner may administer or dispense directly a controlled substance listed in Schedule III, IV, or V in the course of his/her professional practice without a prescription, subject to §1306.07.

(c) An institutional practitioner may administer or dispense directly (but not prescribe) a controlled substance listed in Schedule III, IV, or V only pursuant to a written prescription signed by an individual practitioner, or pursuant to a facsimile of a written prescription or order for medication transmitted by the practitioner or the practitioner's agent to the institutional practitioner-pharmacist, or pursuant to an oral prescription made by an individual practitioner and promptly reduced to writing by the pharmacist (containing all information required in Section 1306.05 except for the signature of the individual practitioner), or pursuant to an order for medication made by an individual practitioner which is dispensed for immediate administration to the ultimate user, subject to §1306.07.

§1306.22 Refilling of prescriptions.

(a) No prescription for a controlled substance listed in Schedule III or IV shall be filled or refilled more than six months after the date on which such prescription was issued. No prescription for a controlled substance listed in Schedule III or IV authorized to be refilled may be refilled more than five times.

(b) Each refilling of a prescription shall be entered on the back of the prescription or on another appropriate document or electronic prescription record. If entered on another document, such as a medication record, or electronic prescription record, the document or record must be uniformly maintained and readily retrievable.

(c) The following information must be retrievable by the prescription number:
  (1) The name and dosage form of the controlled substance.
  (2) The date filled or refilled.

(3) The quantity dispensed.
(4) The initials of the dispensing pharmacist for each refill.
(5) The total number of refills for that prescription.

(d) If the pharmacist merely initials and dates the back of the prescription or annotates the electronic prescription record, it shall be deemed that the full face amount of the prescription has been dispensed.

(e) The prescribing practitioner may authorize additional refills of Schedule III or IV controlled substances on the original prescription through an oral refill authorization transmitted to the pharmacist provided the following conditions are met:
(1) The total quantity authorized, including the amount of the original prescription, does not exceed five refills nor extend beyond six months from the date of issue of the original prescription.
(2) The pharmacist obtaining the oral authorization records on the reverse of the original paper prescription or annotates the electronic prescription record with the date, quantity of refill, number of additional refills authorized, and initials the paper prescription or annotates the electronic prescription record showing who received the authorization from the prescribing practitioner who issued the original prescription.
(3) The quantity of each additional refill authorized is equal to or less than the quantity authorized for the initial filling of the original prescription.
(4) The prescribing practitioner must execute a new and separate prescription for any additional quantities beyond the five-refill, six-month limitation.

(f) As an alternative to the procedures provided by paragraphs (a) through (e) of this section, a computer application may be used for the storage and retrieval of refill information for original paper prescription orders for controlled substances in Schedule III and IV, subject to the following conditions:
(1) Any such proposed computerized application must provide online retrieval (via computer monitor or hard-copy printout) of original prescription order information for those prescription orders that are currently authorized for refilling. This shall include, but is not limited to, data such as the original prescription number; date of issuance of the original prescription order by the practitioner; full name and address of the patient; name, address, and DEA registration number of the practitioner; and the name, strength, dosage form, quantity of the controlled substance prescribed (and quantity dispensed if different from the quantity prescribed), and the total number of refills authorized by the prescribing practitioner.
(2) Any such proposed computerized application must also provide online retrieval (via computer monitor or hard-copy printout) of the current refill history for Schedule III or IV controlled substance prescription orders (those authorized for refill during the past six months). This refill history shall include, but is not limited to, the name of the controlled substance, the date of refill, the quantity dispensed, the identification code, or name or initials of the dispensing pharmacist for each refill and the total number of refills dispensed to date for that prescription order.
(3) Documentation of the fact that the refill information entered into the computer each time a pharmacist refills an original paper, fax, or oral prescription order for a Schedule III or IV controlled substance is correct must be provided by the individual pharmacist who makes use of such an application. If such an application provides a hard-copy printout of each day's controlled substance prescription order refill data, that printout shall be verified, dated, and signed by the individual pharmacist who refilled such a prescription order. The individual pharmacist must verify that the data indicated are correct and then sign this document in the same manner as he would sign a check or legal document (*e.g.,* J.H. Smith, or John H. Smith). This document shall be maintained in a separate file at that pharmacy for a period of two years from the dispensing date. This printout of the day's controlled substance prescription order refill data must be provided to each pharmacy using such a computerized application within 72 hours of the date on which the refill was dispensed. It must be verified and signed by each pharmacist who is involved with such dispensing. In lieu of such a printout, the pharmacy shall maintain a bound log book, or separate file, in which

each individual pharmacist involved in such dispensing shall sign a statement (in the manner previously described) each day, attesting to the fact that the refill information entered into the computer that day has been reviewed by him and is correct as shown. Such a book or file must be maintained at the pharmacy employing such an application for a period of two years after the date of dispensing the appropriately authorized refill.

(4) Any such computerized application shall have the capability of producing a printout of any refill data that the user pharmacy is responsible for maintaining under the Act and its implementing regulations. For example, this would include a refill-by-refill audit trail for any specified strength and dosage form of any controlled substance (by either brand or generic name or both). Such a printout must include name of the prescribing practitioner, name and address of the patient, quantity dispensed on each refill, date of dispensing for each refill, name or identification code of the dispensing pharmacist, and the number of the original prescription order. In any computerized application employed by a user pharmacy the central recordkeeping location must be capable of sending the printout to the pharmacy within 48 hours, and if a DEA Special Agent or Diversion Investigator requests a copy of such printout from the user pharmacy, it must, if requested to do so by the Agent or Investigator, verify the printout transmittal capability of its application by documentation (*e.g.,* postmark).

(5) In the event that a pharmacy which employs such a computerized application experiences system down-time, the pharmacy must have an auxiliary procedure which will be used for documentation of refills of Schedule III and IV controlled substance prescription orders. This auxiliary procedure must ensure that refills are authorized by the original prescription order, that the maximum number of refills has not been exceeded, and that all of the appropriate data are retained for online data entry as soon as the computer system is available for use again.

(g) When filing refill information for original paper, fax, or oral prescription orders for Schedule III or IV controlled substances, a pharmacy may use only one of the two applications described in paragraphs (a) through (e) or (f) of this section.

(h) When filing refill information for electronic prescriptions, a pharmacy must use an application that meets the requirements of part 1311 of this chapter.

§1306.23 Partial filling of prescriptions.

The partial filling of a prescription for a controlled substance listed in Schedule III, IV, or V is permissible, provided that:

(a) Each partial filling is recorded in the same manner as a refilling,

(b) The total quantity dispensed in all partial fillings does not exceed the total quantity prescribed, and

(c) No dispensing occurs after 6 months after the date on which the prescription was issued.

11-46 The Health Care Authority did not have adequate controls to ensure violations of Medicaid laws and regulations by providers are identified and are referred to the Medicaid Fraud Control Unit (MFCU), risking the loss of public resources.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Medicaid Fraud Control Unit	
Questioned Cost Amount:	None	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for low-income individuals who otherwise might go without medical care. The state Medicaid program spent more than $7.5 billion during fiscal year 2011. More than $4.5 billion of that relates to activities of the Health Care Authority, which paid more than $4.4 billion of that directly to providers.

States are required to maintain a Medicaid Fraud Control Unit (MFCU), which investigates and prosecutes fraud by health care providers. The Washington State MFCU is part of the Criminal Justice Division of the Attorney General's Office. Any suspected criminal violations of Medicaid laws and regulations identified by the state Medicaid program must be referred to MFCU for investigation.

When the Health Care Authority receives a complaint of Medicaid fraud or abuse from any source or identifies questionable practices, it must conduct a preliminary investigation to determine whether it has sufficient evidence to warrant a full investigation. This responsibility is designated to the Surveillance and Utilization Review Section (SURS) within the Authority's Office of Program Integrity (OPI).

SURS receives cases requiring a preliminary investigation from a number of sources. Other units within the Authority may identify provider cases based on data mining, submitted claims, or communication with clients. In addition, OPI handles client verification notices and an 800 fraud line, which allow clients and citizens to notify the Authority of suspicious activities. SURS staff also may identify cases during the course of their work. All provider cases forwarded to or identified by SURS are entered into OPI's electronic Case Tracking system.

When a case is entered, it is assigned to an analyst who will determine whether the suspected violations are substantiated. SURS refers any case determined to require a full investigation to MFCU.

Description of Condition

In order for cases of Medicaid provider fraud to be identified, the Authority's SURS Unit must first review any complaints received. If provider fraud is occurring, it is important for SURS to identify this as quickly as possible.

Our audit examined whether the Authority maintains adequate controls to ensure cases involving violations of Medicaid laws and regulations were identified and referred to MFCU in a timely manner.

SURS received a total of 388 cases during fiscal year 2011, and completed a review of 142. The other 246 cases remained open and required additional review at year end. For the open cases, more than 78 percent remained in the system beyond 90 days, and more than 62 percent remained in the system beyond 180 days. Timeframes for an additional 16 percent could not be determined as the dates were missing or inaccurate.

The table below summarizes the results work.

Total Time in System	Closed Cases	Open Cases
0-30 days	85	5
31-60 days	11	7
61-90 days	5	2
91-120 days	11	24
121-150 days	5	6
151-180 days	1	8
More than 180 days	12	154
Inaccurate or missing dates	12	40
Total	**142**	**246**

During fiscal year 2011 SURS referred six cases to MFCU.

Cause of Condition

The Authority stated high caseloads and limited resources did not allow it to do a timely review of cases.

Effect of Condition

By not performing timely preliminary investigations, referrals to MFCU will be delayed and Medicaid fraud may go undetected, resulting in the loss of public resources.

Recommendation

We recommend the Authority complete a timely review of all suspected cases of provider fraud to determine if *sufficient evidence exists to warrant a full investigation*.

Department's Response

The Health Care Authority disagrees with this finding.

The agency has adequate controls to ensure that violations of Medicaid law and regulations are identified and referred to the Medicaid Fraud Control Unit. This is supported by a review of cases in the Case Tracking System and the timeliness in which they are worked. The Case Tracking System is used to track a variety of cases; thus, the timeframes in which those cases are resolved does not necessarily lead to the conclusion of inadequate controls.

Processes are in place to prioritize the work of SURS investigators, ensuring that the agency is addressing those cases with the highest potential for fraud, waste and abuse. These are also the cases that yield the highest return on investment.

SAO's "Description of Condition" and "Recommendation" above do not comport with the Purpose of this Audit as originally described to the Health Care Authority. During detailed analyses conducted with HCA and per SAO's Case Tracking Results spreadsheet, audit purposes included:

- *"To determine if Office of Program Integrity (OPI) analysts are appropriately documenting reasons for not referring cases to MFCU within the Department's Case Tracking System." The conclusion was that OPI analysts were appropriately documenting reasons for not referring cases to MFCU.*
- *To determine if all provider cases entered into OPI's Case Tracking System during SFY11 have been assigned to an analyst for review." The conclusion to this finding was that 95% of the cases were assigned to analysts for review. The cases that were not assigned to an analyst for review are Medical Service Verification (MSV) surveys, which were reviewed in a separate SAO audit and finding.*
- *"To determine how long closed cases remained in OPI's Case Tracking system before being closed." SAO spreadsheet finds that 65% of cases are closed within 30 days of entry.*

The agency believes these findings should be included in this document.

Above, the Auditor states: "By not performing timely preliminary investigations, referrals to MFCU will be delayed and Medicaid fraud may go undetected, resulting in the loss of public resources." This statement is inaccurate. Medicaid fraud will not go undetected. The Health Care Authority completes an initial triage upon the entry of every case into the Case Tracking System. If there is evidence of potential fraud at first review, then the case is worked immediately. The Case Tracking System is used to track a variety of cases, including cases which are entered as "placeholders" and reminders to review provider activities as resources become available. Sixty percent of the cases in the Case Tracking System that were identified as open more than 180 days are Medical Service Verification (MSV) receipts. These have been reviewed in a separate SAO audit and finding. As noted in the response to that finding, there are no federal timeline requirements for MSV reviews. They are assigned a lower priority in HCA since they have not historically led to identification of fraud, and are considered to have limited value.

Auditor's Remarks

We thank the Authority for its response. In order to ensure cases of fraud are properly identified and prosecuted, the Authority must complete its review of suspected cases in a timely manner. It is our determination that control weaknesses are preventing a timely review. By not performing timely preliminary investigations, referrals to MFCU will be delayed and Medicaid fraud may go undetected. The longer frauds go undetected, the larger the potential for the loss of public resources.

We will continue to work with and discuss this issue with the Authority.

Applicable Laws and Regulations

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

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

Title 42, code of Federal Regulations, Section 455 states in part:

> §455.1 Basis and scope.
> This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control.
> (a) Under the authority of sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act, Subpart A provides State plan requirements for the identification, investigation, and

referral of suspected fraud and abuse cases. In addition, the subpart requires that the State—

(1) Report fraud and abuse information to the Department; and
(2) Have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients.

(b) Subpart B implements sections 1124, 1126, 1902(a)(36), 1903(i)(2), and 1903(n) of the Act. It requires that providers and fiscal agents must agree to disclose ownership and control information to the Medicaid State agency.

(c) Subpart C implements section 1936 of the Act. It establishes the Medicaid Integrity Program under which the Secretary will promote the integrity of the program by entering into contracts with eligible entities to carry out the activities of subpart C.

§455.13 Methods for identification, investigation, and referral.

The Medicaid agency must have—

(a) Methods and criteria for identifying suspected fraud cases;
(b) Methods for investigating these cases that—
  (1) Do not infringe on the legal rights of persons involved; and
  (2) Afford due process of law; and
(c) Procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials.

§455.14 Preliminary investigation.

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.

§455.15 Full investigation.

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 recipient has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.
(c) If there is reason to believe that a recipient has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

11-47 The Health Care Authority's internal controls are inadequate to ensure non-emergency medical transportation expenditures are allowable and adequately supported.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles	
Questioned Cost Amount:	None	

Background

The Health Care Authority provides eligible Medicaid recipients transportation to and from non-emergency, medically necessary appointments. Medicaid clients who qualify are provided transportation or are reimbursed for travel costs. The appointments must be for services eligible to be paid by the Medicaid program.

Transportation services include public transit, client and volunteer mileage reimbursement, wheel chair-equipped vans, taxis, ferries and fuel vouchers. In less frequent cases, if a client must travel to a distant provider, lodging and food may be included.

Since 1989, Washington State has used a brokerage system to provide non-emergency medical transportation for eligible Medicaid clients. Brokers contract with HCA to deal directly with the clients to arrange, authorize or deny transportation services. Brokers decide the form of transportation a client receives.

Brokers are expected to verify the client's eligibility with the eligibility database and to authorize or deny the transportation request based on whether it is medically necessary. Brokers are responsible for contracting with transportation providers. The brokers keep all documentation to support allowability of transportation services; the providers keep documentation supporting the trip.

It is the responsibility of the Authority to monitor the brokers to ensure they and the providers comply with federal and state Medicaid regulations and that transportation services are legitimate, allowable, reasonable and adequately supported.

The state has six brokers in nine regions and spent approximately $73.6 million on the program in fiscal year 2011.

Description of Condition

During the previous three audits, we reported the Authority did not adequately monitor brokers to ensure non-emergency transportation expenditures were allowable and supported. To improve monitoring, the Authority planned to make enhancements to their trip information database to enable the input of trip information from brokers. The Authority also planned on-site monitoring of the brokers. However, the trip

information database was not improved and the Authority did not perform on-site monitoring during fiscal year 2011.

Cause of Condition

The Authority stated travel restrictions imposed by the Governor due to budget cuts temporarily prevented it from performing on-site monitoring. The Authority also was not able to use trip information from the trip information database as a monitoring tool because it was not completed.

Effect of Condition

Without adequate monitoring, the Authority cannot ensure non-emergency medical transportation expenditures are legitimate, reasonable and adequately supported.

Recommendation

We recommend the Authority monitor transportation broker contracts and operations to ensure all Medicaid rules are followed and services the brokers provided are legitimate, reasonable and adequately supported.

Department's Response

The Health Care Authority agrees with the finding, but notes that the solution to these issues is now in place. The auditor's report stated incorrectly that the trip information database has not improved.

During SFY2011, the agency did build a trip information database that can be used to verify that all Medicaid rules are followed and that all services the transportation brokers provide are legitimate, reasonable and adequately supported. The database includes new data fields that will allow the agency to more closely monitor transportation services, operations and expenditures.

Brokers began adding information to the system in early 2011, and the agency was able to test the new database with positive results between March 2011 through June 2011.

Other monitoring activities:

- *Desk audits using SAO monitoring tools*
- *Review of financial and operating reports*
- *Review of fleet inventories and inspection schedules*
- *Monthly review of brokers invoices and reports*
- *Reviewed broker reports of incidents and accidents*
- *Reviewed brokers annual independent audits*

From July 2011 through December 2011, the agency conducted on-site monitoring of all six transportation brokers with the new trip information database, and found all six to be in compliance with Medicaid rules and regulations.

Auditor's 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

Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Nonprofit 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 210(f) - Compliance responsibility for vendors.

In most cases, the auditee's compliance responsibility for vendors is only to ensure that the procurement, receipt, and payment for goods and services comply with laws, regulations, and the provisions of contracts or grant agreements. Program compliance requirements normally do not pass through to vendors. However, the auditee is responsible for ensuring compliance for vendor transactions which are structured such that the vendor is responsible for program compliance or the vendor's records must be reviewed to determine program compliance. Also, when these vendor transactions relate to a major program, the scope of the audit shall include determining whether these transactions are in compliance with laws, regulations, and the provisions of contracts or grant agreements.

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

Appendix A, Section C - Basic Guidelines:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
   a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards...
   d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
   j. Be adequately documented.
2. Reasonable costs. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. The question of reasonableness is particularly important when governmental units or components are predominately federally-funded. In determining reasonableness of a given cost, consideration shall be given to:
   a. Whether the cost is of a type generally recognized as ordinary and necessary for the operation of the governmental unit or the performance of the Federal award.
   b. The restraints or requirements imposed by such factors as: Sound business practices; arm's-length bargaining; Federal, State and other laws and regulations; and, terms and conditions of the Federal award.
   c. Market prices for comparable goods or services.
   d. Whether the individuals concerned acted with prudence in the circumstances considering their responsibilities to the governmental unit, its employees, the public at large, and the Federal Government.
   e. Significant deviations from the established practices of the governmental unit which may unjustifiably increase the Federal award's cost.

Washington Administrative Code (WAC) 182-546-5000 Nonemergency transportation – General.

(1) The department covers nonemergency nonambulance transportation to and from covered healthcare services, as provided by the Code of Federal Regulations (42 CFR 431.53 and 42 CFR 440.170) subject to the limitations and requirements under WAC 388-546-5000 through 388-546-6200. See WAC 388-546-1000 for nonemergency ground ambulance transportation.

(2) The department pays for nonemergency transportation for clients covered under state-funded

medical programs subject to funding appropriated by the legislature.

(3) Clients may not select the transportation provider(s) or the mode of transportation.

Washington Administrative Code (WAC) 182-546-5200 Nonemergency transportation broker and provider requirements.

(1) The department requires:
  (a) Brokers and subcontracted transportation providers to be licensed, equipped, and operated in accordance with applicable federal, state, local laws, and the terms specified in their contracts;
  (b) Brokers to:
    (i) Screen their employees and subcontracted transportation providers and employees prior to hiring or contracting, and on an ongoing basis thereafter, to assure that employees and contractors are not excluded from receiving federal funds as required by 42 USC 1320a-7 and 42 USC 1320c-5; and
    (ii) Report immediately to the department any information discovered regarding an employee's or contractor's exclusion from receiving federal funds in accordance with 42 USC 1320a-7 and 42 USC 1320c-5.
  (c) Drivers and passengers to comply with all applicable federal, state, and local laws and regulations during transport.

(2) Brokers:
  (a) Must determine the level of assistance needed by the client (e.g., curb-to-curb, door-to-door, door-through-door, hand-to-hand) and the mode of transportation to be used for each authorized trip;
  (b) Must select the lowest cost available mode or alternative that is both accessible to the client and appropriate to the client's medical condition and personal capabilities;
  (c) Must have subcontracts with transportation providers in order for the providers to be paid by the broker;
  (d) Must provide transportation services comparable to those available to the general public in the local community;
  (e) May subcontract with licensed ambulance providers for nonemergency trips in licensed ground ambulance vehicles; and
  (f) May contract with a federally recognized tribe within the broker's service region to provide transportation services when requested by that tribe. When the department approves the request of a tribe or a tribal agency to administer or provide transportation services under WAC 388-546-5100 through388-546-6200 , tribal members may obtain their transportation services from the tribe or tribal agency with coordination from and payment through the transportation broker.

(3) If the broker is not open for business and is unavailable to give advance approval for transportation to an urgent care appointment or after a hospital discharge, the subcontracted transportation provider must either:
  (a) Provide the transportation in accordance with the broker's instructions and request a retroactive authorization from the broker within two business days of the transport; or
  (b) Deny the transportation, if the requirements of this section cannot be met.

(4) If the subcontracted transportation provider provides transportation as described in subsection (3)(a) of this section, the broker may agree to grant retroactive authorization and must document the reason in the client's trip record.

Washington Administrative Code (WAC) 182-546-5300 Nonemergency transportation – Client eligibility.

(1) The department pays for nonemergency transportation for medical assistance clients, including clients enrolled in a department-contracted managed care organization (MCO), to and from healthcare services when the healthcare service(s) meets the requirements in WAC 388-546-5500.

(2) Clients assigned to the patient review and coordination (PRC) program according to WAC 388-501-0135 may be restricted to certain providers.

(a) Brokers may authorize transportation of a PRC client to only those providers to whom the client is assigned or referred by their primary care provider (PCP), or for covered services which do not require referrals.
(b) If a client assigned to PRC chooses to receive service from a provider, pharmacy, and/or hospital that is not in the client's local community, the client's transportation is limited per WAC 388-546-5700.

Washington Administrative Code (WAC) 182-546-5400 Nonemergency transportation – Client responsibility.

(1) Clients must comply with applicable state, local, and federal laws during transport.
(2) Clients must comply with the rules, procedures and/or policies of the department, brokers, the brokers' subcontracted transportation providers and healthcare service providers.
(3) A client who is noncompliant may have limited transportation mode options available.
(4) Clients must request, arrange, and obtain authorization for transportation at least two business days before a healthcare appointment, except when the request is for an urgent care appointment or a hospital discharge.

Washington Administrative Code (WAC) 182-546-5500 Nonemergency transportation – Covered trips.

(1) The department covers nonemergency transportation for medical assistance clients to and from healthcare services when all of the following apply:
  (a) The healthcare services are:
    (i) Within the scope of coverage of the eligible client's benefit services package; and
    (ii) Covered as defined in WAC 388-501-0050 through388-501-0065 and the specific program rules.
  (b) The healthcare service is medically necessary as defined in WAC 388-500-0005;
  (c) The healthcare service is being provided as follows (see subsection (3) of this section for exceptions):
    (i) Under fee-for-service, by a department-contracted provider;
    (ii) Through a department-contract managed care organization (MCO), by an MCO provider; or
    (iii) Through a regional support network (RSN), by an RSN contractor.
  (d) The trip is to a local provider as defined in WAC 388-546-5100 (see WAC 388-546-5700(3) for local provider exceptions);
  (e) The transportation is the lowest cost available mode or alternative that is both accessible to the client and appropriate to the client's medical condition and personal capabilities;
  (f) The trip is authorized by the broker in advance of a client's travel; and
  (g) The trip is a minimum of three-quarters of a mile from pick-up point to the drop-off point (see WAC 388-546-6200(7) for exceptions to the minimum distance requirement).
(2) Coverage for nonemergency medical transportation is limited to one roundtrip per day, with the exception of multiple medical appointments.
(3) Subsection (1)(c) of this section does not apply if the covered healthcare services is paid for or provided by medicare, a third party insurance, Veteran's Administration, charitable or other voluntary program (Shriners, etc.).

Washington Administrative Code (WAC) 182-546-5550 Nonemergency transportation – Exclusions and limitations.

(1) The following service categories cited in WAC 388-501-0060 are subject to the following exclusions and limitations:
  (a) Adult day health (ADH) - Nonemergency transportation for ADH services is not provided through the brokers. ADH providers are responsible for arranging or providing transportation to ADH services.
  (b) Ambulance - Nonemergency ambulance transportation is not provided through the brokers except as specified in WAC 388-546-5200 (1)(d).

(c) Family planning services - Nonemergency transportation is not provided through the brokers for clients that are enrolled only in TAKE CHARGE or family planning only services.

(d) Hospice services - Nonemergency transportation is not provided through the brokers when the healthcare service is related to a client's hospice diagnosis. See WAC 388-551-1210.

(e) Medical equipment, durable (DME) - Nonemergency transportation is not provided through the brokers for DME services, with the exception of DME equipment that needs to be fitted to the client.

(f) Medical nutrition services - Nonemergency transportation is not provided through the brokers to pick up medical nutrition products.

(g) Medical supplies/equipment, nondurable (MSE) - Nonemergency transportation is not provided through the brokers for MSE services.

(h) Mental health services:

(i) Nonemergency transportation brokers generally provide one round trip per day to or from a mental health service. Additional trips for off-site activities, such as a visit to a recreational park, are the responsibility of the provider/facility.

(ii) Nonemergency transportation of involuntarily detained persons under the involuntary treatment act (ITA) is not a service provided or authorized by transportation brokers. Involuntary transportation is a service provided by an ambulance or a designated ITA transportation provider. See WAC 388-546-4000.

(i) Substance abuse services - Nonemergency transportation is not provided through the brokers for substance abuse services for clients under the state-funded medical programs (medical care services program (MCS)). See WAC 388-546-5200(2).

(j) Chemical dependency services - Nonemergency transportation is not provided through the brokers to or from the following:

(i) Residential treatment;

(ii) Intensive inpatient;

(iii) Recovery house;

(iv) Long-term treatment;

(v) Information and assistance services, which include:

(A) Alcohol and drug information school;

(B) Information and crisis services; and

(C) Emergency service patrol.

(2) The following medical assistance programs have limitations on trips:

(a) State-funded medical care services (MCS) program for clients covered by the disability lifeline program and the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) -Nonemergency transportation for mental health services and substance abuse services is not provided through the brokers. The department does pay for nonemergency transportation to and from medical services as specified in WAC 388-501-0060, excluding mental health services and substance abuse services, and subject to any other limitations in this chapter or other program rules.

(b) Transitional bridge waiver for clients covered by the disability lifeline program and the Alcohol and Drug Addiction Treatment and Support Act (ADATSA)- Nonemergency transportation for mental health services and substance abuse services is not provided through the brokers. The department does pay for nonemergency transportation to and from medical services as covered in the transitional bridge waiver approved by the Centers for Medicare and Medicaid Services, excluding mental health services and substance abuse services, and subject to any other limitations in this chapter or other program rules.

Washington Administrative Code (WAC) 182-546-6000 Nonemergency transportation – Authorization.

(1) The department contracts with brokers to authorize or deny requests for transportation services.

(2) Brokers may refer requests to transport a client to a provider to the department's medical director or designee for a review and/or authorization.
(3) Nonemergency medical transportation, other than ambulance, must be prior authorized by the broker. See WAC 388-546-5200 (3) and (4) and 388-546-6200(4) for granting retroactive authorization.
(4) The broker mails a written notice of denial to each client who is denied authorization of transportation.
(5) A client who is denied nonemergency transportation under this chapter may request an administrative hearing, if one is available under state and federal law.
(6) If the department approves a medical service under exception to rule (ETR), the authorization requirements of this section apply to transportation services related to the ETR service.

Washington Administrative Code (WAC) 182-546-6200 Nonemergency transportation – Reimbursement.

(1) To be reimbursed for trips, meals, and lodging, the requestor must receive prior authorization from the broker at least forty-eight hours in advance of the client's travel.
(2) A client must request reimbursement of preauthorized expenditures for trips, meals, and lodging within thirty days after his or her medical appointment(s). The broker may consider reimbursement requests beyond thirty days if a client shows good cause as defined in WAC 388-02-0020 for having not requested reimbursement within thirty days.
(3) To be reimbursed for mileage, fuel/gas, parking, bridge tolls, and ferry fees, the requestor must provide the broker with legible copies of:
    (a) Receipt(s);
    (b) The operator's driver license;
    (c) Current vehicle registration; and
    (d) Proof of insurance for the vehicle/operator at the time of the trip.
(4) The department or the broker may retroactively authorize and reimburse for transportation costs, including meals and lodging when:
    (a) A client is approved for a retroactive eligibility period, or is approved for a delayed certification period as defined in WAC 388-500-0005;
    (b) The transportation costs were not used to meet a client spenddown liability in accordance with WAC 388-519-0110;
    (c) The transportation costs for which retroactive reimbursement is requested falls within the period of retroactive eligibility or delayed certification;
    (d) The client received medically necessary services that were covered by their medical program for the date(s) of service for which retroactive reimbursement is requested; and
    (e) The request for retroactive reimbursement is made within sixty days from the date of eligibility notification (award letter), not to exceed eight months from the date(s) of service for which reimbursement is requested.
(5) When transportation cost(s) are retroactively authorized, the reimbursement amount must not exceed the reimbursement amount that would have been authorized prior to the date(s) of service.
(6) To be paid by the broker for nonemergency transportation services:
    (a) Ambulance providers must be subcontracted with the broker in accordance with WAC 388-546-5200 (1)(d).
    (b) Nonambulance providers must be subcontracted with the broker in accordance with WAC 388-546-5200 (1)(c).
(7) The department, through its contracted brokers, does not pay for nonemergency transportation when:
    (a) The healthcare service the client is requesting transportation to or from is not a service covered by the client's medical program.
    (b) The covered healthcare service is within three-quarters of a mile from the pick-up point, except when:
        (i) The client's documented and verifiable medical condition and personal capabilities demonstrates that the client is not able to walk three-quarters mile distance;

(ii) The trip involves an area that the broker determines is not physically accessible to the client; or

(iii) The trip involves an area that the department's broker considers to be unsafe for the client, other riders, or the driver.

(c) The client has personal or informal transportation resources that are available and appropriate to the clients' needs;

(d) Fixed-route public transportation service is available to the client within three-quarters of a mile walking distance. Exceptions to this rule may be granted by the transportation broker when the need for more specialized transportation is documented. Examples of such a need may be the client's use of a portable ventilator, a walker, or a quad cane; or

(e) The mode of transport that the client requests is not necessary, suitable, or appropriate to the client's medical condition.

11-48 The Health Care Authority does not have adequate controls to ensure providers meet initial and ongoing eligibility requirements to participate in the Medicaid program.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.776	Hurricane Katrina Relief Program
	93.777	State Survey and Certification of Health Care Providers and Suppliers
	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:	5-1105WA5MAP; 5-1105WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Provider Eligibility	
Questioned Cost Amount:	None	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for certain low-income individuals who otherwise might go without medical care. The state Medicaid program spent more than $7.5 billion during fiscal year 2011. More than $4.5 billion of that relates to activities of the Health Care Authority, which paid more than $4.4 billion of that directly to providers.

The Health Care Authority's Provider Enrollment Unit reviews the qualifications of health care providers who want to participate in the state's Medicaid program.

More than 80 different types of providers, such as durable medical equipment suppliers, physicians, pharmacists, and others, provide services to Medicaid beneficiaries. Federal regulations require any Medicaid provider to have current, valid licenses for their field of service. Each provider must complete and sign a Core Provider Agreement and submit information about their business and what services they provide. Typically, they provide copies of:

- Business license(s).
- Current professional license.
- Internal Revenue Service W-9 (tax identification) form.
- Liability insurance (if applicable).
- Medicare certification (if applicable).
- Drug Enforcement Administration certification (if applicable).

Providers submit these documents to the Provider Enrollment Unit, which reviews them for accuracy and completeness. When the enrollment process is completed, the Unit assigns the provider an identification number.

Certain requirements also apply to specific types of providers, such as those who distribute durable medical equipment, such as wheelchairs, hearing aids and breathing devices. For example, federal law requires these providers to maintain a physical facility from which to do business to ensure clients receive support associated with medical equipment needs. Post office boxes are not considered a physical facility.

During fiscal year 2011, more than 20,000 providers participated in Medicaid programs.

Description of Condition

We reported a finding in our fiscal year 2010 audit regarding a lack of controls to ensure providers meet initial and ongoing Medicaid eligibility requirements.

The Provider Enrollment Unit ensures providers have appropriate licenses when first determining their eligibility. A direct link with the Department of Health has been established to automatically update licensing information. This ensures the Unit has each provider's most current license information. However, the Unit still must ensure any provider with an expired license in the system is not paid for services. This verification did not occur during the fiscal year, which would allow providers with expired licenses to continue providing services to Medicaid clients.

The Unit also must ensure durable medical equipment providers meet eligibility requirements for their field of service. However, the Unit did not ensure equipment providers have a physical location. The Office of Program Integrity's Medical and Hospital Audit Unit completed 28 drive-by verifications over three days in October and November 2010, but have not completed any since then.

In addition, the Affordable Care Act introduced new screening procedures for providers and suppliers as of March 25, 2011. The Act identifies durable medical equipment providers as moderate to high-risk providers, which require unscheduled, unannounced site visits. The Authority has yet to adopt procedures to meet these requirements.

Cause of Condition

The Provider Enrollment Unit uses a computer system that has the capability to deny payment claims from providers who have expired licenses. The Unit stated it has requested a change in procedure to do so, but the change has not been made.

According to the Health Care Authority, budget constraints limited the number of staff assigned to field audits within the Office of Program Integrity during fiscal year 2011. As such, the audit unit did not concentrate on drive-bys of durable medical equipment providers.

Requirements related to the Affordable Care Act were put in place in a short period of time, and the Authority states it was unable to create all the necessary policies and procedures to meet those requirements.

Effect of Condition

Provider eligibility requirements help ensure Medicaid clients receive qualified care and services. Inadequate controls to ensure providers meet continuing eligibility requirements increases the risk ineligible providers may be providing services to Medicaid clients.

Recommendation

We recommend the Authority establish and follow internal controls to ensure:

- All providers participating in the Medicaid program meet eligibility requirements initially and throughout their enrollment. This includes general requirements and requirements specific to medical equipment providers.
- Providers with expired licenses are not paid for services.
- Equipment providers maintain an appropriate physical location for providing services.
- Affordable Care Act requirements are met.

Department's Response

The agency partially agrees with the findings.

However, corrective action steps have already implemented much of the audit recommendations:

- *The Provider Enrollment Unit now ensures appropriate provider licensing eligibility upon initial enrollment and throughout the provider's enrollment. The agency also has established a data-sharing agreement with the Department of Health that automatically updates providers' licensing information. This ensures the Provider Enrollment Unit consistently receives the most current provider licensing information daily. If a Department of Health license has expired, the Health Care Authority is notified, and the ProviderOne payment system ends the taxonomy associated with the provider's file, preventing further payments.*

- *As of March 25, 2011, the Patient Protection and Affordable Care Act introduced new screening procedures for providers and suppliers. The Act identifies Durable Medical Equipment providers as moderate to high-risk business partners who deserve unscheduled, unannounced site visits. The Health Care Authority is finalizing written policies and procedures to comply with the Act. The Health Care Authority estimates it will meet this requirement in January 2013. The agency also has requested computer system changes that will add mandatory data fields needed for compliance with the federal law.*

- *The Health Care Authority has resumed site visits with newly enrolled DME providers. The agency is also planning revalidation site visits for Durable Medical Equipment suppliers not currently enrolled with Medicare or another state's Medicaid agency. The Centers for Medicare and Medicaid Services only requires these providers to be revalidated once every five years. Federal law (42 CFR §455.410 (C) allows the agency to rely on screening, including site visits, conducted by Medicare or another state's Medicaid agency.*

Auditor's Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

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

The auditee shall:

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

Title 42, Code of Federal Regulations, Section 424.57 states in part - Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing privileges.

(c) Application certification standards. The supplier must meet and must certify in its application for billing privileges that it meets and will continue to meet the following standards. The supplier:

(7) Maintains a physical facility on an appropriate site. An appropriate site must meet all of the following:

(i) Must meet the following criteria:

(A) Except for State-licensed orthotic and prosthetic personnel providing custom fabricated orthotics or prosthetics in private practice, maintains a practice location that is at least 200 square feet beginning—

(1) September 27, 2010 for a prospective DMEPOS supplier;
(2) The first day after termination of an expiring lease for an existing DMEPOS supplier with a lease that expires on or after September 27, 2010 and before September 27, 2013; or
(3) September 27, 2013, for an existing DMEPOS supplier with a lease that expires on or after September 27, 2013.

(B) Is in a location that is accessible to the public, Medicare beneficiaries, CMS, NSC, and its agents. (The location must not be in a gated community or other area where access is restricted.)

(C) Is accessible and staffed during posted hours of operation.

(D) Maintains a permanent visible sign in plain view and posts hours of operation. If the supplier's place of business is located within a building complex, the sign must be visible at the main entrance of the building or the hours can be posted at the entrance of the supplier.

(E) Except for business records that are stored in centralized location as described in paragraph (c)(7)(ii) of this section, is in a location that contains space for storing business records (including the supplier's delivery, maintenance, and beneficiary communication records).

(F) Is in a location that contains space for retaining the necessary ordering and referring documentation specified in §424.516(f).

(ii) May be the centralized location for all of the business records and the ordering and referring documentation of a multisite supplier.

(iii) May be a "closed door" business, such as a pharmacy or supplier providing services only to beneficiaries residing in a nursing home, that complies with all applicable Federal, State, and local laws and regulations. "Closed door" businesses must comply with all the requirements in this paragraph.

Title 42, Code of Federal Regulations, Section 424.510 states in part -

Requirements for enrolling in the Medicare program.

(d) Providers and suppliers must meet the following enrollment requirements:

(2) *Content of the enrollment application*. Each submitted enrollment application must include the following:

(iii) Submission of all documentation, including—

(A) All applicable Federal and State licenses, certifications including, but not limited to Federal Aviation Administration; and

(B) Documentation associated with regulatory and statutory requirements necessary to establish a provider's or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program.

Washington Administrative Code 182-502-0010 When the department enrolls.

Nothing in this chapter obligates the department to enroll any eligible healthcare professional, healthcare entity, supplier or contractor of service who requests enrollment.

(2) To enroll as a provider with the department, a healthcare professional, healthcare entity, supplier or contractor of service must, on the date of application:

(a) Be currently licensed, certified, accredited, or registered according to Washington state laws and rules. Persons or entities outside of Washington state, see WAC 388-502-0120;

(b) Have current professional liability coverage, individually or as a member of a group;

(c) Have a current federal drug enforcement agency (DEA) certificate, if applicable to the profession's scope of practice;

(d) Meet the conditions in this chapter and other chapters regulating the specific type of healthcare practitioner;

(e) Sign, without modification, a core provider agreement (CPA) and debarment form (DSHS 09-048) or a contract with the department. (Note: Section 13 of the CPA,

DSHS 09-048 (REV. 08/2005), is hereby rescinded. The department and each provider signing a core provider agreement will hold each other harmless from a legal action based on the negligent actions or omissions of either party under the terms of the agreement.);

(f) Agree to accept the payment from the department as payment in full (in accordance with 42 C.F.R. § 447.15 acceptance of state payment as payment in full and WAC 388-502-0160 billing a client);

(g) Fully disclose ownership and control information requested by the department. If payment for services is to be made to a group practice, partnership, or corporation, the group, partnership, or corporation must enroll and obtain a CPA number to be used for submitting claims as the billing provider. All owners must be identified and fully disclosed in the application; and

(h) Have screened employees and contractors with whom they do business prior to hiring or contracting to assure that employees and contractors are not excluded from receiving federal funds as required by 42 U.S.C. 1320a-7 and 42.U.S.C. 1320c-5.

WAC 182-543-2000
DME and related supplies, prosthetics, orthotics, medical supplies and related services — Eligible providers and provider requirements.

(1) The department pays qualified providers for durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies, repairs, and related services on a fee-for-service basis as follows:
   (a) DME providers for DME and related repair services
   (b) Medical equipment dealers, pharmacies, and home health agencies under their national provider indicator (NPI) for medical supplies;
   (c) Prosthetics and orthotics providers who are licensed by the Washington state department of health in prosthetics and orthotics. Medical equipment dealers and pharmacies that do not require licensure to provide selected prosthetics and orthotics may be paid for those selected prosthetics and orthotics only;
   (d) Physicians who provide medical equipment and supplies in the office. The department may pay separately for medical supplies, subject to the provisions in the department's resource-based relative value scale fee schedule; and
   (e) Out-of-state orthotics and prosthetics providers who meet their state regulations.

(2) Providers and suppliers of durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies and related items must:
   (a) Meet the general provider requirements in chapter 388-502 WAC;
   (b) Have the proper business license and be certified, licensed and/or bonded if required, to perform the services billed to the department;
   (c) Have a valid prescription;
      (i) To be valid, a prescription must:
         (A) Be written on the department's Prescription Form (DSHS 13-794). The department's electronic forms are available on-line at:http://www.dshs.wa.gov/msa/forms/eforms.html;
         (B) Be written by a physician, advanced registered nurse practitioner (ARNP), or physician's assistant certified (PAC);
         (C) Be written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the supply, equipment, or device. Prescriptions must not be back-dated;
         (D) Be no older than one year from the date the prescriber signs the prescription; and
         (E) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity.
      (ii) For dual eligible medicare/medicaid clients when medicare is the primary payer and the department is being billed for the co-pay and/or deductible only, subsection (2)(a) of this section does not apply.
   (d) Provide instructions for use of equipment;

(e) Furnish only new equipment to clients that includes full manufacturer and dealer warranties. See WAC 388-543-2250(3);
(f) Furnish documentation of proof of delivery, upon department request (see WAC 388-543-2200); and
(g) Bill the department using only the allowed procedure codes listed in published DME and related supplies, prosthetics and orthotics, medical supplies and related items billing instructions.

11-49 The Department of Health charged the National Bioterrorism Hospital Preparedness Program for activities that occurred after the grant period had ended.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.889 National Bioterrorism Hospital Preparedness Program
Federal Award Number:	U3REP090208-01, U3REP080103-01
Applicable Compliance Component:	Period of Availability
Questioned Cost Amount:	$38,574.67

Background

The Washington State Department of Health administers the federal National Bioterrorism Hospital Preparedness Program grant that enhances the ability of hospitals and health care systems to prepare for and respond to biological and other public health emergencies. The Department distributes this money to public and private entities that provide these services and retains a portion to pay administrative costs. The Department spent approximately $8.5 million in grant funds in fiscal year 2011.

Grant money is awarded for predefined project periods during which funds may be expended or obligated for allowable program activities. Once a project period has ended, the Department has 90 days to pay any expenses that were incurred during the project period. Within 90 days of the project period ending the Department must file a financial status report with the U.S. Department of Health and Human Services. From that point forward, it may make no further charges the grant unless the grantor approves an extension.

In our fiscal year 2010 audit, we reported in a finding that the Department violated the period of availability requirements of the grant by charging federal grants for expenditures incurred after the grant period had closed. We reported a significant deficiency in internal controls and questioned approximately $155,000.

Description of Condition

The Department had two federal grants whose project periods ended during fiscal year 2011. One ended on July 30, 2010 and one ended on August 8, 2010. Federal regulations allow obligations incurred prior to these dates to be paid through October 28, 2010 and November 6, 2010, respectively.

We reviewed charges made to the grants and determined that three payments totaling $38,574.67 were made for activities occurring after the grants ended. Two of these payments were also made more than 90-days after the project period ended in violation of federal requirements.

The Department modified its internal controls after we issued our fiscal year 2010 audit report in March 2011. However, we were unable to determine if it was following these corrective measures because it had no grant periods that ended between March and June 2011. The internal control finding from fiscal year 2010 remains unresolved, and we will perform a follow-up as part of the fiscal year 2012 audit.

Cause of Condition

Department management thought that because purchase orders were completed prior to the end of the grant periods, the funds were obligated and the expenditures were allowable.

Effect of Condition and Questioned Costs

By paying for activities that occurred after the grant periods, the Department improperly charged expenditures to the federal grants. This could jeopardize future federal funding to the Department.

Additionally, because the Department continued to charge the grants after the closing date, it was unable to file all required financial reports in a timely manner. Interim financial reports were submitted for the grants, but the final reports were late. The final financial reports were due October 28, 2010 and November 6, 2010, but were both submitted November 18, 2010.

We identified $38,574.67 in expenditures that were improperly charged to the National Bioterrorism Hospital Preparedness Program. We are questioning those costs as unallowable charges. The federal grantor could disallow these charges and require the Department to pay back the money.

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.

Recommendations

We recommend the Department limit charges to grants for activities that occur prior to the end of the grant period. We also recommend management responsible for monitoring the spending of federal funds receive additional training on federal grant requirements.

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

Department's Response

We concur with the state auditor's office finding, but wish to be clear that the DOH response to the 2010 finding was implemented as soon as possible after the auditor's had completed their work in March of 2011.

Two of the transactions at issue were completed on 10/29/2010, one day past the ninety day period following the close of the availability period. This was due to a communication problem in getting the transactions entered into the accounting system by the deadline.

We will work with the Office of Financial Management to complete our corrective action plan. We will share this plan with the State Auditor's Office.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

Title 45 Code of Federal Regulations, Part 92 – *Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments,* states*: --*

> Sec. 92.23 Period of availability of funds.
> (a) General. Where a funding period is specified, a grantee may charge to the award only costs resulting from obligations of the funding period unless carryover of unobligated balances is permitted, in which case the carryover balances may be charged for costs resulting from obligations of the subsequent funding period.

(b) Liquidation of obligations. A grantee must liquidate all obligations incurred under the award not later than 90 days after the end of the funding period (or as specified in a program regulation) to coincide with the submission of the annual Financial Status Report (SF-269). The Federal agency may extend this deadline at the request of the grantee.

11-50 The Washington Commission for National and Community Service at the Office of Financial Management does not properly monitor subgrantees to ensure expenditures of AmeriCorps grant funding are allowable and adequately supported.

Federal Awarding Agency:	U.S. Corporation for National and Community Service
Pass-Through Entity:	None
CFDA Number and Title:	94.006 AmeriCorps 94.006A AmeriCorps – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	06AFHWA001; 09ACHWA001; 09RCHWA002; 09RFHWA001; 10ESHWA001; 10FXHWA002; 11ACHWA001
Applicable Compliance Component:	Sub-Recipient Monitoring
Questioned Cost Amount:	None

Background

AmeriCorps is a national program that provides funds to national and local organizations that recruit and train individuals for community service. Full-time members receive a living allowance and are eligible for health insurance and child care benefits. After successfully completing the required term of service, AmeriCorps members receive a voucher that may be used to pay off qualified student loans or to pay qualified educational expenses.

The Office of Financial Management administers the AmeriCorps program through the Washington Commission for National and Community Service. In state fiscal year 2011, 14 non-state entities and five state agencies spent almost $16 million of the approximately $18 million available to the state for the program. For the purpose of this audit, state agencies are not considered separate subgrantees and are audited as a single entity. The majority of the money was spent on living allowances and benefits for approximately 1,300 AmeriCorps members.

The Commission, as the grantee, is legally accountable to the federal Corporation for National and Community Service for ensuring grant funds are properly spent. Federal regulations require the grantee to ensure the eligibility of individuals seeking to become AmeriCorps members.

Because many AmeriCorps members have access to vulnerable populations, one of the requirements is that a member cannot be registered, or required to be registered, on a state sex offender registry. Federal regulations require the state to perform a state criminal registry search and a National Sex Offender Public Registry search. The results of these two checks must be printed and retained at the time they are performed. The Commission has delegated member selection and direct supervision to the subgrantees that oversee the specific projects. The supervising organization collects and retains all required documentation regarding an applicant's eligibility. All requirements must be met and records complete prior to member selection and enrollment in the program. Grant provisions state "The grantee is responsible for ensuring that subgrantees or other organizations carrying out activities under this award comply with these provisions, including regulations and OMB circulars incorporated by reference."

For subgrantees, the Commission reviews member eligibility and compliance with federal regulations, and AmeriCorps grant requirements. It performs a risk assessment of every subgrantee each year to determine the level of monitoring needed. It must perform onsite visits for high- and medium-risk subgrantees. It must pay two visits to high-risk subgrantees, within three months of the program start date. New subgrantees are automatically assessed as high-risk. While not required, the grantor recommends the Commission visit low-risk subgrantees. The Commission is to examine eligibility documentations during on-site visits.

Description of Condition

We examined whether the Commission:

- Is performing risk assessments based on accurate and complete documentation,
- Is performing onsite monitoring in a timely manner and following up on identified non-compliance.
- Is doing a review to ensure payments were being made only to eligible members.

We reviewed grant files for all 13 non-state entity programs for documentation to support each of these elements and found the Commission:

- Assessed one subgrantee new to administering AmeriCorps as low-risk.
- Visited six subgrantees during fiscal year 2011. Of these six, three were assessed as high risk, one was assessed at medium risk and two were assessed at low risk. The grant files for two high-risk subgrantees document only one site visit each.
- Had documentation that showed that all eligibility criteria were met for three of the six subgrantees visited. Documentation for the other three reviews was incomplete, showing less than 30 percent of the background checks were reviewed.
- Performed five of the six onsite reviews five to eight months after the start of the programs.

The Commission relies on its subgrantee monitoring process to ensure that only eligible members are paid, since they do not review or monitor eligibility prior to payments. We found eligibility reviews were not conducted for seven of the 13 subgrantees due to their low-risk status.

Cause of Condition

The Commission was unaware it was responsible for ensuring members were eligible. Because of this, the subrecipient monitoring process was not designed to give the Commission assurance regarding the eligibility of all members. The Commission's monitoring is not adequate because it does not include a full review of member eligibility documentation in a timely manner.

Effect of Condition

Programs at some subgrantees are never examined and the majority of the examinations performed are done after the member has completed 50 percent to 75 percent of the program. Without monitoring to ensure subgrantees comply with federal requirements, the Commission has no assurance members are eligible to participate in the program or that grants funds are being used properly. In addition the AmeriCorps Program cannot be certain that individuals who are registered sex offenders are kept from serving in the program.

Recommendation

We recommend the Commission strengthen internal controls over monitoring sub-recipients to ensure full compliance with federal requirements. We recommend the Commission maintain support showing that sub-recipients are meeting federal grant requirements.

Commission's Response

For clarifying purposes, the Commission is the pass-through entity for federal AmeriCorps funding awarded by the Corporation for National and Community Service (CNCS) and has contractual agreements with all sub-recipients including five state agencies. Each sub-recipient, including five state agencies, is viewed as a distinct sub-recipient. The sub-recipients are required to implement certain program operational requirements and all are accountable to the State Commission.

The use of the word "grantee" has two different applications and when combined the above implies that the grantee is both the Commission and the 17 sub-recipients who have separate and distinct responsibilities.

The Commission's role as grantee is to monitor the activities of sub-recipients to ensure that the federal awards are used for the authorized purpose in compliance with laws, regulations, and the provisions contained in the contractual agreements. Since the Commission does not operate programs, eligibility verification and criminal history checks are properly performed at the sub-recipient program level.
To clarify, the state is not required to perform the two-part background checks. This is the responsibility of the sub-recipient (program operator) to perform state criminal registry and National Sex Offender Public Registry checks.

The above sentence should be clarified that the sex offender registry (National Sex Offender Public Registry) is a national registry, not a state registry as noted above.

The CNCS does not expect any Commission to be in the role of being directly responsible for member selection and supervision. The State Commission does not operate AmeriCorps programs and as such is not required to review eligibility documentation for all 1,300 AmeriCorps to ensure they meet eligibility standards.

The Commission appreciates the other insights and recommendations contained in this report. Based on areas identified for improvement, we will carry out a series of program monitoring enhancements and take the following steps to improve consistency and internal controls in the overall implementation of the monitoring process with the following actions:

- *Require subgrantees to submit eligibility certification confirmation on their member roster, signed by an authorized program official, stating that the members have met CNCS eligibility requirements beginning with the 2012-13 Program Year;*
- *Build a timetable upon receipt of CNCS grant awards to ensure that programs identified in all the risk categories receive the type of thorough monitoring and frequency depending on their classification;*
- *Maintain documentation in the monitoring file that details each finding or corrective action for each program that includes any follow up and resolution to ensure it is completed in a consistent and timely manner;*
- *Revise procedures to have consistent standards regarding the percentage of member files to be reviewed, and identify the random selection process to select members' files chosen for review. (The CNCS does not require a 100% member file verification as part of the monitoring process)*

We look forward to engaging in a dialogue with State Auditor staff to clarify any points and will begin immediately to implement recommendations identified above and found in the preliminary draft report.

Auditor's Concluding Remarks

We thank the Commission for its response. To reiterate, we contend the Commission, as the grantee, is legally accountable to the Corporation for National and Community Service for ensuring compliance with federal regulations and grant funds are properly spent. This includes ensuring all members are eligible. We do not disagree with the delegation of the eligibility determination to the sub-recipients but it is our position that the federal grantor cannot be assured the Commission paid only eligible members based on the current sub-recipient monitoring practices.

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

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:

(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.

2010 AmeriCorps Grant Provisions, Section IV, Part A, subpart 1 states:

1. Grantee, for the purposes of this agreement, means the direct recipient of this grant "45 CFR part 2542.510". The grantee is legally accountable to the Corporation for the use of grant funds and is bound by the provisions of the grant. The grantee is responsible for ensuring that subgrantees or other organizations carrying out activities under this award comply with these provisions, including regulations and OMB circulars incorporated by reference.

Title 45, Code of Federal Regulations, Part 2540 states in part:

§2540.200 To whom must I apply suitability criteria relating to criminal history?

You must apply suitability criteria relating to criminal history to an individual applying for, or serving in, a position for which an individual receives a Corporation grant-funded living allowance, stipend, education award, salary, or other remuneration.

§2540.201 What suitability criteria must I apply to a covered position?

An individual is ineligible to serve in a covered position if the individual:

(a) Is registered, or required to be registered, on a State sex offender registry or the National Sex Offender Registry; or

(b) Has been convicted of murder, as defined in section 1111 of title 18, United States Code.

§2540.202 What two search components of the National Service Criminal History Check must I satisfy to determine an individual's suitability to serve in a covered position?

Unless the Corporation approves an alternative screening protocol, in determining an individual's suitability to serve in a covered position, you are responsible for conducting and documenting a National Service Criminal History Check, which consists of the following two search components: (a) *State criminal registry search.* A search (by name or fingerprint) of the State criminal registry for the State in which your program operates and the State in which the individual resides at the time of application; and (b) *National Sex Offender Public Registry.* A name-based search of the Department of Justice (DOJ) National Sex Offender Public Registry (NSOPR).

§2540.203 When must I conduct a State criminal registry check and a NSOPR check on an individual in a covered position?

(a) The State criminal registry check must be conducted on Foster Grandparents, Senior Companions, and AmeriCorps State and National participants and grant-funded staff with recurring access to children, persons age 60 or older, or individuals with disabilities, who

enroll in, or are hired by, your program after November 23, 2007. For all other covered individuals, the State criminal registry check must be conducted on an individual who enrolls in, or is hired by, your program on or after October 1, 2009.

(b) The National Sex Offender Public Web site check must be conducted on an individual who is serving, or applies to serve, as a Foster Grandparent, Senior Companion, or AmeriCorps State and National participant or grant-funded staff with recurring access to children, persons age 60 or older, or individuals with disabilities on or after November 23, 2007. For all other covered individuals, the National Sex Offender Public Web site check must be conducted on an individual who enrolls in, or is hired by, your program on or after October 1, 2009.

(c) For an individual who serves consecutive terms of service in your program with a break in service of no more than 30 days, no additional check is required after the first term.

§2540.204 What procedures must I follow in conducting a National Service Criminal History Check for a covered position?

You are responsible for following these procedures: (a) Verify the individual's identity by examining the individual's government-issued photo identification card, such as a driver's license; (b) Obtain prior, written authorization for the State criminal registry check and the appropriate sharing of the results of that check within the program from the individual (but not for the NSOPR check); (c) Document the individual's understanding that selection into the program is contingent upon the organization's review of the individual's criminal history, if any; (d) Provide a reasonable opportunity for the individual to review and challenge the factual accuracy of a result before action is taken to exclude the individual from the position; (e) Provide safeguards to ensure the confidentiality of any information relating to the criminal history check, consistent with authorization provided by the applicant; and (f) Ensure that an individual, for whom the results of a required State criminal registry check are pending, is not permitted to have access to children, persons age 60 and older, or individuals with disabilities without being accompanied by an authorized program representative who has previously been cleared for such access.

§2540.205 What documentation must I maintain regarding a National Service Criminal History Check for a covered position?

You must: (a) Document in writing that you verified the identity of the individual in a covered position by examining the individual's government-issued photo identification card, and that you conducted the required checks for the covered position; and (b) Maintain the results of the National Service Criminal History check (unless precluded by State law) and document in writing that you considered the results in selecting the individual.

11-51 The Employment Security Department did not ensure all background checks were performed for AmeriCorps members as required by federal regulations.

Federal Awarding Agency:	U.S. Corporation for National and Community Service
Pass-Through Entity:	None
CFDA Number and Title:	94.006 AmeriCorps 94.006A AmeriCorps – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	06AFHWA001; 09ACHWA001; 09RCHWA002; 09RFHWA001; 10ESHWA001; 10FXHWA002; 11ACHWA001
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	$ 85,554.24 Non-ARRA Actual $506,647.00 Non-ARRA Projected $ 6,014.15 ARRA Actual $ 10,490.00 ARRA Projected

Background

AmeriCorps is a national service program that provides funds to national and locally based organizations to recruit and train AmeriCorps members. Full-time members receive a living allowance and are eligible for health insurance and child care benefits. After successfully completing the required term of service, AmeriCorps members receive a voucher that may be used to pay off qualified student loans or to pay qualified educational expenses.

The Employment Security Department is one of several state agencies that administer the AmeriCorps program. In fiscal year 2011 the Department spent more than $9 million of the approximately $18 million available to the state for the program. Approximately $4.4 million of this was spent on living allowances and benefits for nearly 1,000 AmeriCorps members. Most of these members are selected and directly supervised by organizations the Department oversees, such as non-profits or educational institutions. The supervising organizations collect the required documentation for these members and send it to the Department. The Department must ensure all requirements have been met and records are complete prior to enrolling the member.

The Department also directly oversaw 42 members. Federal regulations state the Department must ensure individuals it will supervise are eligible to become AmeriCorps members. In order to be eligible, individuals cannot be registered, or required to be registered, on a state sex offender registry. Federal regulations require the state to perform a state criminal registry search and a National Sex Offender Public Registry search. The results must be printed and retained at the time they are performed.

The Department requested and received approval from the federal grantor to use an Alternative Search Protocol to ensure background checks are performed for applicants the Department does not directly supervise. The approved Alternative Search Protocol requires the organizations overseeing members to conduct the two required background checks prior to accepting an individual for the program. The organizations must sign a certification for each applicant stating the background checks were performed and no disqualifying offenses were identified and send it to the Department. The Department must retain the certification. In addition, the Department, when performing monitoring visits of organizational sites, must review the member files and ensure the background checks were properly performed and the reports were retained.

Description of Condition

We examined the files of all 42 members supervised by the Department who enrolled during the fiscal year for evidence that background checks were performed. We determined the Department did not do so for 16

prior to the member's term of service. All 16 had a National Sex Offender Public Registry check in the file, but 11 had the dates removed and five were performed after we requested the files. The Department stated it realized the checks were missing so they ran a new check and removed the date for 11 of the files and left the date for the other five. Of the 16 files, nine were also missing a proper state background check. Six of the files contained state background checks performed after we had requested the member's files. The other three had state background checks that were performed in August 2011, after the members had completed their service.

We also randomly selected 62 stipend payments for testing, 17 of which were paid with American Recovery and Reinvestment Act funding. For members who were directly supervised by the Department, we determined whether the Department had a copy of the state and national background checks in the member's file. For members supervised by other organizations, we examined whether the Department had the certification from the organization stating the background check was performed. We determined files for seven members did not contain the required documentation.

Cause of Condition

The Department does not have sufficient internal controls to ensure compliance with federal regulations. The Department relies on one individual to ensure all background check documentation is completed in a timely manner and is in the member's file prior to the member being enrolled. The Department does not have written policies or procedures to guide this process and does no secondary review to ensure background checks have been completed.

Effect of Condition and Questioned Costs

Without the documentation to show background checks were performed, the federal grantor cannot be assured living allowances and benefits were paid only to eligible members. In addition, the Department cannot be certain that all enrolled members do not have disqualifying offenses.

We identified $91,568 in living allowance and benefit payments to members for whom the Department did not have adequate documentation to determine eligibility. Of this amount, $6,014 was funded by Recovery Act money. Additionally, by using a sampling method that allows us to project our results to the entire population of living allowances paid, we estimate questioned costs of $517,137. Of this amount, $10,490 is funded by Recovery Act 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 it expenditures.

Recommendation

We recommend the Department establish internal controls for monitoring member files to ensure eligibility requirements have been met and are fully documented. We also recommend the Department communicate with the federal grantor to determine whether questioned costs need to be repaid.

Department's Response

The Employment Security Department (ESD) does not agree that individuals who served as members in the AmeriCorps program were ineligible. We will work with the grantor agency to resolve this finding and related questioned costs.

ESD recognizes the importance of having established procedures to comply with Commission for National and Community Service (CNCS) grant requirements for member background checks. The department's Washington Service Corps (WSC) has clear expectations regarding the required documentation and the retention of this information. These expectations are regularly communicated to staff and sub-recipients.

The 16 members missing background check documentation had completed certifications on file and those certifications were completed at the time of the members' enrollment in the program. These certifications were signed by department staff that completed the background checks and are attesting the member met CNCS background check requirements. During the audit it was discovered that the original background check documents were missing from the WSC files. They were subsequently rerun during the audit and provided to the auditor. The WSC has verified that enrolled members supervised by department staff for the current program year are in compliance with background check regulations.

The audit provided the WSC with the opportunity to identify areas for internal control improvements. As a result, the WSC immediately initiated corrective action to implement stronger internal controls to ensure eligibility requirements will be fully documented and retained as required by CNCS regulations. This will be an ongoing effort on the part of the Washington Service Corps and includes the following:

- *Creating a background check policy and procedures to ensure compliance with requirements.*
- *Retaining printed copies of the background check documents for all members. These documents will be filed centrally at WSC headquarters.*
- *Contracting with a CNCS approved Federal Bureau of Investigation "channeler" providing a vendor portal to ensure background checks for all potential members are handled within a reasonable period of time and cleared before the member's service start date.*
- *Ensuring all background checks received from sub-recipients are completed prior to the start of the member's term of service. This will be accomplished by a series of reviews by WSC staff. Initially a WSC program coordinator will review all background check documentation submitted by sub-recipients. This review will be for completeness and accuracy of information submitted and validation of documents identified on the enrollment checklist. The review will be performed before the member is authorized to start their term of service. The documentation will then be forwarded to a different WSC program coordinator for a secondary review. A final review will be performed by WSC staff enrolling the member(s) into eGrants. A member's enrollment will not be processed until all required documentation is obtained.*
- *Creating a centralized database of background check results to ensure completeness and compliance of member records for the upcoming 2012-13 program year.*
- *Providing WSC staff and sub-recipient supervisors with mandatory training planned for April 2012 on CNCS background check requirements and new WSC processes. Special emphasis will be on the new centralized process for receiving all background check documentation in WSC headquarters prior to the member starting service. Staff and sub-recipient supervisors will be held accountable for ensuring compliance with these requirements. An additional sub-recipient supervisor training session is scheduled in May 2012 that will incorporate changes to background check requirements resulting from anticipated updates to the Federal Register.*
- *Scheduling an internal WSC staff meeting on September 11, 2012 to evaluate the implementation of the new background check process and solicit feedback for improvements.*
- *Providing updates to staff and sub-recipients on questions or concerns received on background check processes. WSC will routinely discuss background check compliance in regular monthly staff meetings from this point forward to ensure instructions are clear and compliance requirements are understood.*

WSC is in the process of hiring a compliance coordinator with a strong background in compliance monitoring to ensure corrective actions taken by the department are being implemented. This individual will be responsible for:

- *Assisting in the development and delivery of training on the new background check policy and procedures to WSC staff and sub-recipients across the state.*

- *Overseeing transition to the new WSC background check processes and member eligibility requirements for program year 2012-13.*
- *Traveling to sub-recipients across the state to provide on-site monitoring of background check documentation for the 2011-12 program year. This enhanced monitoring effort will supplement the program's established risk-based monitoring process.*

Auditor's Concluding Remarks

We thank the Department for its response. To reiterate, we do not state the Department employed ineligible members. We state the federal grantor cannot be assured the Department paid only eligible members because it did not meet federal requirements. For the 16 directly supervised members the Department refers to in its response, we are aware that certifications were present in some, possibly all files. We did not reference these certifications in our finding because they do not meet requirements and therefore we did not examine them. The documentation on original background checks that was missing is the only acceptable form of documentation per federal law.

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

Applicable Laws and Regulations

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

> The auditee shall:
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.
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> §2540.200 To whom must I apply suitability criteria relating to criminal history?
> You must apply suitability criteria relating to criminal history to an individual applying for, or serving in, a position for which an individual receives a Corporation grant-funded living allowance, stipend, education award, salary, or other remuneration.
>
> §2540.201 What suitability criteria must I apply to a covered position?
> An individual is ineligible to serve in a covered position if the individual:
> (a) Is registered, or required to be registered, on a State sex offender registry or the National Sex Offender Registry; or
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>
> §2540.202 What two search components of the National Service Criminal History Check must I satisfy to determine an individual's suitability to serve in a covered position?
> Unless the Corporation approves an alternative screening protocol, in determining an individual's suitability to serve in a covered position, you are responsible for conducting and documenting a National Service Criminal History Check, which consists of the following two search components: (a) *State criminal registry search.* A search (by name or fingerprint) of the State criminal registry for the State in which your program operates and the State in which the individual resides at the time of application; and (b) *National Sex Offender Public*

Registry. A name-based search of the Department of Justice (DOJ) National Sex Offender Public Registry (NSOPR).

§2540.203 When must I conduct a State criminal registry check and a NSOPR check on an individual in a covered position?

(a) The State criminal registry check must be conducted on Foster Grandparents, Senior Companions, and AmeriCorps State and National participants and grant-funded staff with recurring access to children, persons age 60 or older, or individuals with disabilities, who enroll in, or are hired by, your program after November 23, 2007. For all other covered individuals, the State criminal registry check must be conducted on an individual who enrolls in, or is hired by, your program on or after October 1, 2009.

(b) The National Sex Offender Public Web site check must be conducted on an individual who is serving, or applies to serve, as a Foster Grandparent, Senior Companion, or AmeriCorps State and National participant or grant-funded staff with recurring access to children, persons age 60 or older, or individuals with disabilities on or after November 23, 2007. For all other covered individuals, the National Sex Offender Public Web site check must be conducted on an individual who enrolls in, or is hired by, your program on or after October 1, 2009.

(c) For an individual who serves consecutive terms of service in your program with a break in service of no more than 30 days, no additional check is required after the first term.

§2540.204 What procedures must I follow in conducting a National Service Criminal History Check for a covered position?

You are responsible for following these procedures: (a) Verify the individual's identity by examining the individual's government-issued photo identification card, such as a driver's license; (b) Obtain prior, written authorization for the State criminal registry check and the appropriate sharing of the results of that check within the program from the individual (but not for the NSOPR check); (c) Document the individual's understanding that selection into the program is contingent upon the organization's review of the individual's criminal history, if any; (d) Provide a reasonable opportunity for the individual to review and challenge the factual accuracy of a result before action is taken to exclude the individual from the position; (e) Provide safeguards to ensure the confidentiality of any information relating to the criminal history check, consistent with authorization provided by the applicant; and (f) Ensure that an individual, for whom the results of a required State criminal registry check are pending, is not permitted to have access to children, persons age 60 and older, or individuals with disabilities without being accompanied by an authorized program representative who has previously been cleared for such access.

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