Financial Findings Reported Under Government Auditing Standards

12-01 The State's internal controls over Medicaid payments processed by ProviderOne are inadequate to ensure those payments are properly processed and recorded.

Background

On January 1, 2012, the state transferred administration of the Medicaid program, including responsibility for payments, from the Department of Social and Health Services (DSHS) to the Health Care Authority (HCA). The transfer shifted significant accounting responsibilities from DSHS to HCA.

The state is responsible for designing and following internal controls to ensure Medicaid payments are properly processed and recorded into its accounting and financial reporting system. DSHS contracted with a vendor, which uses a system known as ProviderOne, to process approximately 57 million transactions totaling $5.4 billion each year for the state. These transactions represent a material portion or 41 percent of the $13.2 billion in human services expenditures reported in the state's general fund.

As discussed below, we identified weaknesses in internal controls that represent a significant deficiency in the state's controls and adversely affect its ability to ensure payments through the ProviderOne system are properly processed and recorded. A significant deficiency is a weakness in internal controls that could lead to inaccurate or unreliable accounting data.

Description of Condition

Our audit identified the following weaknesses in internal controls which, when taken together, we consider to be a significant deficiency:

- The HCA did not have an adequate process in place to verify that all ProviderOne transactions were transmitted to the state's accounting system from January 1 to June 30, 2012.

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

Cause of Condition

DSHS, HCA and the vendor did not adequately address responsibilities, controls and requirements for monitoring in the contract. Some HCA personnel did not learn of their responsibilities to ensure vendor payment information was accurately transferred into the state accounting system until our audit. Additionally, neither state agency understood the full extent of their monitoring responsibilities for ProviderOne.

Effect of Condition

The failure to monitor transaction information processed by the ProviderOne system could lead to inaccurate financial reporting in the state's general fund. Additionally, the lack of monitoring creates an environment in which the state cannot be sure the vendor maintains proper internal controls to prevent:

- Misuse, loss or misappropriation of public funds.
- Inaccurate payments.

- Unauthorized access to confidential, health-related information held by the vendor.
- Unauthorized software changes to the ProviderOne system.

To compensate for the internal control deficiencies we were required to perform additional audit procedures to verify the human services expenditures reported in the state's general fund.
We will be issuing additional findings related to ProviderOne:

- A noncompliance finding in our Single Audit of the State of Washington, which examines compliance with federal grant requirements and internal controls over the expenditure of grant money.
- Findings in a report on our information technology systems review of ProviderOne, which is a more detailed assessment of the ProviderOne application and general controls over its operations.

Recommendations

We recommend the State establish internal controls to ensure:

- Reconciliation procedures are in place to ensure ProviderOne transactions are accurately transferred to the state's accounting and financial reporting system.

- Adequate monitoring and oversight of the ProviderOne system to verify internal controls are in place and effective in ensuring the accuracy, integrity and privacy of the information.

State's Response

The State recognizes the significance and the priority of internal controls and takes them very seriously. HCA recognizes that a complete and adequate control process requires duplicate business validations of the transfer of transactions from ProviderOne to AFRS. While the two-step validation was lacking, HCA did perform daily validations and had controls in place to ensure the accuracy of the ProviderOne to AFRS interface.

- In January 2012, the ProviderOne system was enhanced to produce two AFRS interface files; one for DSHS transactions and one for HCA transactions. This enhancement was necessitated by the merger of DSHS/Medicaid with HCA. At the time of the system change, DSHS continued their established accounting process that validated the DSHS transactional data ProviderOne to AFRS interface. However, HCA Finance was not aware of this requirement and therefore did not institute a similar process for the HCA transactional data ProviderOne to AFRS interface.
- While the accounting validation step was missing, HCA continued to validate the daily interface at the technical/system level so controls were in place to assure the accuracy of the interface.
- Once HCA realized that the second accounting validation step was not in place, and that SAO did not consider the technical validation processes to be adequate, HCA immediately instituted the accounting validation step, including the completion of daily reconciliations from January 1 to present. The results of that reconciliation confirmed the results of the technical process above, and verified that all ProviderOne transactions had been properly accounted for in AFRS.

The State does not fully agree with the general statement that the HCA did not adequately monitor the ProviderOne system. However, HCA recognizes the importance of internal controls and has taken steps to enhance its ability to monitor the accuracy, integrity and privacy of the system and related functions.

- HCA believes that the Certification process conducted by the federal Centers for Medicare and Medicaid Services (CMS) documented that sufficient internal controls are in place. ProviderOne was implemented in May 2010 and was successfully certified by the federal Centers for Medicare and Medicaid Services (CMS) in August 2010, with no weaknesses cited. The CMS Certification Review is a comprehensive review of system criteria that includes over 600 Review Criteria, including a review of financial and internal security components. In addition to state-prepared documentation for each of the Review Criteria, a team of 7 CMS reviewers with expertise on specific system components were on-site for a week to conduct the review. The On-site Certification Team reviewed prepared documentation prior to their arrival, interviewed staff,

and performed additional verification by actual system interaction and testing. The federal certification process is very comprehensive in nature, using proven, standardized testing methodologies that allow the federal government to validate their 90% funding of the development and implementation of the system and 75% of operational funding. Washington's ProviderOne certification was the first in the country to achieve federal certification without a single finding from the federal certification team.

HCA recognizes the value of adding a requirement to the ProviderOne vendor contract for an independent audit of internal system controls. While neither expected nor required by the federal government for any Medicaid payment system, to strengthen HCA's ability to monitor vendor controls, Washington State has now added a requirement for external audit.

Auditor's Concluding Remarks

We thank the State for their diligence in addressing the internal control issues discussed. These actions will enhance the fiscal accountability and financial reporting of the State's financial activity. The implementation of reconciliation procedures by HCA demonstrates the commitment to correct internal control weaknesses.

The HCA did not adequately monitor the ProviderOne system. ProviderOne system controls consist of general controls and application controls:

- General controls are intended to ensure the integrity and availability of the data as well as enforce management's control over the access to the data and programs.
- Application controls are specific to an application and provide assurance only authorized data is accepted, data entry and processing are complete and accurate and reports are reliable.

The CMS review was performed on site-in Olympia and did not include testing program change procedures or system controls at the vendor's location. Unauthorized program changes made by the vendor could cause the ProviderOne application controls to be ineffective. For example, a programmer could have the application bypass all edits or other application controls when certain transactions are processed.

Effective general controls form the foundation of effective application controls. The Authority's monitoring of ProviderOne did not include procedures to test whether general controls at the vendor were adequate.
We reaffirm our finding and will evaluate the state's corrective action during our next audit.

Applicable Laws and Regulations

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

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

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

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

Washington State Office of Financial Management, State Administrative & Accounting Manual

Chapter 20 - Internal Control and Auditing,
Section: 20.10.20, July 1,2008
The Budget and Accounting Act is found in Chapter 43.88 RCW. Section 43.88.160 (4) requires that the director of the Office of Financial Management (OFM), as an agent of the governor:

"Develop and maintain a system of internal controls and internal audits comprising methods and procedures to be adopted by each agency that will safeguard its assets, check the accuracy and reliability of its accounting data, promote operational efficiency, and encourage adherence to prescribed managerial policies for accounting and financial controls. The system developed by the director shall include criteria for determining the scope and comprehensiveness of internal controls required by the classes of agencies, depending on the level of resources at risk. Each agency head or authorized designee shall be assigned the responsibility and authority for establishing and maintaining internal audits following the standards of internal auditing of the Institute of Internal Auditors..."

Section: 20.15.50.a - Annual assurance

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

Periodically, an agency should conduct a comprehensive review of the internal control structure to determine if it is adequately addressing agency risks. This can be done agency-wide at one time or by sections of the agency over a period of time. Agencies must maintain adequate written documentation of activities conducted in connection with risk assessments, review of internal control activities and follow-up actions. This documentation includes any checklists and methods used to complete these activities. Refer to Subsection 20.25.50 for required documentation. For sample checklists and procedures, refer to the OFM Administrative and Accounting Resources website at: http://www.ofm.wa.gov/resources/default.asp.

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

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

12-02 The Department of Health did not obtain sub-award information or file reports required by the Federal Funding Accountability and Transparency Act for the Special Supplemental Nutrition Program for Women, Infants, and Children.

Federal Awarding Agency:	U.S. Department of Agriculture
Pass-Through Entity:	None
CFDA Number and Title:	10.557 Special Supplemental Nutrition Program For Women, Infants and Children
Federal Award Number:	7WA700WA7; 7WA700WA1; 7WA700WA2
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The State Department of Health administers the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). This program provides funding for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

The Department distributes grant money to county health districts, non-profits, and tribes to administer the program and provide service. The Department spent $150,886,709 million in WIC funds in fiscal year 2012; of this, it passed through $34,930,232 to subrecipients for client services.

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

The Department's Grants Management Division is responsible for ensuring compliance with this requirement.

Description of Condition

The Department did not follow its process to collect and submit Accountability Act-required data from subrecipients. Based on information in the contract file, the Department filed a report for only one of 56 subrecipients during fiscal year 2012.

Cause of Condition

When we asked Department management why they did not follow established policies and procedures for collecting and submitting required data, they stated they did not monitor reporting activity to ensure compliance.

Effect of Condition

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

Recommendation

We recommend the Department follow established policies and procedures over FFATA reporting and submit all required reports for each sub-award of $25,000 or more by the applicable deadline.

Department's Response

We concur with the finding that the Department did not obtain sub-award information and file reports required by the Federal Funding Accountability and Transparency Act. We have revised our procedures, effective October 1, 2012, and have put forth new communications within the agency to comply with this reporting requirement.

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.

2 CFR170.330 Total compensation. APPENDIX A TO PART 170—AWARD TERM

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

12-03 The Department of Health does not adequately monitor subrecipients of the Special Supplemental Nutrition Program for Women, Infants, and Children.

Federal Awarding Agency:	U.S. Department of Agriculture
Pass-Through Entity:	None
CFDA Number and Title:	10.557 Special Supplemental Nutrition Program for Women, Infants, and Children
Federal Award Number:	7WA700WA7; 7WA700WA1; 7WA700WA2
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

The State Department of Health administers the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). This program provides funding for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

The Department distributes grant money to county health districts, non-profits, and tribes to administer the program and provide service. The Department spent $146,556,215 in WIC funds during fiscal year 2012; of this, it passed through $35,909,157 to subrecipients.

Subrecipient Monitoring

Pass-through entities are responsible for monitoring the subrecipients' use of federal awards to ensure they comply with federal law and grant agreements. The Department does two types of monitoring for the WIC program: fiscal monitoring and programmatic.

Fiscal monitoring includes collecting supporting documentation for expenditures paid and performing on-site reviews of expenditures and accounting functions.

Programmatic monitoring is done to observe how the subrecipients administer the program, and to verify eligibility of clients and ensure all regulations are being followed. WIC program staff oversee both processes. We identified no issues with programmatic monitoring.

Subrecipients are not allowed to make a profit from federal grant funds, only to receive reimbursement of actual costs incurred. Therefore, the pass-through entity must ensure all reimbursements to subrecipients are based on actual expenditures.

Description of Condition

The Department lacks internal controls related to monitoring the compliance of its subrecipients in these areas:

Collection of grant activity information from subrecipients:

The Department did not collect documentation supporting the majority of its subrecipient reimbursement requests during the fiscal year. For the period from July 1 to December 31, 2011, it collected no supporting information. Beginning January 1, 2012, the Department started collecting supporting documentation for its county health district subrecipients. However, it did not collect supporting documentation for non-profits and tribe subrecipients during the fiscal year. Of the $35.9 million paid to subrecipients, $21.7 million was paid to non-profits and tribes.

Subrecipient fiscal monitoring through on-site visits:

The Department contracted with a certified public accountant for on-site fiscal monitoring of subrecipients. Each subrecipient is scheduled to receive on-site monitoring once during a defined two-year period. During fiscal year 2012, 61 subrecipients received WIC funds. The Department stopped performing on-site monitoring as of August 5, 2011; consequently, only five of the 61 subrecipients received an on-site visit during the year.

We reviewed the reports of on-site monitoring performed and determined the certified public accountant only reviewed expenditures from May and June 2011, even though the two year monitoring period was from January 1, 2011 through December 31, 2012. We determined this monitoring is not adequate in scope or frequency to ensure expenditures of federal funds are supported or allowable.

Cause of Condition

Although Department management designed new processes for subrecipient monitoring, they were not fully operational prior to the end of the audit period. County health districts were told to submit additional supporting documentation with reimbursement requests, but no additional requirements were put in place for non-profits or tribes. The Department paid these reimbursements without collecting documentation and stated the increased documentation requirement was not fully implemented by the end of the fiscal year.

In response to the previous findings issued for other federal grant programs also monitored by the certified public accountant, the Department redesigned the on-site monitoring reports to provide more detailed and meaningful information. It also decided to cease current monitoring while this redesign occurred and did not perform onsite monitoring for almost 11 months of the audit period.

The Department has no written policies and procedures to ensure:

- Staff understands how to comply with all federal compliance and monitoring requirements for subrecipients.
- Subrecipients are monitored to ensure they are paid only for actual costs.

Effect of Condition

The Department cannot be sure it is reimbursing only allowable and actual costs.

Recommendation

We recommend the Department establish appropriate internal controls over subrecipient monitoring to ensure it reimburses subrecipients only for actual costs that are supported by documentation in accordance with federal requirements. We also recommend the Department develop policies and procedures over the monitoring and payment of subrecipients.

Department's Response

Collection of grant activity information from subrecipients.

The Department concurs with the State Auditor's Office finding. Effective January 2012, the Department of Health required local health jurisdictions to provide summary level expenditure data by object to accompany the monthly invoices to which the local health jurisdictions complied. Beginning October 2012, the Department clarified the requirement that the summary level data must be accompanied by system generated reports. The Department will develop a corrective action plan regarding the collection of supporting documentation for all its subrecipients including non-profits and tribes.

We will work closely with the Office of Financial Management to develop and institute a successful corrective action plan for the finding above.

Subrecipient fiscal monitoring through on-site visits.

The Department concurs with the State Auditor's Office finding. The certified public accountant's contract with the Department of Health ended on December 31, 2011. The next fiscal monitoring cycle would have started on January 1, 2012. However, the Department was delayed in selecting a contracted certified public accountant for reviewing fiscal year 2012, and the Department did not contract with the certified public accountant until September 2012. Consequently the fiscal monitoring visits began in September 2012. All subrecipients are monitored using the same fiscal monitoring standards and processes.

The fiscal monitoring process has three distinct elements:

1. *The certified public accountant employs a risk-based monitoring process consistent with OMB A-133 standards and reviews a minimum of three invoices and purchases over $150. More invoices are reviewed if necessary. The certified public accountant then summarizes the outcome of the fiscal monitoring visit in a report to the Department.*
2. *Department staff reviews the fiscal monitoring report and determines the corrective action necessary, if any. In some cases, staff may require additional fiscal information before determining what action to take. The organization receives a copy of the report, along with a letter from the Department outlining issues requiring corrective action and the date by which a response is required.*
3. *The Department staff conducts follow up to ensure that appropriate actions are taken to correct deficiencies noted in the fiscal monitoring report.*

Additionally, Department staff has taken other steps to increase fiscal oversight of subrecipients, including increasing the number of site visits to the local health jurisdictions. In June 2012, the Department hired a Financial Examiner who will follow up on issues identified in the fiscal monitoring report that may require additional technical assistance.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

OMB Circular A-133 Compliance Supplement Subpart C—Auditees

Section 300 - Auditee responsibilities.

The auditee shall:

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

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

Section 400(d) - Pass-through entity responsibilities.

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

(3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

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

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

(7) Require each subrecipient to permit the pass-through entity and auditors to have access to the records and financial statements as necessary for the pass-through entity to comply with this part.

United States Department of Agriculture regulations at 7 CFR 246.19(b) state the following:

(b) *State agency responsibilities.*

(1) The State agency shall establish an ongoing management evaluation system which includes at least the monitoring of local agency operations, the review of local agency financial and participation reports, the development of corrective action plans to resolve Program deficiencies, the monitoring of the implementation of corrective action plans, and on-site visits. The results of such actions shall be documented.

(2) Monitoring of local agencies must encompass evaluation of management, certification, nutrition education, breastfeeding promotion and support, participant services, civil rights compliance, accountability, financial management systems, and food delivery systems. If the State agency delegates the signing of vendor agreements, vendor training, or vendor monitoring to a local agency, it must evaluate the local agency's effectiveness in carrying out these responsibilities.

(3) The State agency shall conduct monitoring reviews of each local agency at least once every two years. Such reviews shall include on-site reviews of a minimum of 20 percent of the clinics in each local agency or one clinic, whichever is greater. The State agency may conduct such additional on-site reviews as the State agency determines to be necessary in the interest of the efficiency and effectiveness of the program.

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 for 2012*, Part 3, states in part:

Section M. Subrecipient Monitoring:

Compliance Requirements

A pass-through entity is responsible for:

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

12-04 The Department of Health did not obtain a Data Universal Numbering System (DUNS) number from subrecipients prior to awarding federal dollars under the Special Supplemental Nutrition Program for Women, Infants, and Children.

Federal Awarding Agency:	U.S. Department of Agriculture
Pass-Through Entity:	None
CFDA Number and Title:	10.557 Special Supplemental Nutrition Program For Women, Infants and Children
Federal Award Number:	7WA700WA7; 7WA700WA1; 7WA700WA2
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

The State Department of Health administers the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). This program provides funding for supplemental foods, health care referrals and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

The Department distributes grant money to county health districts, non-profits, and tribes to administer the program and provide services. The Department spent $150,886,709 in WIC funds in fiscal year 2012; of this it passed through $34,930,232 to subrecipients for client services.

Federal law requires state agencies to obtain a Data Universal Numbering System (DUNS) number from a subrecipient before making a sub-award. DUNS numbers are used to identify organizations that are receiving funding under grants and cooperative agreements and to provide consistent name and address data for electronic grant application systems.

The Department's program staff are responsible for ensuring compliance with this requirement.

Description of Condition

The Department did not obtain DUNS numbers from any of its 55 WIC subrecipients prior to awarding federal funds.

Cause of Condition

Department management did not follow their own policies and procedures for obtaining DUNS numbers. It did not give subrecipients the form it uses to collect DUNS numbers as part of their contracts or inform them of the requirement to provide a DUNS number.

Effect of Condition

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

Recommendation

We recommend the Department develop internal controls to ensure adherence to established policies and procedures for obtaining DUNS numbers from subrecipients.

Department's Response

We concur with the finding that the Department did not obtain a Data Universal Numbering System (DUNS) number from subrecipients prior to awarding federal dollars. We have revised our procedures, effective October 1, 2012, and have put forth new communications within the agency to comply with this reporting requirement.

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.

2 CFR 25.200: Requirements for program announcements, regulations, and application instructions says in part.

> (a) Each agency that awards types of Federal financial assistance included in the definition of "award" in §25.305 must include the requirements described in paragraph (b) of this section in each program announcement, regulation, or other issuance containing instructions for applicants that either:
>
> (1) Is issued on or after the effective date of this part; or
>
> (2) Has application or plan due dates after October 1, 2010.
>
> (b) The program announcement, regulation, or other issuance must require each entity that applies and does not have an exemption under §25.110 to:
>
> (3) Provide its DUNS number in each application or plan it submits to the agency.
>
> (c) For purposes of this policy:
>
> (1) The applicant is the entity that meets the agency's or program's eligibility criteria and has the legal authority to apply and to receive the award. For example, if a consortium applies for an award to be made to the consortium as the recipient, the consortium must have a DUNS number. If a consortium is eligible to receive funding under an agency program but the agency's policy is to make the award to a lead entity for the consortium, the DUNS number of the lead entity will be used.
>
> (2) A "program announcement" is any paper or electronic issuance that an agency uses to announce a funding opportunity, whether it is called a "program announcement," "notice of funding availability," "broad agency announcement," "research announcement," "solicitation," or some other term.

12-05 The Department of Health does not have sufficient internal controls to ensure all of its subrecipients receive audits when required.

Federal Awarding Agencies:	U.S. Department of Agriculture; U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	10.557 Special Supplemental Nutrition Program For Women, Infants and Children 93.069 Public Health Emergency Preparedness 93.889 National Bioterrorism Hospital Preparedness Program 93.917 HIV Care Formula Grants
Federal Award Number:	7WA700WA7; 7WA700WA1; 7WA700WA2; 1H75TP000369-01; 2U90TP017010-10; 3U90TP017010; U3REP090228; X07HA00083; X08HA16845; X09HA20267.
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

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

The Department uses a database to track audits of subrecipients. It sends a postcard to all subrecipients asking them whether they were required to have a Circular A-133 audit in their most recent fiscal year. The subrecipient is to return the postcard and supply a copy of the audit if one was performed. If the subrecipient indicates they did not need an audit, or does not return the postcard, Department staff access the federal audit clearinghouse to see if an audit was reported. This monitoring is performed centrally for all Departmental subrecipients and all responses and audit issues are recorded in the Department's database.

Description of Condition

The Department lacks the necessary internal controls to ensure all subrecipients receive an audit in accordance with federal regulations. The Department checks the federal audit clearinghouse records when subrecipients do not return the postcard. This detects subrecipients who received an audit and filed it with the clearinghouse. However, this process alone does not allow the Department to identify:

- Subrecipients who were required to have an audit, but did not have one performed.
- Subrecipients who had an audit, but did not file it with the federal audit clearinghouse.

Without further contact with these subrecipients, the Department does not know whether they met audit requirements.

We reported similar issues during the fiscal year 2011 audit.

Cause of Condition

The Department requires subrecipients to report whether they need an audit. However, staff responsible for ensuring compliance with federal audit requirements do not follow up with subrecipients who do not respond to the Department's requests for information. While the Department has policies and procedures regarding this requirement, they do not address how to follow up with non-responsive subrecipients.

Effect of Condition

The Department is not certain whether all of its subrecipients comply with federal grant requirements.

Recommendation

We recommend the Department improve internal controls to ensure it determines the federal audit status of all subrecipients.

Department's Response

We concur with the finding that the Department did not further contact subrecipients who did not either return the postcard or file an audit with the federal audit clearinghouse. We will revise our procedures and make repeated contact with non-responsive subrecipients. The agency's goal will be to achieve 100% determination of all subrecipients' audit requirements.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

Section 300

The auditee shall:

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

Section 400(d) - Pass-through entity responsibilities.

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

(1) Identify Federal awards made by informing each subrecipient of CFDA title and number, award name and number, award year, if the award is R&D, and name of Federal agency. When some of this information is not available, the pass-through entity shall provide the best information available to describe the Federal award.

(2) Advise subrecipients of requirements imposed on them by Federal laws, regulations, and the provisions of contracts or grant agreements as well as any supplemental requirements imposed by the pass-through entity.

(3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

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

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

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

(7) Require each subrecipient to permit the pass-through entity and auditors to have access to the records and financial statements as necessary for the pass-through entity to comply with this part.

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

Section M. Subrecipient Monitoring:

Compliance Requirements

A pass-through entity is responsible for: …

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

12-06 The Recreation and Conservation Office did not file reports required by the Federal Funding Accountability and Transparency Act for the Pacific Coast Salmon Recovery 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:	NA06NMF4380091, NA07NMF4380301 NA08NMF4380608, NA09NMF4380363 NA10NMF4380435, NA10NMF4380357 NA11NMF4380267
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

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

In fiscal year 2012, the Office spent $29.4 million in federal program funds.

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

Description of Condition

During fiscal year 2012, the Office made 85 sub-awards for the program totaling $21,927,689.

During our review, we found the Office did not have internal controls in place to ensure the fiscal year 2012 Accountability Act reports were filed.

The Office stated the federal electronic reporting system would not allow them to file all of the required reports. They also stated they had attempted to contact the federal grantor regarding this issue to get it corrected. However, the Office was unable to provide any documentation to show that it attempted to submit the reports or of communication with the federal grantor during the audit period.

Cause of Condition

Office management did not monitor reporting activity to ensure compliance. Management was not aware of the monthly reporting requirement.

Effect of Condition

We randomly selected and tested nine of the 85 subawards to determine whether the Recreation and Conservation Office was in compliance with the federal Accountability Act reporting requirements. Our testing determined that four subawards were not entered into the federal reporting system. Five of the nine were not entered timely by the end of the month following the month in which the subaward was made. Four of the five were entered more than one year after the subaward.

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

Recommendation

We recommend the Office establish adequate policies and procedures for reporting and submit all required reports for each sub-award of $25,000 or more by the applicable deadline.

Office's Response

We agree with the auditors' finding. The following actions will be taken to address the finding. Monthly we will complete the Accountability Act reports.

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.

2 CFR170 APPENDIX A TO PART 170—AWARD TERM

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

12-07 The Department of Commerce does not adequately monitor subrecipients of the HOME Investment Partnership Program to ensure subrecipients use federal grant money for authorized purposes and in compliance with laws, regulations, and grant and contract provisions.

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

Background

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

In fiscal year 2012, the Department spent approximately $1 million for the General Purpose program. The Department passed through approximately $3.6 million to subrecipients such as non-profits, local governments and housing authorities for the Tenant Based program These subrecipients determine households who are eligible for the Tenant Based program, provide rental assistance and perform housing quality standard inspections.

Federal regulations require the Department to monitor the grant-funded activities of subrecipients. This includes performing site visits at the subrecipients to review financial and programmatic records and observe operations. This requirement is fundamental to adequate subrecipient monitoring and helps ensure federal awards are used for authorized purposes and are in compliance with laws, regulations, and grant and contract provisions.

Description of Condition

During our review, we found that the Department does not have a specific on-site monitoring frequency guideline for the Tenant Based program. The Department selects subrecipients for on-site monitoring based on one consolidated risk assessment for its housing programs. However, since all housing programs are considered during the risk assessment and the Department has no specific on-site monitoring frequency guideline for each program, Tenant Based subrecipients are not always selected for on-site monitoring. We found that the Department did not perform <u>any</u> on-site monitoring of Tenant Based subrecipients in fiscal year 2012. Further, we randomly selected six out of 19 subrecipients and found that the Department did not perform any on-site monitoring for any of the six in the last three years.

Cause of Condition

The Department considered the consolidated risk-based assessment selection approach to be adequate for subrecipient monitoring.

Effect of Condition

For the Tenant Based program, subrecipients determine which households are eligible for the program. The subrecipients also perform housing quality standard inspections required by federal regulation. When the Department does not perform on-site monitoring of subrecipient records, it cannot ensure that:

- Only eligible individuals or households receive Tenant Based Rental Assistance.

- The program meets the earmarking requirement that at least 90 percent of households receiving assistance are families whose annual income does not exceed 60 percent of the median family income.
- Housing quality standards inspections are properly conducted on all Tenant Based rental housing projects.

Recommendations

We recommend the Department:

- Develop an on-site monitoring frequency guideline that provides reasonable assurance all subrecipients are in compliance with grant requirements.
- Review subrecipient records in accordance with the frequency guideline to ensure HOME grant funds are used for tenant rental assistance for eligible households in accordance with the earmarking requirements and inspections are performed annually as required.

Department's Response

We concur with the finding and have taken corrective action including entering client income information into the federal Integrated Disbursement and Information System (IDIS) to ensure compliance with the earmarking requirement. We are also judgmentally selecting grantees for review. From these TBRA grantees we are requesting copies of participant income verification and Housing Quality Standards (HQS) inspection reports.

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,* 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.
(7) Require each subrecipient to permit the pass-through entity and auditors to have access to the records and financial statements as necessary for the pass-through entity to comply with this part.

U.S. Office of Management and Budget Circular A-133 Compliance Supplement 2012, Part 4-Department of Housing and Urban Development (HUD), CFDA 14.239 Home Investment Partnership Program, G. Matching, Level of Effort, Earmarking, states in part:

3. Earmarking
a. Each participating jurisdiction must invest HOME funds made available during a fiscal year so that, with respect to tenant-based rental assistance and rental units not less than 90 percent of (1) the families receiving assistance are families whose annual income do not exceed 60 percent of the median family income for the area, as determined and made available by HUD, with adjustments for smaller and larger families at the time of occupancy or at the time funds are invested, whichever is later, or (2) the dwelling units assisted with such funds are occupied by families having such incomes (24 CFR section 92.216).

Title 24, Code of Federal Regulations, Subtitle A, Part 92, Subpart E, 92.216 - Income targeting: Tenant based rental assistance and rental units, states in part:

Each participating jurisdiction must invest HOME funds made available during a fiscal year so that, with respect to tenant-based rental assistance and rental units:
(a) Not less than 90 percent of:
(1) The families receiving such rental assistance are families whose annual incomes do not exceed 60 percent of the median family income for the area, as determined and made available by HUD with adjustments for smaller and larger families (except that HUD may establish income ceilings higher or lower than 60 percent of the median for the area on the basis of HUD's findings that such variations are necessary because of prevailing levels of construction cost or fair market rent, or unusually high or low family income) at the time of occupancy or at the time funds are invested, whichever is later; or
(2) The dwelling units assisted with such funds are occupied by families having such incomes;
(b) The remainder of:
(1) The families receiving such rental assistance are households that qualify as low-income families (other than families described in paragraph (a)(1) of this section) at the time of occupancy or at the time funds are invested, whichever is later; or
(2) The dwelling units assisted with such funds are occupied by such households.

U.S. Office of Management and Budget Circular A-133 Compliance Supplement 2012, Part 4 (March 2011)-Department of Housing and Urban Development (HUD), CFDA 14.239 Home Investment Partnership Program, N. Special Tests and Provisions, 3. Housing Quality Standards, states in part:

The participating jurisdiction must perform on-site inspections of rental housing occupied by tenants receiving HOME-assisted tenant-based rental assistance to determine compliance with housing quality standards (24 CFR sections 92.251, 92.252, and 92.504(b)).

Title 24, Code of Federal Regulations, Subtitle A, Part 92, Subpart K, 92.504 - Participating jurisdiction responsibilities; written agreements; on-site inspection, states in part:

(d) On site inspections:

(2) Tenant-based rental assistance. The participating jurisdiction must perform annual on-site inspections of rental housing occupied by tenants receiving HOME-assisted TBRA to determine compliance with the property standards of § 92.251.

12-08 The Department of Commerce does not have internal controls to ensure the Department pays out HOME Investment Partnership program income before requesting federal cash draws and interest earned on federal cash advances is returned to the federal government.

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

Background

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

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

In fiscal year 2012, the Department requested more than $4 million of HOME funds. The program generated approximately $860,000 in income.

Description of Condition

During our review, we found the Department does not have controls in place to ensure HOME program income is paid before requesting federal HOME funds. In fiscal year 2012, the average program income balance at the time of federal cash draws was approximately $900,000. The Department did not first use the available program income for loans before requesting federal funds. We also found that the Department does not have controls to ensure any interest earned on program income in excess of $100 is returned to the grantor.

Cause of Condition

The Department stated that paying HOME program income requires manual adjustments of federal draw amounts and additional administrative work. The Department stated it rarely disbursed the HOME program income due to the complexity of the manual adjustments and additional administrative work required.

Additionally, the Department was not aware that it may owe interest to the federal government when it had unspent program income on hand.

Effect of Condition

As a result of this condition, the Department requested and received excess federal cash totaling $900,000 during fiscal year 2012. Further, the Department may be required to submit interest earned on this money to the federal government, if the interest earnings exceeded $100.

Recommendation

We recommend the Department:

- Develop policies and procedures necessary to disburse HOME program income before requesting additional federal cash draws.
- Consult with its grantor and the state Office of Financial Management to determine if any interest earnings are owed to the federal government.

Department's Response

The Department concurs with this audit finding. The Department has reviewed its processes and updated its procedures so that program income is used prior to federal funding sources.

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.

Circular A-102 Common Rule for the administration of grants and cooperative agreements to state and local governments, 24 C.F.R. §_85___.21 Payment, states in part:

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

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

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

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

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

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

> (c) Disbursement of HOME funds.

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

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

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

12-09 The Department of Commerce does not have sufficient internal controls to ensure all of its subrecipients receive audits as required.

Federal Awarding Agency:	U.S. Department of Housing and Urban Development Environmental Protection Agency Department of Energy Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	14.239 HOME Investment Partnerships 66.468 Capitalization Grants for Drinking Water 66.468A Capitalization Grants for Drinking Water- American Recovery and Reinvestment ACT (ARRA) 81.042 Weatherization Assistance for Low Income Persons 93.568 Low Income Home Energy Assistance Program 93.569 Community Services Block Grant
Federal Award Number:	2012G992201; 2012G99BX11; 2011G992201; 2011G992212; 2010G992201; 2010G992212; 2010G992204; M11-SG-53-0100; M10-SG-53-0100; M09-SG-53-0100; DE-EE0004207; DE-EE0000086; FS-99083910-0; FS-99083909-0; FS-99083908-1; FS-99083907-1; FS-99083906-0; 08B1WACOSR; 09B1WACOSR; 10B1WACOSR; 0901WACOS2
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

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

The Department and its subrecipients sign an agreement that includes standard terms and conditions, including the A-133 audit requirement. It also notifies the subrecipients that they must provide the Department with a copy of the audit report no later than nine months after the subrecipient's fiscal year end. The Department also has a written policy and procedures aimed at ensuring all subrecipient audits are received, reviewed, and entered into the central database. The policy and procedures specify that the individual programs are responsible for receiving and tracking audits required for their program.

Once the audit reports have been received, they are to be forwarded on to the internal auditor to be input in the Department's central database. The internal auditor is to review the audit report and notify any programs that have federal dollars at risk. If any findings were reported, the program manager is responsible for requesting corrective action from the subrecipient and for ensuring the corrective actions are performed.

Description of Condition

The Department does not follow its internal policies and procedures to ensure all subrecipients receive the required audit, if needed.

Further, the Department does not have a process to ensure its subrecipients submit audit reports. Instead, the program managers wait for audit reports from the subrecipients. There is not a sufficient tracking mechanism at the program level or the central level to ensure each subrecipient meeting the dollar threshold is receiving a required

audit. Audits received centrally are recorded in the central database; however, this process alone does not allow the Department to identify:

- Subrecipients who were required to have an audit, but did not have one performed.

Without further contact with these subrecipients, the Department does not know whether they met audit requirements.

We reported similar issues during the fiscal year 2011 audit.

Cause of Condition

The Department has a policy and procedures that would ensure compliance with federal requirements, but failed to completely follow them. Audits are recorded in the central database when received by the Department; however, tracking was not being done at the program level. The program managers believed the monitoring process was the responsibility of the internal auditor, although the internal auditor and the written procedures said otherwise. This miscommunication of who had responsibility for tracking reports led to over-reliance on the central system and a breakdown of the controls.

Effect of Condition

We judgmentally selected 24 of the Department's subrecipients across the five programs. The Department did not have audit reports for three of the 24 subrecipients as required by OMB Circular A-133.

The Department cannot be certain whether all of its subrecipients comply with federal grant requirements, and, therefore, cannot ensure that it has met the monitoring requirement of its federal grantor.

Recommendation

We recommend the Department follow its existing policy and procedures, or design new ones that will ensure it determines the federal audit status of all subrecipients.

Department's Response

Partially concur. In response to a similar audit finding in the SWSA report issued in March 2012, Commerce enhanced its Contract Management System (CMS) with an audit tracking module. Functionality includes the ability to store audit reports from SAO, CPA firms, and Federal sources; search by contract or vendor number for audit reports; record audit receipt dates; and track requests for management decision letters. Additionally, staff can generate CMS reports to identify contractors with federal expenditures of $500,000 or greater to help identify subrecipients. Other reports provide lists of audit due dates and lists of audit findings. Commerce implemented enhancements in October 2012.

Commerce will refine the process of monitoring audits and provide updated written guidance on roles and responsibilities that apply throughout the agency. Training on use of the audit function in CMS is underway.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

Section 300

The auditee shall:

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

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

Section 400(d) - Pass-through entity responsibilities.

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

(1) Identify Federal awards made by informing each subrecipient of CFDA title and number, award name and number, award year, if the award is R&D, and name of Federal agency. When some of this information is not available, the pass-through entity shall provide the best information available to describe the Federal award.

(2) Advise subrecipients of requirements imposed on them by Federal laws, regulations, and the provisions of contracts or grant agreements as well as any supplemental requirements imposed by the pass-through entity.

(3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

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

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

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

(7) Require each subrecipient to permit the pass-through entity and auditors to have access to the records and financial statements as necessary for the pass-through entity to comply with this part.

U.S. Office of Management and Budget Circular A-133, *Compliance Supplement for 2012*, Part 3 – Compliance Requirements states:

Section M. Subrecipient Monitoring:

Compliance Requirements

A pass-through entity is responsible for: …

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

12-10 The Employment Security Department did not attempt to collect $440,925 overpaid to claimants for Federal Additional Compensation Unemployment Insurance.

Federal Awarding Agency:	U.S. Department of Labor
Pass-Through Entity:	None
CFDA Number and Title:	17.225 Unemployment Insurance 17.225A Unemployment Insurance – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	UI-22347-12-55-A-53; UI-21133-11-55-A-53; UI-19616-10-55-A-53;
Applicable Compliance Component:	Special Tests and Provisions
Questioned Cost Amount:	$440,925 ARRA

Background

The Employment Security Department administers the Unemployment Insurance program that provides benefits to workers during periods of involuntary unemployment. The federal government and employers in Washington State primarily fund the program. In fiscal year 2012, Employment Security paid approximately $2.8 billion in benefits, $1.5 billion of which was paid with money from the federal government.

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

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

Once an overpayment notice letter is sent to a claimant, the Department has three years in which to initiate collection action. State law does not allow proceedings to collect such overpayments to begin after the three years have elapsed.

Description of Condition

The Department has established collection methods for benefit overpayments that begin shortly after the overpayment notice letter is sent. The Department did not use these methods to collect any Federal Additional Compensation overpayments during fiscal year 2012. Prior to June 30, 2009, $440,925 in Federal Additional Compensation overpayments were assessed. The Department had three years to begin collection of these overpayments before they become uncollectible under state law. All of these overpayments are now uncollectible.

Cause of Condition

The Department relies on software systems to record and track overpayments. Beginning in fiscal year 2009, and continuing through fiscal year 2012, the federal and state governments have passed legislation that made significant changes to the Unemployment Insurance program. Each change required the Department to reprogram its software systems. Due to the complexity of programming changes and limitations on staff able to perform them, the Department was not able to make all changes immediately, but instead had to prioritize each change as it occurred. The Federal Additional Compensation overpayments were not incorporated into the software system and were not included in the Department's collections.

Management stated so far they have been unable to come up with a solution for Federal Additional Compensation overpayments that will meet state and federal legal and accounting requirements. They also did not use an alternative method to ensure collection efforts began prior to expiration of the three-year period.

Effect of Condition

As of June 30, 2012, $440,925 in Federal Additional Compensation overpayments became uncollectible because the Department had not initiated collection by the deadline for doing so. We are questioning these costs since the Department found them to be overpayments and did not attempt to collect them.

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

Recommendation

We recommend the Department establish and follow procedures to ensure collection of Federal Additional Compensation overpayments. We further recommend the Department begin collection on Federal Additional Compensation overpayments before they become uncollectible.

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

Department's Response

On September 7, 2012, we completed the necessary computer programming to bill, collect, and account for FAC overpayments. We have mailed billing statements to claimants who had an outstanding FAC overpayment balance. As of November 13, 2012, we have successfully collected $1,978,761.66 in FAC overpayments. Our collection efforts will continue as permitted by state and federal law so that we ensure we are appropriately collecting outstanding balances from claimants required to repay these overpayments.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

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

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

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

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

12-11 The Employment Security Department does not have controls to ensure compliance 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-22347-12-55-A-53; UI-21133-11-55-A-53; UI-19616-10-55-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 during periods of involuntary unemployment. The federal government and employers in Washington State primarily fund the program. In fiscal year 2012, Employment Security paid approximately $2.8 billion in benefits, $1.5 billion of which was paid 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 Unemployment Insurance operations in terms of cost, time, and effort. **BAM investigators must exhaust all avenues in obtaining information."** The Department, as required by federal regulation, 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 four 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, 2010 and 2011 audits, noting the Department did not comply with U.S. 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 U.S. Labor Department requires states to try to collect information using any and all of the following methods: in-person, telephone, facsimile, mail, and e-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, through September of 2012, if a claimant did not respond, the case was to be forwarded to a local employment center for a job search review to be scheduled which could result in benefit denial. Beginning in October of 2011 claimants selected for a BAM audit are advised that failure to return the completed questionnaire within 10 days will result in a denial of future benefits until they satisfy the request.

Description of Condition

Based on our review we determined the Department still did not have sufficient internal controls to ensure compliance with federal regulations. We found:

- Parts of the BAM manual that serve as the policy and procedures for the Department did not comply with federal requirements.
- Investigators were not always following the parts of the BAM manual that were compliant.
- While BAM supervisory reviews were occurring, they were not adequately detecting noncompliance with federal regulations and the noncompliance rate of reviewed investigations was slightly higher than those without a review.

During the audit period the Department adopted new procedures that included increasing supervisory case review and oversight, revising investigation documentation to include more details on what work was performed, and creating a new procedure for denial of claims when a claimant fails to respond to inquiries. While we acknowledge that procedures were changed, we found 11 percent of the investigations were noncompliant with federal regulations.

Cause of Condition

Management asked investigators not to use portions of the BAM manual beginning November 1, 2011. Since portions of the BAM manual were not in effect, the Department was non-compliant with federal regulations requiring written procedures. Investigators were also given informal guidance by email to decrease the number of attempts to collect certain information. Supervisors were unaware this guidance was in direct conflict with federal requirements.

Investigators were not consistently following the parts of the BAM manual left in place during the audit period. We also determined the BAM supervisory reviews were not detecting inadequate investigations. Management stated no policy or procedure was in place to specify how extensive the supervisory reviews should 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 addition, the Department still is not complying with Labor Department requirements for the BAM Program. For this audit we randomly selected 80 claims the Department had investigated: 41 paid claims and 39 denied claims, and found:

- In two cases, the investigator did not verify wage or other data with prior employers or third parties.

- In four cases from the 41 paid claims, the investigator did not verify reported job searches.
- Files for three of the cases did not document enough attempts to contact the claimant.

In September of 2011 the U.S. Department of Labor designated Washington 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 U.S. Department of Labor's concerns.

Recommendation

We again recommend Employment Security ensure:

- Written procedures cover all investigative and administrative functions of the BAM unit and adhere to federal guidelines as required.
- Investigators properly identify and address all issues by following the properly updated written procedures.
- Supervisors properly review completed cases to ensure procedures were followed.

Department's Response

Proposed response to the State Auditor's Office (SAO) Single Audit Report regarding the Benefit Accuracy Measurement unit (BAM)

As noted by the auditor, the Employment Security Department (ESD) made significant improvements in the compliance rate for BAM investigations. The rate of non-compliant BAM investigations decreased as a result of multiple improvements implemented by the department. ESD anticipates this positive trend will continue in the current fiscal year due to ongoing process improvement efforts by investigative, supervisory and management staff.

Transition and Orientation Period

The BAM unit was impacted by organizational restructuring and a reduction-in-force during the last fiscal year. Both the manager and supervisor were replaced with individuals with management and program experience; however, neither had prior knowledge in BAM. Both stepped up to the challenge of learning the intricacies of BAM and related UI laws and policies.

During the audit period recommendations from the previous audit were prioritized and most were implemented immediately. The exceptions of the 2012 audit finding focused primarily upon inadequate contact attempts, inadequacy of existing policies and procedures and supervisory review of completed cases. Actions taken or planned by the department to address the auditor's concerns include the following:

Outdated BAM Procedures Manual. *The BAM Procedures Manual was updated as of July 2012. Although ESD completed a revision of the manual, U.S. Department of Labor (USDOL) Region 6 regularly provides additional policies and guidance to assist in revising BAM methods and procedures. These tools will greatly assist the BAM supervisor in evaluating and updating the content of the current manual.*

Contact attempts for claimants and employers. *One of the biggest challenges for BAM units across the country is the lack of clear guidance from USDOL concerning the required number of contact attempts for claimants, employers and for work search verifications. USDOL provided email clarification to Washington on the acceptable number of attempts for each situation. USDOL released a draft Unemployment Insurance Program Letter (UIPL) in late May 2012 regarding the number of contact attempts for claimants which is now the basis of Washington's current standard. ESD is adhering to these revised standards.*

Work search verification. *BAM investigators followed a directive from their former supervisor to make one attempt to contact employers for work search verification. This process was not determined inadequate in the supervisory review because, at the time, it was the standard set forth by the supervisor. The standard has since been changed to require two contact attempts to verify a work search contact. ESD is adhering to this revised standard.*

Following is a list of additional improvements implemented or planned for ensuring fully compliant BAM investigations:

Personnel and Training

- *Position descriptions for investigators were updated to include more rigorous requirements to improve the recruitment and retention of experienced and knowledgeable investigators.*
- *All investigators have completed investigator training provided by the state of Washington. In addition, one investigator attended a week-long investigator training offered by USDOL. Two investigators attended additional adjudicator training. Additional adjudicator training is planned for 2013 for investigative staff.*
- *Holding regular unit meetings to discuss topics such as case coding, unusual or particularly challenging cases, identifying and resolving barriers to completing a successful investigation, best practices and improving communications with other department units.*
- *Communication and cooperation with other units within ESD has increased, resulting in quicker resolution of issues. An intra-agency work group including BAM and the Claims Centers began in April 2012 to develop an Operational Level Agreement. The group established a process to share improper claims during the Key Week with the Claims Center staff.*
- *Increased development of support staff to better understand and anticipate the needs of investigators. BAM's program assistant supports the team by assisting with Sun investigative system administration, maintenance of National Directory of New Hire reports for investigators, assisting with the monitoring of case assignments for the year, maintenance of case files, tracking improper claims and all weeks reviews, and tracking and disseminating documents scanned into the department's imaging system.*

Forms and Manuals

- *Creation of a detailed contact log form showing time/date/method of contact and fact finding notes. Since September 2012, investigators are required to document all contact attempts to claimants and employers on the contact log to comply with the auditing standard.*
- *More emphasis is placed on the narrative summaries that detail the complexities of the case, identification and resolution of potential issues, unusual coding or other unusual circumstances. In 2013, the team will revise the case summary form and develop standardized language, when applicable, for ease in writing summaries.*
- *BAM forms were updated and implemented in June 2012 to improve accuracy, effectiveness and response rate.*
- *A new toll-free number was implemented in June 2012 to increase claimant and employer response rates. The BAM unit had challenges with incoming faxes not reaching the investigators. We identified a capacity issue with the equipment and have since implemented a process where incoming faxes are imaged and routed to an electronic folder for easy access.*
- *Increased use of all available reference resources within ESD and with USDOL. A new USDOL website was established in May 2012 to facilitate communication between USDOL and BAM units across the country.*
- *Obtained security access and training for investigative staff on two additional state agency databases increasing the potential to get accurate, up-to-date contact information for employers.*

Procedures

- *Creation of internal tracking folders on a shared drive to capture unusual investigative issues and recommended procedures to increase consistency and accuracy in coding. This practice is included in the BAM Procedures Manual so that it contains all BAM resources in one comprehensive electronic tool.*

- *In October 2011, an open-ended denial of benefits was implemented for those claimants failing to respond to requests for information. The response rate of claimant questionnaires for paid claims improved since the change in policy. The challenge to gather information still exists with denied claimants as there is less incentive to respond.*
- *Increased Supervisory Review has begun. Currently a supervisory review is conducted on 35-40% of the cases. In 2013, a checklist will be created for investigators so that they can review their own work prior to supervisory review. The unit is also developing a process and checklist for supervisory review with the intent of providing investigators with feedback on coding errors and/or deficiencies in their investigations or case summaries. This data will be used as a basis for ongoing performance evaluations and continuous improvement.*

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 UC 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) . . .

ET Handbook No. 395, 5th Edition; Benefit Accuracy Measurement State Operations Handbook, states in part:

> The following general requirements must also be adhered to during the course of BAM investigations:
>
> a. Investigative Method. Investigations are comprised of reviews of SWA records and interviews of claimants, employers, and third parties. Initially all BAM investigation interviews were conducted in person. In 1993, alternative methodologies were implemented which allowed states the option to substitute telephone, FAX, e-mail and standard mail for in-person verification of contacts with employers, third parties and on some work search verifications.
>
> 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.** This contrasts to UI operations, which are held to a reasonable attempts standard.

12-12 The Department of Transportation did not have sufficient internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act are filed.

Federal Awarding Agency:	Federal Transit Administration	
Pass-Through Entity:	None	
CFDA Number and Title:	20.500	Federal Transit-Capital Investment Grants
	20.507	Federal Transit-Formula Grants (Urbanized Area Formula Program)
	20.509	Formula Grants for Other Than Urbanized Areas
	20.509A	Formula Grants of Other Than Urbanized Areas – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	WA-18-X039, WA-18-X043, WA-18-X048, WA-18-X049, WA-85-X001, WA-85-X002, WA-85-X003, WA-86-X001, WA-03-0152, WA-04-0027, WA-04-0028, WA-04-0036, WA-04-0045, WA-04-0071, WA-04-0072	
Applicable Compliance Component:	Reporting	
Questioned Cost Amount:	None	

Background

The Public Transportation Division of the Washington State Department of Transportation administers the formula rural general public transportation funds (Formula Grants for Other Than Urbanized Areas) and discretionary bus and bus facility funds (Federal transit – Capital Investment Grants) that are awarded to rural recipients. Funds under the formulized program are used to sustain or expand general public transportation services, purchase capital equipment, on rare occasion fund construction projects and administration costs. Funds under discretionary bus and bus facility program are used to purchase capital equipment and on rare occasion fund construction projects.

In fiscal year 2012, the Division spent $10,544,637 under the Formula Grants for Other than Urbanized Areas program; approximately 94% of this amount was passed through to subrecipients who needed the funding for public transportation projects that serve non-urbanized areas. The Division also reimbursed $2,091,412 under the Federal Transit – Capital Investment Grants as pass through grants to subrecipients whose discretionary bus and bus facilities program projects have already been approved and apportioned by Congress.

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

Description of Condition

During fiscal year 2012 the Division executed agreement amounts of $11,518,522 to subrecipients under the Other than Urbanized Areas program and $530,400 under the Federal Transit – Capital Investment Grants. During our review, we found the Division did not have the necessary internal controls in place to ensure the required Accountability Act reports were filed for any of its sub-awards.

The Division attempted to file these sub-awards in early fiscal year 2012 but encountered technical difficulties with the system and was not able to complete the filing. The Division did not continue its effort during the remaining part of fiscal year 2012 and did not file any reports. Since our field work, the Division has contacted the Federal Transit Administration for filing assistance; however, the Division has not filed any reports yet.

Cause of Condition

The Division did not have sufficient internal processes in place to monitor the filing status of the required reports, continue the effort to submit them or consult with the federal grantor on filing alternatives.

Effect of Condition

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

Recommendation

We recommend the Department:

- Create policies, procedures and other internal controls sufficient to ensure it submits the reports for each sub-award of $25,000 or more by the applicable deadline.
- Provide the necessary training for all employees who oversee reporting and who document the accuracy and completion of the reports.
- Monitor reporting of this information to ensure compliance with the requirement.

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Department's Response

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.

The Department appreciates the State Auditor's work regarding the Statewide Single Audit (SWSA). The "technical difficulties" encountered in filing the required Federal Funding Accountability and Transparency Act (FFATA) reports resulted when the Department made its initial attempts to file the FFATA reports in Fiscal Year 2012 and discovered that the grantor, the Federal Transit Administration (FTA), had not yet entered the award information in its computer system to allow the Department to enter sub-award data and file the reports. The FTA recently input grant award information into the computer system; however, to prevent entering data twice or losing data in the event the FTA did not input all award data into the FTA system, the Department has contacted them to determine if WDOT can now safely input sub-award data and file the required FFATA reports. The Department also made several other attempts to contact the FTA during and after fiscal year 2012 for guidance and to determine when the system would be available for filing reports. As a result of the audit, the Department is seeking written clarification with the FTA on system availability and use for filing reports. The Department will strengthen internal controls and will continue to work with the FTA until the required FFATA sub-award data can be input and the reports can be filed.

Recommendation:

- *Create policies, procedures and other internal controls sufficient to ensure it submits the report for each sub-award of $25,000 or more by the applicable deadline.*

  The Public Transportation Division is implementing new procedures to ensure FFATA reporting is filed timely.

- *Provide the necessary training for all employees who oversee reporting and who document the accuracy and completion of the reports.*

  Procedures will include appropriate training for employees

- *Monitor reporting of this information to ensure compliance with the requirement.*

The new procedure includes assigning the FFATA reporting to one individual, with review and monitoring by another staff member and management.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

Title 2, Code of Federal Regulations, Section 170 states in part:

APPENDIX A TO PART 170—AWARD TERM

I. Reporting Subawards and Executive Compensation.

b. Reporting of first-tier subawards.

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

2. Where and when to report.

i. You must report each obligating action described in paragraph a.1. of this award term to http://www.fsrs.gov.

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

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

12-13 The Department of Health did not file reports required by the Federal Funding Accountability and Transparency Act for the Drinking Water Program.

Federal Awarding Agency:	U.S. Environmental Protection Agency	
Pass-Through Entity:	None	
CFDA Number and Title:	66.468	Capitalization Grants for Drinking Water State Revolving Fund
	66.468A	Capitalization Grants for Drinking Water State Revolving Fund – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	FS-99083911	
Applicable Compliance Component:	Reporting	
Questioned Cost Amount:	None	

Background

The State Department of Health administers the Drinking Water State Revolving Fund Program, which provides loans and other financial assistance to publicly- or privately-owned community water systems and non-profit non-community water systems for eligible drinking water infrastructure projects.

In fiscal year 2012, the Department spent $20.9 million in federal program funds, approximately $1.4 million of which was provided by the American Recovery and Reinvestment Act.

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

Description of Condition

During fiscal year 2012, the Department made 12 sub-awards for the program totaling $11,723,224. It did not file the required Accountability Act reports for any of the awards.

Cause of Condition

Department management stated they did not monitor reporting activity to ensure compliance.

Effect of Condition

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

Recommendation

We recommend the Department follow established policies and procedures over reporting and submit all required reports for each sub-award of $25,000 or more by the applicable deadline.

Department's Response

We concur with the finding that the Department did not obtain sub-award information and file reports required by the Federal Funding Accountability and Transparency Act. We have revised our procedures, effective October 1, 2012, and have put forth new communications within the agency to comply with this reporting requirement.

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.

2 CFR170.330 Total compensation. APPENDIX A TO PART 170—AWARD TERM

I. Reporting Subawards and Executive Compensation.

a. Reporting of first-tier subawards.

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

12-14 The Department of Services for the Blind did not determine eligibility for all Vocational Rehabilitation program applicants within the allowed period of time.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Vocational Rehabilitation Grants to States
Federal Award Number:	H126A110072; H126A120072
Applicable Compliance Component:	Client Eligibility
Questioned Cost Amount:	None

Background

The Vocational Rehabilitation program is designed to assess, plan, develop, and provide vocational rehabilitation services for individuals with disabilities. The Department of Services for the Blind administers the federal Vocational Rehabilitation program for visually impaired individuals. The Department received approximately 15 percent ($7.8 million) of the total federal Vocational Rehabilitation funding received by the state during fiscal year 2012.

Only eligible individuals may receive services from the Vocational Rehabilitation program. An eligible individual has a physical or mental impairment that results in a substantial impediment to employment; could obtain employment as a benefit of vocational rehabilitation; and requires vocational rehabilitation to prepare for, secure, retain or regain employment. The Department's counselors must determine whether or not an individual meets these criteria within 60 days after an individual applies for services. Federal guidelines allow the counselors to make an exception to this requirement due to unforeseen circumstances, such as an applicant not being able to make an appointment or a need for additional evidence to ensure the individual is eligible or will benefit from the services. When these exceptions are used the Department and the individual must agree to a specific extension of time.

Description of Condition

During fiscal year 2012, the Department found 325 individuals eligible for vocational rehabilitation services. Our audit found that for 51 of these individuals, eligibility determinations were made from 61 to 274 days after application. We reviewed documentation related to those 51 cases to determine whether the delay was the responsibility of the Department and if the client agreed to an extension. We determined:

- The Department could have prevented delays in 18 cases where counselors did not perform eligibility determination steps efficiently.
- The Department did not have documentation that it communicated the delay to the client in 22 cases.
- The Department did not record a specific extension in 48 cases.

Cause of Condition

The Department stated its current eligibility system does not effectively identify deadlines to its counselors. The Department designed controls to compensate for this in January 2012. These controls identified only cases that had gone beyond the deadline and not those approaching it.

Effect of Condition

Applicants eligible for Vocational Rehabilitation services did not start receiving assistance in a timely manner.

Recommendation

The Department should improve its internal controls to ensure counselors:

- Understand approval criteria and complete eligibility determinations in a timely manner.

- Communicate with applicants to determine a specific extension of time and effectively document reasons for delays.

Agency's Response

The Department acknowledges the finding. While individual situations may create need to delay an eligibility past the 60-day timeline, case file documentation should be clear about the reason for a delay, and that the customer is in agreement for the delay.

Training was provided at the Vocational Rehabilitation Counselor meeting on October 10, 2012, and at subsequent regional team meetings, to ensure that the awareness of the timeline, the need to meet the timeline, and the need to clearly document reasons for delay of eligibility beyond the 60-day timeline is understood by counselors and supported by their team members.

A system for monthly review of timelines to eligibility is in place. Team leaders review overdue eligibility cases to ensure documentations are in place that describe clearly reasons for delay. A method for checking status of eligibilities before they are overdue exists in the system, and training for accessing that tool has been provided VR counselors on October 10, 2012. The tool requires multiple steps for a staff to access; in a future planned upgrade of the case management system this tool will be in a more prominent "dashboard" feature, allowing a more streamlined, easy access to the data.

Auditor's 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.

OMB Circular A-133 Compliance Supplement 2012, Part 4 – Department of Education, Vocational Rehabilitation Cluster, III.E.1., states in part:

The State VR Agency must determine whether an individual is eligible for VR services within a reasonable period of time, not to exceed 60 days, after the individual has submitted an application for the services unless (Section 102(a)(6) of the Act (29 USC 722(a)(6)):

a. Exceptional and unforeseen circumstances beyond the control of the State VR agency preclude making an eligibility determination within 60 days and the State agency and the individual agree to a specific extension of time; or
b. The State VR Agency is exploring an individual's abilities, capabilities, and capacity to perform in work situations through trial work experiences in order to determine the eligibility of the individual or the existence of clear and convincing evidence that the individual is incapable of benefiting in terms of an employment outcome from VR services.

12-15 The Department of Services for the Blind did not have adequate internal controls to ensure compliance with federal suspension and debarment requirements 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
Federal Award Number:	H126A110072; H126A120072
Applicable Compliance Component:	Suspension and Debarment
Questioned Cost Amount:	None

Background

The Vocational Rehabilitation program is designed to assess, plan, develop and provide services for individuals with disabilities. The Department of Services for the Blind administers the federal Vocational Rehabilitation program for visually impaired individuals. The Department received approximately 15 percent ($7.8 million) of total federal vocational rehabilitation funding received by the state during fiscal year 2012.

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

- Checking the federal Excluded Parties List System
- Collecting a certification from the vendor or subrecipient.
- Adding a clause or condition to the covered transaction with the vendor or subrecipient.

Description of Condition

The Department contracts with vendors to provide services allowed under the program. In May 2012, the Department began including a debarment certification in all new contracts. The Department had no controls over this area in place prior to May 2012.

For fiscal year 2012, we found 17 vendors paid during the audit period that would be subject to suspension and debarment requirements. We found the Department did not verify that 16 of the 17 vendors were not suspended or debarred. The vendor that was verified had a contract start date of June 2012.

Cause of Condition

During fiscal year 2012, the Department was made aware of the requirement that it ensure all vendors receiving more than $25,000 in Vocational Rehabilitation grant funds are not suspended or debarred. However, the Department was unable to fully establish controls in order to be in compliance by fiscal year end.

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 17 vendors receiving more than $25,000 in the Excluded Parties List System and found none were debarred or suspended. Therefore, we will not question any costs related to these vendors.

Recommendation

We recommend the Department establish internal controls to 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.

Agency's Response

The Department agrees with the finding. As a corrective action, the Department developed a revised contract general terms and conditions in Aprils of 2012 that includes appropriate certification language for contractor signatures. Additionally, the Department initiated a monthly process effective August of 2012 to review expenditures and identify any vendor that has been paid in excess of $25,000 over the prior 12 months. These vendors are checked against the Excluded Parties List System to verify that the vendor has not been suspended or debarred.

Auditor's Remarks

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

Applicable Laws and Regulations

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

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

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.

12-16 The Department of Services for the Blind did not comply with federal requirements for reporting Vocational Rehabilitation program expenditures.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Vocational Rehabilitation Grants to States
Federal Award Number:	H126A100072; H126A110072; H126A120072
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The Vocational Rehabilitation program is designed to assess, plan, develop and provide services for individuals with disabilities. The Department of Services for the Blind administers the program for visually impaired individuals. It received approximately 15 percent ($7.8 million) of total program funding received by the state during fiscal year 2012.

The federal government requires grant recipients to report program expenditures to grantors. For the Vocational Rehabilitation program, the Department must submit the Federal Financial Report and the Program Cost Report to the Rehabilitation Services Administration within the Department of Education. The Federal Financial Report, submitted semi-annually and after a grant closes, details program expenditures related to a specific grant. The Program Cost Report, submitted annually, details all program spending for the prior federal fiscal year. The Department must ensure the completeness and accuracy of reports before submitting to Rehabilitation Services.

Description of Condition

Reporting controls

We found the Department did not have sufficient review processes for reports submitted to Rehabilitation Services. The review of the Federal Financial reports occurs after submission. Only one individual prepares and reviews the Program Cost reports. No one at the Department does an independent review of the reports before submission.

Reporting errors

We reviewed the four Federal Financial Reports submitted during fiscal year 2012, which related to federal fiscal year 2010, 2011, and 2012 awards. The Department did not base indirect expenses listed on each report on an approved payment rate. Without an approved rate by the grantor, agencies cannot request reimbursement for indirect expenses and should not report them. (See finding 12-17 regarding the questioned costs associated with the identified indirect expenses.) Additionally, the Department incorrectly calculated the federal share of indirect expenses on the 2011 award reports. The federal grantor only covers a portion of program costs (78.7 percent), and the remainder must be covered with state dollars. The Department recorded the state amount of 21.3 percent, when it should have recorded the federal amount. We also found the Department submitted the reports from eight to more than 100 days after the due date.

We also reviewed the annual Program Cost report submitted for expenditures during fiscal year 2011. We found the Department incorrectly recorded what it spent on Innovation and Expansion Activities, or those costs associated with developing new ways to better serve the program's customers. The amount recorded was $409,891, but supporting documentation showed it to be $509,891. We also found the Department incorrectly classified amounts paid for services provided to Vocational Rehabilitation customers, which make up about 36 percent of total program expenditures. Grantees must designate costs as "Assessment, Counseling, Guidance, and Placement" or "Other Services." It listed costs for services provided by Department staff as "Other Services" and costs for services from other providers as "Assessment, Counseling, Guidance, and Placement." Actual costs for services fall under both categories.

Cause of Condition

The Department did not consider the importance of having an appropriate review process when designing internal controls over reporting program information. This lack of monitoring allowed some errors to go unchecked. Additionally, the Department did not have a complete understanding of grant and reporting requirements.

Effect of Condition

Federal 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.

Recommendation

The Department should establish and implement internal controls to ensure reports are complete and accurate prior to submittal to the federal grantor.

The Department should provide training on reporting requirements to all staff preparing and reviewing financial reports to ensure they have a full understanding of how to complete the reports.

Agency's Response

The Department agrees with the audit finding and is now current on VR federal cost reports.

- *The Department has been in contact with the Department of Education/Rehabilitation Services Administration (RSA) staff to correct prior SF-425 reports. The corrections will include separation of indirect costs from direct allocated expenditures and to correctly reflect the federal portion of the indirect costs. The rates used for indirect costs will be addressed by the Department in the agency response to finding 12-17.*

- *The Department has developed an internal checklist for steps in preparation and review of the federal cost reports. The checklist requires interaction from three separate staff member to ensure proper reviews of submitted cost information.*

- *The Department will take advantage of any training opportunities made available through RSA and the Region 10 Technical Assistance & Continuing Education (TACE) center. TACE has started to include fiscal staff in their quarterly meetings which the Department has participated in.*

- *The Department will self report to RSA By November 15, 2012 for RSA actions in response to the audit findings for reporting errors on the FY11 RSA-2. The FY11 RSA-2 has been published, so it will be their decision to reopen the report.*

Auditor's Remarks

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

Applicable Laws and Regulations

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

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

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

Code of Federal Regulations, Title 34 – Education, Part 80.41, states in part:

(a) *General.* (1) Except as provided in paragraphs (a) (2) and (5) of this section, grantees will use only the forms specified in paragraphs (a) through (e) of this section, and such supplementary or other forms as may from time to time be authorized by OMB, for:

3) Grantees shall follow all applicable standard and supplemental Federal agency instructions approved by OMB to the extend required under the Paperwork Reduction Act of 1980 for use in connection with forms specified in paragraphs (b) through (e) of this section. Federal agencies may issue substantive supplementary instructions only with the approval of OMB. Federal agencies may shade out or instruct the grantee to disregard any line item that the Federal agency finds unnecessary for its decision making purposes.

(b) *Financial Status Report*—(1) *Form.* Grantees will use Standard Form 269 or 269A, Financial Status Report, to report the status of funds for all nonconstruction grants and for construction grants when required in accordance with § 80.41(e)(2)(iii).

(4) *Due date.* When reports are required on a quarterly or semiannual basis, they will be due 30 days after the reporting period. When required on an annual basis, they will be due 90 days after the grant year. Final reports will be due 90 days after the expiration or termination of grant support.

Code of Federal Regulation, Title 34 – Education, Subtitle B: Regulations of the Offices of the Department of Education (Continued), Chapter iii: Office of Special Education and Rehabilitative Services, Department of Education, part 361: State Vocational Rehabilitation Services Program,

Subpart B: State Plan and Other Requirements for Vocational Rehabilitation Services, Administration

361.40 - Reports.

(a) The State plan must assure that the designated State agency will submit reports, including reports required under sections 13, 14, and 101(a)(10) of the Act-

(1) In the form and level of detail and at the time required by the Secretary regarding applicants for and eligible individuals receiving services under this part; and

(2) In a manner that provides a complete count (other than the information obtained through sampling consistent with section 101(a)(10)(E) of the Act) of the applicants and eligible individuals to-

(i) Permit the greatest possible cross-classification of data; and

(ii) Protect the confidentiality of the identity of each individual.

(b) The designated State agency must comply with any requirements necessary to ensure the accuracy and verification of those reports.

12-17 The Department of Services for the Blind charged indirect costs related to the Vocational Rehabilitation program to its federal grant without an approved indirect cost rate.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Vocational Rehabilitation Grants to States
Federal Award Number:	H156A110072; H126A120072
Applicable Compliance Component:	Allowable Costs/ Cost Principles
Questioned Cost Amount:	$1,259,024.49

Background

The Vocational Rehabilitation program is designed to assess, plan, develop, and provide vocational rehabilitation services for individuals with disabilities. The Department of Services for the Blind administers the federal Vocational Rehabilitation program for visually impaired individuals. The Department received approximately 15 percent ($7.8 million) of total federal Vocational Rehabilitation funding received by the state during fiscal year 2012.

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

Description of Condition

The Department did not have controls in place to appropriately charge indirect costs to the Vocational Rehabilitation program. It charged them to the grant using a rate not approved by the federal grantor. This is not allowable.

Cause of Condition

The Department was not aware it needed to have approval for its temporary rate used during the fiscal year. The Department planned to request approval for a final rate after the close of the fiscal year.

Effect of Condition and Questioned Costs

We identified $1,259,024.49 in indirect expenditures charged to the federal grant during fiscal year 2012. Without an approved indirect cost rate, the federal grantor cannot ensure indirect costs charged to the grant are allowable or appropriate. We are questioning the indirect costs charged to the federal grant of $1,259,024.49.

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 internal controls to ensure an indirect cost proposal is submitted to the grantor for approval and update it annually. The Department should have controls in place to ensure the approved correct rate is being applied to the program's indirect costs. The Department should consult with its grantor to determine if any questioned costs should be repaid.

Department's Response

The Department agrees with the audit finding. Staff did not fully understand the indirect cost recovery rules for the Department of Education. The Department will submit indirect rate cost proposals for FFY12 and FFY13 to the Department of Education and negotiate a settlement for any costs determined to be unallowable.

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.

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

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

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

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

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

12-18 The Office of Superintendent of Public Instruction's internal controls over subrecipient monitoring are not adequate to ensure only proper and allowable costs are charged to the School Improvement Grants program.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.377 School Improvement Grants 84.388 School Improvement Grants, American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	S377A090048A; S377A100048; S388A090048A
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

The Office of Superintendent of Public Instructions (Office) administers the School Improvement Grants program. The program is intended to dramatically improve the academic achievement of students in the State's lowest-achieving five percent of Title 1 or Title 1 eligible schools.

The Office spent $22.5 million in School Improvement funds in fiscal year 2012, $16 million of which was paid from American Recovery and Reinvestment Act funds. Subrecipients received $21.3 million of total grant expenditures.

Federal regulations require the Office to monitor subgrant-supported activity to assure compliance with applicable Federal requirements and that performance goals are being achieved.

Prior to allowing a subrecipient school district to receive grant funds, the Office provides guidance regarding how federal funds are allowed to be spent. They also establish budgets for the districts that specify how much can be spent within specific categories of expenses such as salaries, supplies or travel. School districts claim School Improvement Grant funds electronically and are not required to submit supporting documentation at the time of the requests. Therefore, it is critical that the Office have monitoring processes in place to assure that the districts are spending grant funds for allowable purposes and complying with federal regulations.

Description of Condition

We determined that while the Office is monitoring its subrecipients' progress toward performance measures, it is not performing sufficient fiscal monitoring to ensure grant funds are being spent only for allowable purposes. During fiscal year 2012, the Office used contractors to perform subrecipient monitoring consisting of onsite visits of the districts. These contractors met with district and school staff quarterly and created monitoring reports for each quarter. These reports document monitoring of subrecipients' progress toward meeting performance measures related to the grant program, but do not include any fiscal monitoring.

The Office does have a consolidated program review process that they use to monitor fiscal activity for many of their federal grant programs. While the Office stated they are going to include the School Improvement Grants in this process for fiscal year 2013, it was not included during fiscal year 2012.

Cause of Condition

The Office's program staff believed the monitoring performed by the contractors was sufficient to meet federal requirements for subrecipient monitoring.

Effect of Condition

Because the Office is not performing sufficient fiscal monitoring, the risk of reimbursing school districts for costs that are unallowable is increased.

Recommendation

We recommend the Office create and perform internal controls that ensure fiscal monitoring of subrecipients. We also recommend this monitoring be sufficient to ensure subrecipients are reimbursed only for proper and allowable costs for the School Improvement Grants program.

Department's Response

Through our own review of agency processes involving federal funds, we also recognized the need for increasing our fiscal monitoring related to this program. Therefore, last summer, staff developed a fiscal monitoring checklist and incorporated their subrecipient monitoring to align with our comprehensive consolidated program review process (CPR).

The CPR process is the basis for monitoring all but one of our other Department of Education grant funds received by this agency. The CPR process is recognized as a model by the Department of Education and shared with other states that are struggling to meet compliance with this requirement. The SIG program has formally been a member of the CPR team since last fall and has been performing on-site reviews since January, 2013, with a significant focus on compliance with fiscal requirements.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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.

Title 34, Code of Federal Regulations, Section 80.40 - Monitoring and reporting program performance.

(a) *Monitoring by grantees.* Grantees are responsible for managing the day-to-day operations of grant and subgrant supported activities. Grantees must monitor grant and subgrant supported activities to assure compliance with applicable Federal requirements and that performance goals are being achieved. Grantee monitoring must cover each program, function or activity.

12-19 The Department of Health paid unreasonable indirect cost rates to a subrecipient of the Public Health Emergency Preparedness grant.

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
Federal Award Number:	1H75TP000369-01 2U90TP017010-10; 3U90TP017010.
Applicable Compliance Component:	Allowable Costs/Cost Principles
Questioned Cost Amount:	$9,156.27
Likely Questioned Cost:	$42,965.08

Background

The State Department of Health administers the Public Health Emergency Preparedness Program. This federal grant is designed to assist public health departments prepare for public health emergencies.

The Department spent $12.6 million in these grant funds in fiscal year 2012. Approximately $7.5 million was distributed to reimburse su-recipients, primarily county health districts and tribes, to oversee training, meetings, purchases of supplies and equipment, and create and update emergency response plans.

Reimbursement requests often include an amount for indirect costs such as general supplies or administrative staff salaries. These are billed as a percentage rate of their direct costs, such as staff salaries. The Department's grants management division maintains a list of approved indirect rates for subrecipients. When a reimbursement request comes in, the staff member reviewing the reimbursement request is to use the list to determine whether the indirect rate is allowable. If no approved indirect rate is on file, the reviewer uses his or her judgment to determine whether the submitted rate is reasonable.

The Department is required to comply with federal regulations on allowable costs by type of expenditure.

Description of Condition

The Department did not adequately review the supporting documentation received before paying subrecipients. We determined one subrecipient was paid an average indirect cost rate of 98 percent for three reimbursement requests. This rate is unreasonably high for an indirect cost rate and the amounts paid total $9,156.27. An average indirect rate is 10 percent to 20 percent. The U.S. Health and Human Services default rate is 10 percent of direct costs. We found documentation supporting 11 other payments to the same subrecipient was insufficient to determine what indirect rate was charged. Because subrecipients usually bill a consistent indirect rate each month, we determined it is likely this subrecipient charged a similar indirect rate for these payments as well

Cause of Condition

While the payment review process includes multiple staff members, none did a review to ensure the indirect rate was reasonable. The Department's list of approved indirect rates for subrecipients is incomplete. Eighty-six percent of the subrecipients on the list, including the one noted above, do not have an approved indirect rate posted for the reviewers to reference.

Effect of Condition and Questioned Costs

We identified costs of $9,156.27 that were not adequately supported and appear to be unallowable based on federal cost principles. We are questioning these costs. We identified an additional $42,965.08 in likely unallowable costs. The federal grantor could disallow these charges and require the Department to repay 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.

Recommendation

We recommend the Department ensure the list of approved indirect rates for subrecipients is complete and that reviewers of payments to subrecipients ensure only allowed indirect rates are reimbursed. The Department should consult with its grantor to determine what, if any, of the questioned costs should be repaid.

Department's Response

We concur with the finding concerning the excess indirect rate charged by a subrecipient and agree that Department of Health needs to ensure that amounts billed for administrative costs are reasonable and not excessive, and are consistent with an approved rate or cost allocation plan. We will review our procedures for checking the administrative component of these invoices.

As of January 2012, the Department initiated a requirement that all invoices for reimbursement of expenditures by Local Health Jurisdictions (LHJs) will include supporting documentation. Subsequently, we have clarified this requirement to ensure that supporting documentation must be sourced directly from the entity's accounting system. In addition, we are performing tests of indirect expenditures as a part of our on-going subrecipient monitoring of LHJs.

We will work closely with the Office of Financial Management to develop a corrective action plan. We thank the Auditor's office for the professional work by their staff.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

> The auditee shall:
>
> (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, Appendix A, C1-3), *Cost Principles for State, Local and Indian Tribal Governments*, states in part:
Attachment A:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
   a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
   b. Be allocable to Federal awards under the provisions of this Circular.
   c. Be authorized or not prohibited under State or local laws or regulations.
   d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
   e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
   f. Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.
   g. Except as otherwise provided for in this Circular, be determined in accordance with generally accepted accounting principles.

h. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period, except as specifically provided by Federal law or regulation.
i. Be the net of all applicable credits.
j. Be adequately documented.

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.
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 this Circular 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 Attachments C, D, and E.

12-20 The Department of Health does not adequately monitor subrecipients 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:	1H75TP000369-01; 2U90TP017010-10; 3U90TP017010; U3REP090228
Applicable Compliance Component:	Subrecipient Monitoring
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 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 health care partners. These entities oversee training, meetings, purchasing of supplies and equipment, and generate reports on the program.

The Department spent $12.6 million in Public Health Emergency Preparedness funds and $6.6 million in Hospital Preparedness Program funds in fiscal year 2012.

Subrecipient Monitoring

Pass-through entities are responsible for monitoring subrecipients' use of federal awards to ensure they comply with federal law and grant agreements. Subrecipients are not allowed to make a profit from federal grant funds, only to receive reimbursement of actual costs. The Department is responsible for notifying subrecipients of federal requirements.

We reported findings for fiscal year 2010 and 2011 stating the Department did not adequately monitor subrecipients or collect or review supporting documentation for expenditures reimbursed to subrecipients for either program.

Description of Condition

The Department lacks internal controls related to monitoring the compliance of its subrecipients in the following areas:

Collection of grant activity information from subrecipients:

The Department did not collect documentation supporting most subrecipient reimbursement requests for either program during the fiscal year. It requested the subrecipients receiving the majority of the program funds submit more supporting documentation with reimbursement requests beginning January 1, 2012. We determined, however, that many subrecipients did not comply and still were reimbursed.

Subrecipient monitoring through on-site visits:

The Department contracts with a certified public accountant for on-site fiscal monitoring of subrecipients. Each subrecipient is scheduled for on-site monitoring once during a defined, two-year period. During fiscal year 2012, 78 subrecipients received funds for Hospital Preparedness and/or Public Health Emergency Preparedness. The Department stopped on-site monitoring as of August 6, 2011 during a redesign of reports generated by the certified public accountant, and consequently only six of the 78 subrecipients received an on-site visit.

We reviewed the available on-site monitoring reports and determined the public accountant reviewed only recent expenditures even though the monitoring period was from January 1, 2011 through December 31, 2012.

We determined the on-site monitoring was not adequate to ensure expenditures of federal funds are supported and allowable.

Follow up of inappropriate amounts charged to the grant by subrecipients:

The Department does not adequately address subrecipient noncompliance. It also does not recover questioned costs reported by fiscal monitoring reports in a timely manner. We noted that three of the six monitoring reports identified some instances of subrecipient non-compliance, including unallowable expenditures, questioned costs, and unsupported billing rates for time and effort. Department management stated no follow up was performed with two of the subrecipients. Follow up was begun with the third subrecipient and the Department identified a large amount of potentially unallowable costs. The follow up was not complete by the end of the fiscal year and therefore no overpayment amount had been finalized, even though the on-site monitoring visit was 11 months earlier.

Required subrecipient notification of federal grant information:

We reviewed the contract files for 16 subrecipients and determined the Department did not notify any of the selected subrecipients of the Catalog of Federal Domestic Assistance title, award name or award number in the contract language

Cause of Condition

Although Department management designed new processes for subrecipient monitoring, they were not fully operational prior to the end of the audit period. Subrecipients were told to submit increased support with reimbursement requests however, many were not submitting the documentation or were submitting incomplete documentation. The Department still paid these reimbursements and stated the increased documentation requirement was not fully in place by the end of the fiscal year.

In response to the previous findings the Department decided to redesign the on-site monitoring reports to provide more detailed and meaningful information. It also decided to cease current monitoring while this redesign occurred and did not perform onsite monitoring for almost 11 months of the audit period.

The Department has no written policies and procedures to ensure:

- Staff understands how to comply with all federal compliance and monitoring requirements for subrecipients.
- Required grant information is included in subrecipient contracts.
- That it obtains reimbursements for amounts determined to be inappropriately charged to the grant.

New policies and procedures were being created during the fiscal year but were not completed by year end.

Effect of Condition

The Department cannot be sure it is reimbursing only allowable and actual costs and that its subrecipients are not profiting from federal dollars. By not adequately addressing identified noncompliance by subrecipients it is not requiring prompt reimbursement of federal funds.

The Department is not adequately informing subrecipients of all federal grant information. This could lead to improper use of federal funds by subrecipients.

Recommendation

We recommend the Department establish appropriate internal controls to:

- Ensure it pays subrecipients only for actual costs, supported by documentation in accordance with federal requirements.
- Ensure that on-site monitoring visits are frequent and thorough enough to provide adequate monitoring.
- Ensure it collects and returns all improper payments to the federal government
- Ensure it informs subrecipients of all required federal information when entering into an agreement with a subrecipient.

Department's Response

Collection of grant activity information from subrecipients:

The Department of Health partially concurs with the State Auditor's Office finding. Effective January 2012, the Department of Health required local health jurisdictions to provide summary level expenditure data by object to accompany the monthly invoices to which the local health jurisdictions complied. Beginning October 2012, the Department clarified the requirement that the summary level data must be accompanied by system generated reports. The contract language was amended to reflect this requirement. As of October 2012, the Department of Health is currently receiving this clarified requirement for all local health jurisdictions.

We will work closely with the Office of Financial Management to develop and institute a successful corrective action plan for the finding above.

Subrecipient monitoring through on-site visits:

The Department concurs with the State Auditor's Office finding. The certified public accountants contract with the Department of Health ended on December 31, 2011. The next fiscal monitoring cycle would have started on January 1, 2012. However, the Department was delayed in selecting a contracted certified public accountant for reviewing fiscal year 2012, and the Department did not contract with the certified public accountant until September 2012. Consequently the fiscal monitoring visits began in September 2012. All subrecipients are monitored using the same fiscal monitoring standards and processes.
The fiscal monitoring process has three distinct elements:

1. *The certified public accountant employs a risk-based monitoring process consistent with OMB A-133 standards and reviews a minimum of three invoices and purchases over $150. More invoices are reviewed if necessary. The certified public accountant then summarizes the outcome of the fiscal monitoring visit in a report to the Department.*

2. *Department staff reviews the fiscal monitoring report and determine the corrective action necessary, if any. In some cases, staff may require additional fiscal information before determining what action to take. The organization receives a copy of the report, along with a letter from the Department outlining issues requiring corrective action and the date by which a response is required.*

3. *The Department staff conducts follow up to ensure that appropriate actions are taken to correct deficiencies noted in the fiscal monitoring report.*

Additionally, Department staff has taken other steps to increase fiscal oversight of subrecipients, including increasing the number of site visits to the local health jurisdictions. In June 2012, the Department hired a Financial Examiner who will follow up on issues identified in the fiscal monitoring report that may require additional technical assistance.

We will work closely with the Office of Financial Management to develop and institute a successful corrective action plan for the finding above.

Follow up of inappropriate amounts charged to the grant by subrecipients:

The Department concurs with the State Auditor's Office finding. Cost recovery is part of the process described in the DOH Response to the previous finding. Once the issues, including ineligible costs, have been identified in the fiscal monitoring report, the organization is notified. The Department staff then conducts follow up to ensure that both monetary and nonmonetary issues are resolved. In addition the Department of Health is drafting a fiscal monitoring policy that will detail the procedures for initiating corrective action regarding issues noted on fiscal monitoring reports. It is estimated that this policy will be approved by June 2013.

We will work closely with the Office of Financial Management to develop and institute a successful corrective action plan for the finding above.

Required subrecipient notification of federal grant information:

The Department of Health concurs with the State Auditor's Office finding. As of October 1, 2012 for nonconsolidated contracts and November 15th, 2012 for consolidated contracts, the contract has been updated to include this information. The Department is in compliance with this federal requirement.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

OMB Circular A-133 Compliance Supplement Subpart C—Auditees

Section 300 - Auditee responsibilities.

The auditee shall:

…

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

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

Section 400(d) - Pass-through entity responsibilities.

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*, Part 3 – Compliance Requirements, states:

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.

The Department of Health and Human Services Grants Policy Statement, page II-29, states:

Subrecipients and contractors under grants are subject to the requirements of the cost principles otherwise applicable to their type of organization and to any requirements placed on them by the recipient to be able to comply with the terms and conditions of the award.

The cost principles do not address profit or fee. HHS policy allows the payment of fee on SBIR/STTR grants, but HHS will not provide profit or fee to any other type of recipient under any other grant program. A fee may not be paid by a recipient to a subrecipient/consortium participant, including a for-profit organization. However, a fee (profit) may be paid to a contractor providing routine goods or services under a grant in accordance with normal commercial practice.

12-21 The Department of Health does not have sufficient internal controls to ensure it meets federal level of effort requirements for the Public Health Emergency Preparedness and National Bioterrorism Hospital Preparedness programs.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.069 Public Health Emergency Preparedness
	93.889 National Bioterrorism Hospital Preparedness Program
Federal Award Number:	2U90TP017010-10; 3U90TP017010; U3REP090228
Applicable Compliance Component:	Level of Effort
Questioned Cost Amount:	None

Background

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

The Department distributes money to hospitals, outpatient facilities, tribes, health centers, poison control centers, emergency management services and others. These entities oversee training, meetings, purchasing of supplies and equipment, and generate reports on the program. The Department spent $12.6 million in Public Health Emergency Preparedness funds and $6.6 million in Hospital Preparedness Program funds in fiscal year 2012.

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

We reported a finding in our fiscal year 2011 audit, noting the Department did not have sufficient internal controls to ensure compliance with matching and level of effort requirements for either grant program.

Description of Condition

In fiscal year 2012 the Department put in place internal controls to ensure it met matching requirements for both grants. We consider the matching portion of last year's finding resolved.

However, the Department still 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, it reported to the grantor that it spent $0 for its level of effort requirement.

Cause of Condition

The Department was not tracking level of effort spending because management previously determined the required expenditures under the federal level of effort requirement to be $0. While the Department now concurs this position was incorrect and that controls must be implemented to ensure it meets level of effort requirements, it was unable to do so prior to the end of the fiscal year.

Effect of Condition

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

Recommendation

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

Department's Response

The Department does not agree that the expenditures identified by the auditor are subject to maintenance of effort requirements. We will confer with our federal grantors on this matter to get a clear understanding and resolve this issue. We thank the Auditor's office for the professional work by their staff.

Auditor's Concluding Remarks

We thank the Department for its response. We re-affirm our finding but agree that seeking clarification and resolution through the federal grantor would be beneficial.

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

Applicable Laws and Regulations

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

The auditee shall:

…

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

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

FY11 Hospital Preparedness Program Notice of Grant Award

7. Maintenance of Funding
Sec. 319C-2(h) (1) of the Public Health Service Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA) (P.L. 109-417), requires the awardee maintain expenditures at a level that is not less than the average level of the preceding two years.

Public Health Emergency Preparedness Budget Period 10 Extension Guidance, Component 2:

B. Budget Requirements….

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 Guidance (MSF)

Background: Section 319C-1(i)(2) of the Public Health Service Act, as amended by PAHPA (P.L. 109-417) 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.* (emphasis in original)

12-22 The University of Washington does not have monitoring controls to ensure subrecipients receiving less than $500,000 from the University obtain audits when required.

Federal Awarding Agencies:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.145 AIDS Education and Training Centers
	93.600 Head Start
Federal Award Number:	90HC0002
	U91HA06801
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

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

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

Description of Condition

The University of Washington does not have monitoring controls to ensure domestic and foreign subrecipients receiving less than $500,000 from the University obtain audits when required. We found the University ensures subrecipients awarded more than $500,000 from the University receive an audit each year. However, the University is not ensuring that subrecipients who receive less than $500,000 from the University, but whose total expenditures of federal awards exceed $500,000 annually, obtain the required audit. Further, the University does not include the requirement to obtain an audit in the subcontract language with foreign subrecipients.

Cause of Condition

The University does not monitor subrecipient's compliance with federal audit requirements when the subrecipient's total award from the University is less than $500,000. Rather, for domestic subrecipients, it relies on the subrecipient to adhere to the subcontract language, which requires the subrecipient to submit an A-133 report when their total spend exceeds $500,000. Additionally, for foreign subrecipients the University has not included language related to A-133 requirements as A-133 is not applicable to foreign entities, however, the University has maintained a practice of obtaining other audit documentation from the foreign entities with subcontracts awarded exceeding $500,000.

Effect of Condition

The University is not certain whether all of its subrecipients complied with federal grant requirements. The University is unable to determine whether:

- Subrecipients who spend $500,000 or more in total federal grant money, from all sources, submitted an audit report.

- Subrecipients received findings that would impact the University's award and that timely corrective action is taken.

Recommendation

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

University's Response

The University will work to enhance its existing controls to ensure all of its subrecipients receive audits when required including entities who receive less than $500,000 from the University but whose total expenditures may exceed more than $500,000 annually.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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:

(1) Identify Federal awards made by informing each subrecipient of CFDA title and number, award name and number, award year, if the award is R&D, and name of Federal agency. When some of this information is not available, the pass-through entity shall provide the best information available to describe the Federal award.

(2) Advise subrecipients of requirements imposed on them by Federal laws, regulations, and the provisions of contracts or grant agreements as well as any supplemental requirements imposed by the pass-through entity.

(3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

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

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

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

(7) Require each subrecipient to permit the pass-through entity and auditors to have access to the records and financial statements as necessary for the pass-through entity to comply with this part.

U.S. Office of Management and Budget Circular A-133, *Compliance Supplement 2012*, Part 3 – Compliance Requirements states:

Section M. Subrecipient Monitoring:

Compliance Requirements

A pass-through entity is responsible for: …

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

12-23 The Department of Social and Health Services does not have internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act for the Child Support Enforcement grant are filed.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.563 Child Support Enforcement
Federal Award Number:	1104WA4004; 1204WA4005
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The Department of Social and Health Services administers the Child Support Enforcement grant. This grant is used to collect support obligations owed by absent parents to their children, to locate absent parents, to establish paternity and to obtain child, spousal and medical support.

The Department distributes grant money to county commissioners, clerks, and prosecutors to administer in a way that supports enforcement services. The Department spent $85,419,369 in Child Support Enforcement funds in fiscal year 2012; of this it passed through $27,402,691 to subrecipients.

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

Description of Condition

During our review, we found the Department did not have controls in place to file the Accountability Act reports for 72 sub-awards it made that exceeded the $25,000 reporting requirement. These sub-awards totaled $38,595,000.

Cause of Condition

Department management stated they were not aware of the reporting requirement for the Child Support Enforcement grant.

Effect of Condition

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

Recommendation

We recommend the Department:

- Create policies, procedures and other internal controls sufficient to ensure it submits the reports for each sub-award of $25,000 or more by the applicable deadline.
- Provide the necessary training for all employees who oversee reporting and document its accuracy and completion.
- Monitor reporting of this information to ensure compliance with the requirement.

.

Department's Response

The Department concurs with this finding. While the Department was aware of the FFATA reporting requirements effective October 1, 2010, the initial guidance from the Administration for Children and Families (ACF) was that the requirements did not apply to state child support programs. The Department received official notification from ACF in November 2012 that state child support programs were required to report.

The following procedures were implemented to ensure compliance with FFATA reporting:

- *The Division of Child Support (DCS) has completed the reporting requirements for sub recipients meeting the $25, 000 thresholds for SFY12 and SFY13.*
- *The DCS has updated the desk manual to reflect the reporting requirements and time frames for future reporting.*

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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.

2 CFR170.330 Total compensation. APPENDIX A TO PART 170—AWARD TERM

I. Reporting Subawards and Executive Compensation.

b. Reporting of first-tier subawards.

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

12-24 The Department of Social and Health Services did not obtain a Data Universal Numbering System (DUNS) number from subrecipients prior to awarding federal dollars under the Child Support Enforcement grant.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.563 Child Support Enforcement
Federal Award Number:	1104WA4004; 1204WA4005
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

The Department of Social and Health Services administers the Child Support Enforcement grant to obtain the support obligations owed by absent parents to their children, to locate absent parents, to establish paternity and to obtain child, spousal and medical support.

The Department distributes grant money to county commissioners, clerks and prosecutors to administer the grant and to provide support enforcement services. The Department spent $85,419,369 in Child Support Enforcement funds in fiscal year 2012; of this it passed through $27,402,691 to 97 subrecipients.

Federal law requires state agencies to obtain a Data Universal Numbering System (DUNS) number from a subrecipient before making a sub-award. DUNS numbers are used to identify organizations that are receiving funding under grants and cooperative agreements and to provide consistent name and address data for electronic grant application systems.

The Department's Grants Management and Contracting divisions are responsible for ensuring compliance with this requirement.

Description of Condition

The Department does not have internal controls in place to obtain DUNS numbers from its Child Support Enforcement subrecipients prior to awarding federal funds.

Cause of Condition

Department management was not aware of the requirement.

Effect of Condition

The Department has not complied with the requirement. By not obtaining DUNS numbers from subrecipients prior to awarding federal funds, the Department cannot ensure public transparency for the money it provides.

Recommendation

We recommend the Department:

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

Department's Response

The Department concurs with this finding. While the Department was aware of the FFATA reporting requirements effective October 1, 2010, the initial guidance from the Administration for Children and Families (ACF) was that the requirements did not apply to state child support programs. The Department received official notification from ACF in November 2012 that state child support programs were required to report.

As of December 1, 2012, the Department has obtained DUNS numbers from all sub recipients and has completed the reporting requirements for SFY12 and SFY13.

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.

2 CFR 25.200: Requirements for program announcements, regulations, and application instructions says in part.

> (c) Each agency that awards types of Federal financial assistance included in the definition of "award" in §25.305 must include the requirements described in paragraph (b) of this section in each program announcement, regulation, or other issuance containing instructions for applicants that either:
>
> (1) Is issued on or after the effective date of this part; or
>
> (2) Has application or plan due dates after October 1, 2010.
>
> (b) The program announcement, regulation, or other issuance must require each entity that applies and does not have an exemption under §25.110 to: . . .
>
> (3) Provide its DUNS number in each application or plan it submits to the agency.
>
> (c) For purposes of this policy:
>
> (1) The applicant is the entity that meets the agency's or program's eligibility criteria and has the legal authority to apply and to receive the award. For example, if a consortium applies for an award to be made to the consortium as the recipient, the consortium must have a DUNS number. If a consortium is eligible to receive funding under an agency program but the agency's policy is to make the award to a lead entity for the consortium, the DUNS number of the lead entity will be used.
>
> (2) A "program announcement" is any paper or electronic issuance that an agency uses to announce a funding opportunity, whether it is called a "program announcement," "notice of funding availability," "broad agency announcement," "research announcement," "solicitation," or some other term.

12-25 The Department of Commerce does not have adequate controls to ensure it draws Low-Income Home Energy Assistance Program federal funds in accordance with the Cash Management Improvement Act Agreement.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.568 Low-Income Home Energy Assistance
Federal Award Number:	12B1WALIEA
Applicable Compliance Component:	Cash Management
Questioned Cost Amount:	None

Background

The primary purpose of the Cash Management Improvement Act agreement is to ensure states request federal funds exactly when they are needed and that no interest is gained or lost by either federal or state governments. The agreement specifies the funding technique to be used by the Department of Commerce when requesting federal funds. For the Low-Income Home Energy Assistance Program (LIHEAP), the agreement states that the Department shall draw funds at least semi-monthly for the program administrative costs and benefit payments.

During our audit period, the Department drew down more than $63 million in federal funds for the program's benefit payments and administrative costs.

Description of Condition

During our review, we found that the Department does not have adequate controls to ensure it draws program federal funds in accordance with the draw frequency specified in the cash management agreement. When the Department draws federal funds, it focuses on ensuring draw amounts are correct based on actual payments. However, the Department did not monitor the federal drawdown frequency to ensure it was in accordance with the cash management agreement.

Cause of Condition

From October 2011 to February 2012 the person responsible for processing draws was reassigned to another position. While Department management believed it was drawing down LIHEAP funds in accordance with the cash management agreement, it was not aware it had to draw the funds according to a specific schedule.

Effect of Condition

The Department did not draw down the program federal funds in accordance with the draw frequency specified in the cash management agreement. We selected 10 LIHEAP federal cash draws out of a total of 33 for review to determine whether the cash draws were processed within 15 days since the last draw date. We found that four draws out of the 10 were not processed within 15 days from the last draw.

The table below summarizes what we found.

Exceptions	Draw amount	Number of days from previous draw date
1	$ 3,094,650.86	51
2	$ 823,806.40	145
3	$ 224,540.61	29
4	$ 150,190.96	26

Delaying legitimate federal drawdown requests results in state funds being advanced longer than necessary and lost interest revenue.

Recommendation

We recommend the Department establish procedures to monitor the frequency of draws of federal program funds in accordance with the cash management agreement.

Department's Response

The Department concurs with this audit finding. The Department has reviewed its procedures and corrected the timing of the LIHEAP federal draws to coincide with CMIA Agreement.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

Circular A-102, *Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments,* adopted by the U.S. Department of Health and Human Services in Title 45, Code of Federal Regulations, section 92.21, 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.
>
> (d) *Reimbursement.* Reimbursement shall be the preferred method when the requirements in paragraph (c) of this section are not met. Grantees and subgrantees may also be paid by reimbursement for any construction grant. Except as otherwise specified in regulation, Federal agencies shall not use the percentage of completion method to pay construction grants. The grantee or subgrantee may use that method to pay its construction contractor, and if it does, the awarding agency's payments to the grantee or subgrantee will be based on the grantee's or subgrantee's actual rate of disbursement.

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

- 93.568 Low Income Home Energy Assistance
- Recipient: 103-Department of Commerce
- Technique: Modified Payment Schedule - (ACH Semi-Monthly Drawdown-COM)-The state shall request funds at least semi-monthly for administrative costs and program benefit payments to the subrecipients since the last draw.

12-26 The Department of Commerce does not have internal controls to ensure reports required by the Federal Funding Accountability and Transparency Act are filed for the Low-Income Home Energy Assistance Program.

Federal Awarding Agency:	U. S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.568 Low-Income Home Energy Assistance Program
Federal Award Number:	12B1WALIEA
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The State Department of Commerce administers the Low-Income Home Energy Assistance Program, which provides assistance to low income households to meet their home energy needs. The assistance is provided to households through local community based organization sub-awards. In fiscal year 2012, the Department spent approximately $77 million in federal program funds.

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

Description of Condition

During our review, we found the Department did not have controls in place to ensure Accountability Act reports were filed for 51 sub-awards for the program totaling $66,026,230. It did not file the required Accountability Act reports for any of the sub-awards.

Cause of Condition

Department management believed the Low-Income Home Energy Assistance Program was exempt from the Accountability Act reporting requirement.

Effect of Condition

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

Recommendation

We recommend the Department establish policies and procedures over reporting in accordance with the Accountability Act and submit all required reports for each sub-award of $25,000 or more by the applicable deadline.

Department's Response

The Department concurs with this audit finding. The Department operated with the understanding that Health and Human Services did not require LIHEAP to report under FFATA. When the FFATA reporting requirements were first introduced in 2010, the Department performed a thorough review of all federally funded programs and identified the programs affected by the new requirements. At that time, the Department contacted HHS who

provided written assurance that LIHEAP was not required to report under FFATA. January 31, 2013, the Department received clarification from HHS that 2012 awards were included in this requirement.

The Department trained the appropriate LIHEAP staff on the FFATA requirements and the use of the FSRS database to submit LIHEAP data. The Department is finalizing procedures to ensure FFATA data is entered into the FSRS database, and that LIHEAP complies with reporting requirements. The Department will complete these actions by March 29, 2013.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

Title 2, Code of Federal Regulations, Section 170 states in part:

> APPENDIX A TO PART 170—AWARD TERM
>
> I. Reporting Subawards and Executive Compensation.
>
> a. Reporting of first-tier subawards.
>
> 1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111–5) for a subaward to an entity (see definitions in paragraph e. of this award term).
>
> 2. Where and when to report.
>
> i. You must report each obligating action described in paragraph a.1. of this award term to http://www.fsrs.gov.
>
> ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)
>
> 3. What to report. You must report the information about each obligating action that the submission instructions posted at http://www.fsrs.gov specify.

12-27 The Department of Commerce, Community Services and Housing Division, did not comply with period of availability requirements for its Low-Income Home Energy Assistance program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.568 Low-Income Home Energy Assistance Program
Federal Award Number:	G-10B1WALIEA; G-11B1WALIEA
Applicable Compliance Component:	Period of Availability
Questioned Cost Amount:	$29,944.23

Background

The Low-Income Home Energy Assistance program (LIHEAP) assists organizations in providing programs and services to low-income people to meet the costs of home energy, increase their energy self-sufficiency, and reduce their vulnerability resulting from energy needs. Program funds can be also be used for home weatherization services under the Weatherization Assistance Program. In Washington State, the organizations that received LIHEAP weatherization funds include 19 non-profits and six local government agencies.

In fiscal year 2012, the Department spent $77 million in federal program funds. Approximately $10.9 million of this amount was spent on weatherization services.

Only costs resulting from expenditures incurred during the funding period may be charged to the grant. This includes the amounts of orders placed, contracts and sub-grants awarded, goods and services received, and similar transactions during a given period that will require payment by the Department during that same period.

Description of Condition

We tested a random sample of expenditures charged to the federal fiscal year 2011 grant and found three expenditures totaling $29,944.23 that were incurred during federal fiscal year 2010. These expenditures had originally been charged to the 2010 grant, but were transferred to the 2011 grant. The transfer took place during our scope of state fiscal year 2012.

Cause of Condition

Department fiscal staff did not properly review costs transferred from one grant year to another grant year to ensure they were within the proper period of availability.

Effect of Condition and Questioned Costs

We are questioning $29,944.23 that was charged to the 2011 grant before the grant's period of availability began. This transaction occurred during state fiscal year 2012. 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 ensure only expenditures made during the proper period of availability are charged to grants.

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

Department's Response

The Department concurs with the finding. The Department will review the federal criteria regarding period of availability with fiscal staff. The focus of this review and training will be to ensure staff understand that when expenditures are made or are moved from one fiscal year to another, staff must match the period of service to the award's period of availability. Commerce will work with the granting agency to determine the treatment of the questioned costs.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

U.S. Office of Management and Budget (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.

2 CFR Section 215.28 - Period of availability of funds.

> Where a funding period is specified, a recipient may charge to the grant only allowable costs resulting from obligations incurred during the funding period and any pre-award costs authorized by the Federal awarding agency.

12-28 The Department of Early Learning does not have adequate internal controls over direct payments to child care providers.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.575	Child Care and Development Block Grant
	93.596	Child Care Mandatory and Matching Funds of the Child Care and Development Fund
	93.713	Child Care and Development Block Grant – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	G1101WACCDF; G1201WACCDF	
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 2012, DEL paid approximately $75.9 million to child care centers and providers through the Working Connections Child Care Program.

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

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

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

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

Description of Condition

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

In fiscal year 2012, DEL only reconciled one month of child care payments to attendance records.

Cause of Condition

During fiscal year 2012, DEL was still revising its internal controls over provider payments and was not able to put a monthly reconciliation of child care payments to provider attendance records completely into operation.

Effect of Condition

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

Our current audit was for the purpose of determining compliance with federal laws and grant requirements, and did not examine the provider payments in the same manner as our other audit. Therefore, we did not review payments for compliance in that way and questioned costs are not included with this finding.

Recommendation

We recommend the Department continue to follow detailed monitoring procedures for provider payments that include reconciliations of provider attendance records to payments.

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

Departments' Response

The Department of Early Learning was in the process of completing expanded audits (two additional months of auditing) at the end of FY12, resulting in ***overpayments of $401,028*** *and* ***$4,329 in underpayments*** *being identified. The agency is in the process of hiring five additional audit staff for the reconciliations of provider attendance records to payments. If the amount is determined to be an overpayment or underpayment, DEL audit staff generate the appropriate process with the Office of Financial Recovery. The provider can ask for an administrative hearing if they believe the amount determined by the audit is incorrect.*

The Department is continuing to work on an electronic time and attendance system which will reduce the potential errors in payment. DEL performs the Improper Payment Act audit as federally required every three years, with the next report due June 30, 2014.

As reported in the agency response, several of the recommendations provided by the SAO have been implemented or are in the process of implementation.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

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

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

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

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

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

The licensee must also keep records of:

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

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

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

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

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

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

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

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

Attendance reconciliation:

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

12-29 The Department of Early Learning did not maintain federally required documentation for $21,328.61 in payroll costs charged to the Child Care Development Fund.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.575	Child Care and Development Block Grant
	93.596	Child Care Mandatory and Matching Funds of the Child Care Development Fund
	93.713	Child Care and Development Block Grant – American Recovery and Reinvestment Act
Federal Award Number:	G1101WACCDF; G1201WACCDF	
Applicable Compliance Component:	Allowable Costs / Cost Principles	
Questioned Cost Amount:	$21,328.61	

Background

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

Recipients may use grant money only for costs that are allowable and related to the grant's purpose. Federal regulations specify the documentation they 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, 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, so long as the estimate is reconciled to actual work activity at least quarterly.

Description of Condition

Between July 2011 and January 2012, the Department had certifications on file for an employee who did not work 100 percent of the time on the Child Care Development grant. The employee worked 50 percent on the Child Care Development grant and 50 percent on administrative duties. Because a certification had been completed, the employee did not maintain time records or other personnel activity reports as required.

Cause of Condition

Department management did not compare the actual duties of, and work performed by, this employee to the payroll certification for the grant.

Effect of Condition and Questioned Costs

We identified $21,328.61 in direct payroll and benefits incorrectly charged to the Child Care Development 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 expenditures.

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

A previous audit performed in February 2012 had already identified an issue with the recording of payroll certifications to support grant costs. The department implemented a more formal, closely reviewed process at that time for collecting payroll certifications. The incident cited in this audit occurred prior to these changes. The payroll costs charged to CCDF were valid, as the employee was working half-time on CCDF-related activities during this time period. However, the certifications were not completed accurately. The department is confident the new payroll certification process will ensure that all employee salaries and benefits are accurate and supported with the proper documentation.

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.

12-30 The Department of Social and Health Services does not have adequate internal controls over client eligibility for the Child Care Development Fund, resulting in the payment of child care services for ineligible clients.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.575	Child Care and Development Block Grant
	93.596	Child Care Mandatory and Matching Funds of the Child Care Development Fund
	93.713	Child Care and Development Block Grant – American Recovery and Reinvestment Act
Federal Award Number:	G1101WACCDF; G1201WACCDF	
Applicable Compliance Component:	Cost Principles/Eligibility	
Known Questioned Cost Amount:	$ 3,590	
Likely Questioned Cost Amount:	$18,591,983	

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 2012, DEL paid approximately $75.9 million to child care centers and providers through the Working Connections Child Care Program.

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

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

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

Description of Condition

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

- In most cases, a DSHS caseworker processes client eligibility information and authorizes services without any secondary review or approval.
- Caseworkers can authorize services in the eligibility system without verifying client household income or employment activity.
- Caseworkers have the system access that is needed to directly alter payment information in the payment system.
- DSHS audits child care payments monthly, but reviews only 1 percent of open authorizations. This does not provide enough coverage to address the internal control weaknesses to ensure payments are not made to ineligible clients.

Cause of Condition

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

Effect of Condition and Questioned Costs

The Department of Early Learning paid for child care services for ineligible clients.

We examined eligibility for 133 clients who received child care services. These clients were selected by a random sampling method from a population of all child care payments made during our scope. We determined 10 of these clients were ineligible or their eligibility was not fully supported:

- One client's income exceeded the threshold.
- Two clients' households had a parent living at home who was not working or attending job training or education programs. There was no documentation to establish that these parents were incapable of providing care for the child.
- Four clients did not provide verification of wages or work schedules for all working members of the household. Further review of one of these clients showed income exceeded the threshold.
- Three clients did not report all members of the household, based on documentation in their case files and inquiry from DSHS staff. Therefore, their incomes were not included when eligibility was determined. Further review of one of these clients showed continued noncompliance with requests from DSHS for household member verification and proof of residency, but they continued to receive services.

We identified $3,590 in Child Care and Development grant costs paid to ineligible clients. We are questioning those costs as unallowable. We question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support expenditures. The federal grantor could disallow these charges and require the Department to repay the money.

Based on our sampling method that allows us to project our results to the entire population of clients, we estimate potential unallowable costs paid to ineligible clients to be $18,591,983.

Recommendations

We recommend the DSHS and DEL work together to develop internal controls that will ensure eligibility is established and supported prior to authorizing child care services to clients. We also recommend that DSHS and DEL improve the current review process to cover a larger population of authorized payments and ensure eligibility was determined correctly.

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

Department's Response

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

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

- *A supervisory review is required for payment requests that exceed certain parameters. The supervisor reviews the need for the additional payment and either approves the payment by submitting the authorization to SSPS or denies the payment if the consumer is not eligible. All special authorizations require supervisor review for approval.*
- *New workers have 100% of their work audited by Leadworkers. Due to the high volume of work and the number of new employees, these audits may be conducted as either pre or post-authorization.*

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

The Department partially concurs with this finding. WAC 170-290-0012 requires a consumer to provide verification of employment or employment activity including income, hours of work and work schedule to receive childcare subsidy payments. WAC and processing guidelines require workers to request verification if not provided by the consumer. Childcare program training supports and reinforces these requirements.

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

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

- *Within the Childcare Contact Center environment, it is rare for a case to have the same staff member authorize four or more payments in a 15 month period without authorization activity from other staff members. A monthly Integrity Report containing cases that meet this criteria is reviewed by regional staff. To date, the report has not identified any cases resulting in a finding of improper authorization activities. A monthly integrity report of all exception payments is reviewed by regional staff as a secondary post-authorization audit. The audit is intended as a quality assurance measure and validation of internal controls.*
- *The Department has instituted a separation of duties protocol that does not allow a staff member who activates a license-exempt provider to make any authorization changes for that provider.*
- *When a license-exempt provider has a provider number created by SSPS or has had no payment authorizations for the previous 90 days, they must have their file activated prior to having payments submitted to SSPS.*

SAO finding - DSHS audits child care payments monthly, but reviews only 1 percent of open authorizations. This does not provide enough coverage to address the internal control weaknesses to ensure payments are not made to ineligible clients.

The Department partially concurs with this finding. Working with monthly data provided by the Health Care Authority, the Department audits additional childcare eligibility activity to identify error prone cases and areas where policy clarification, training or systems support can increase accuracy. DSHS also performs 100% of a combination of pre/post audits of all new childcare workers. From January to December of 2012, the child care unit hired 24 new line staff, 2 leadworkers, and one non-permanent supervisor. As described earlier, exception authorizations must be reviewed and approved by a supervisor before payment can be made. In addition to DSHS audits, DEL performs audits focusing on provider billing.

DEL RESPONSE:

DEL is in the process of working with DSHS on several issues around eligibility as identified in the 2012 Subsidy Study report. This includes supporting the training needs of eligibility workers, and how to help them to be accurate in their determinations.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

The auditee shall:

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

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

U. S. Department of Health and Human Services regulations at 45 CFR 98.20 state in part:

Subpart C—Eligibility for Services

§ 98.20 A child's eligibility for child care services.

(a) In order to be eligible for services under § 98.50, a child shall:

(1) (i) Be under 13 years of age; or,

(ii) At the option of the Lead Agency, be under age 19 and physically or mentally incapable of caring for himself or herself, or under court supervision;

(2) Reside with a family whose income does not exceed 85 percent of the State's median income for a family of the same size; and

(3) (i) Reside with a parent or parents (as defined in § 98.2) who are working or attending a job training or educational program; or

(ii) Receive, or need to receive, protective services and reside with a parent or parents (as defined in § 98.2) other than the parent(s) described in paragraph (a)(3)(i) of this section.

(A) At grantee option, the requirements in paragraph (a)(2) of this section and in § 98.42 may be waived for families eligible for child care pursuant to this paragraph, if determined to be necessary on a case-by-case basis by, or in consultation with, an appropriate protective services worker.

(B) At grantee option, the provisions in (A) apply to children in foster care when defined in the Plan, pursuant to § 98.16(f)(7).

(b) Pursuant to § 98.16(g)(5), a grantee or other administering agency may establish eligibility conditions or priority rules in addition to those specified in this section and § 98.44 so long as they do not:

(1) Discriminate against children on the basis of race, national origin, ethnic background, sex, religious affiliation, or disability;

(2) Limit parental rights provided under Subpart D; or

(3) Violate the provisions of this section, § 98.44, or the Plan. In particular, such conditions or priority rules may not be based on a parent's preference for a category of care or type of provider. In addition, such additional conditions or rules may not be based on a parent's choice of a child care certificate.

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

E. Eligibility

1. Eligibility for Individuals

Lead Agencies must have in place procedures for documenting and verifying eligibility in accordance with the following Federal requirements, as well as the specific eligibility requirements selected by each State/Territory/Tribe in its approved Plan.

a. Children must be under age 13 (or up to age 19, if incapable of self care or under court supervision), who reside with a family whose income does not exceed 85 percent of State/territorial/tribal median income for a family of the same size, and reside with a parent (or parents) who is working or attending a job-training or education program; or are in need of, or are receiving, protective services. Tribes may elect to use State or tribal median income (42 USC 9858n(4); 45 CFR sections 98.20(a) and 98.80(f)).

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

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.

12-31 Edmonds Community College did not comply with time and effort requirements for its Head Start Program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.600 Head Start
Federal Award Number:	10CH0107/28, 10CH0107/29
Applicable Compliance Component:	Allowable Costs / Cost Principles
Questioned Cost Amount:	$596,035.20

Background

Edmonds Community College administers the Head Start Program to promote the school readiness of low-income preschool children (ages 3 to 5) and infants and toddlers (birth through age 3) by enhancing their cognitive social and emotional development in learning environments that support their growth in language, literacy, mathematics, science, social and emotional functioning, creative art, physical skills, and approaches to learning.

In fiscal year 2012, the College spent $5.49 million in federal funds on the program, approximately 78 percent of which were payroll expenses.

Grants may only be used to pay for costs that are allowable and related to the grant's purpose. Federal regulations specify the documentation that must be kept to support employee payroll charged to federal grants. Such documents must:

- Reflect only the activity for which the employee is compensated by the institution.
- Reflect activity applicable to each sponsored agreement and to each category needed to identify Facilities and Administrative costs and the functions to which they are allocable.
- Be signed by the employee or responsible official(s) at least annually using suitable means of verification that the work was performed.

The College prepares a budget for each fiscal year specifying how much each employee in the program will be compensated. To confirm time charged to the program, the College requires hourly employees to fill out timesheets and classified employees to enter time in a tracking system. However, the College does not require time and effort reporting such as certifications or timesheets for exempt employees.

Description of Condition

There were a total of 12 exempt employees who charged all of their salaries to the program during fiscal year 2012. The College did not have time and effort documentation for any of the 12 exempt employees.

Cause of Condition

When we asked the College why they did not obtain time certifications as required, the College stated its budgeting process was adequate support for the exempt staff.

Effect of Condition

We identified $596,035.20 in direct payroll charges to the Head Start program that did not have the required time and effort documentation. 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 an entity has not complied with grant regulations and/or when it does not have adequate documentation to support its expenditures.

Recommendation

We recommend the College establish a process to certify the work exempt employees performed for the program at least annually.

The College should consult with its grantor to determine how much, if any, of the questioned costs should be repaid.

Department's Response

Edmonds CC is requesting that the time and effort finding be dropped due to the following:

Unlike OMB Circular A-87 there is no requirement in A-21 for a certification for an employee that is charged 100% to a federal grant. The finding refers to OMB Circular A-21, J.10.c, but is silent about J.10.b.1.(b) which references only employees that are charged to more than one agreement or other funds.
b. Payroll distribution.
(1) General Principles,
(b) The apportionment of employees' salaries and wages which are chargeable to more than one sponsored agreement or other cost objective will be accomplished by methods which will –

All through J.10 it speaks to multiple agreements; not once is 100% funding by one agreement mentioned as is specifically mentioned in A-87. J.10 is only in reference to employees that are funded by more than one agreement or funds.

Every three years DHHS/Administration for Children and Family (ACF) conducts a comprehensive on-site accounting and service monitoring review of all Headstart contracts. The Federal Review Team is composed of 10 or more ACF professional consultants each an expert in a designated service area including accounting, fiscal, and federal grant management. An after-the-fact certification of exempt employees working in a single federal agreement has never been brought to our attention by the ACF Federal Review Teams, never reported as a finding or as a management letter concern.

Although we still maintain that the certifications are not required for exempt employees working in a single federal agreement, we felt that it was in the best interest of our county-wide Head Start program and future federal funding, that we manually reconstruct the written certifications of time and effort for the 12 exempt employees in question. They confirm the verbal assurances given during the audit and have been signed by the employees, supervisors and director. We have forwarded those to the auditors office. Since these employees were:

- *Hired solely for Head Start positions*
- *Assigned only to Head Start locations*
- *Specifically listed by name, title, salary and % of time in the 11/12 federal application materials and*
- *Have completed the Head Start tasks assigned to them,*

we feel that these certifications are as credible now as they would have been if created at the end of the 11/12 fiscal year and we respectfully request that they be <u>included</u> in the SAO Head Start audit paperwork and evidence.

Auditor's Concluding Remarks

We thank the Department for its response and cooperation and assistance throughout the audit. We re-affirm that an after the fact reconciliation or confirmation of payroll hours charged to the Head Start program must be made. We will review the status of the Departments' corrective action during our next audit.

Applicable Laws and Regulations

OMB Circular A-133 Compliance Supplement Subpart C—Auditees

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.

U.S. Office of Management and Budget (OMB) Circular A-21, *Principles for Determining Costs Applicable to Grants, Contracts, and Other Agreements with Educational Institutions*, Section J-General Provisions for Selected Items of Cost,

Subsection 10.b. states in part:

b. Payroll Distribution

(2) Criteria for Acceptable Methods.

(a) The payroll distribution system will

(i) be incorporated into the official records of the institution;

(ii) reasonably reflect the activity for which the employee is compensated by the institution; and

(iii) encompass both sponsored and all other activities on an integrated basis, but may include the use of subsidiary records. (Compensation for incidental work described in subsection a need not be included.)

(b) The method must recognize the principle of after the fact confirmation or determination so that costs distributed represent actual costs, unless a mutually satisfactory alternative agreement is reached. Direct cost activities and F&A cost activities may be confirmed by responsible persons with suitable means of verification that the work was performed. Confirmation by the employee is not a requirement for either direct or F&A cost activities if other responsible persons make appropriate confirmations.

(c) The payroll distribution system will allow confirmation of activity allocable to each sponsored agreement and each of the categories of activity needed to identify F&A costs and the functions to which they are allocable. The activities chargeable to F&A cost categories or the major functions of the institution for employees whose salaries must be apportioned (see subsection b.(1)b)), if not initially identified as separate categories, may be subsequently distributed by any reasonable method mutually agreed to, including, but not limited to, suitably conducted surveys, statistical sampling procedures, or the application of negotiated fixed rates.

(d) Practices vary among institutions and within institutions as to the activity constituting a full workload. Therefore, the payroll distribution system may reflect categories of activities expressed as a percentage distribution of total activities.

(e) Direct and F&A charges may be made initially to sponsored agreements on the basis of estimates made before services are performed. When such estimates are used, significant changes in the corresponding work activity must be identified and entered into the payroll distribution system. Short term (such as one or two months) fluctuation between workload categories need not be considered as long as the distribution of salaries and wages is reasonable over the longer term, such as an academic period.

(f) The system will provide for independent internal evaluations to ensure the system's effectiveness and compliance with the above standards.

(g) For systems which meet these standards, the institution will not be required to provide additional support or documentation for the effort actually performed.

Subsection 10.C states in part:

a. Examples of Acceptable Methods for Payroll Distribution:

(1) Plan Confirmation: Under this method, the distribution of salaries and wages of professorial and professional staff applicable to sponsored agreements is based on budgeted, planned, or assigned work activity, updated to reflect any significant changes in work distribution. A plan confirmation system used for salaries and wages charged directly or indirectly to sponsored agreements will meet the following standards:

(a) A system of budgeted, planned, or assigned work activity will be incorporated into the official records of the institution and encompass both sponsored and all other activities on an integrated basis. The system may include the use of subsidiary records.

(b) The system will reasonably reflect only the activity for which the employee is compensated by the institution (compensation for incidental work described in subsection a need not be included). Practices vary among institutions and within institutions as to the activity constituting a full workload. Hence, the system will reflect categories of activities expressed as a percentage distribution of total activities. (See Section H for treatment of F&A costs under the simplified method for small institutions.)

(c) The system will reflect activity applicable to each sponsored agreement and to each category needed to identify F&A costs and the functions to which they are allocable. The system may treat F&A cost activities initially within a residual category and subsequently determine them by alternate methods as discussed in subsection b.(2)(c).

(d) The system will provide for modification of an individual's salary or salary distribution commensurate with a significant change in the employee's work activity. Short term (such as one or two months) fluctuation between workload categories need not be considered as long as the distribution of salaries and wages is reasonable over the longer term, such as an academic period. Whenever it is apparent that a significant change in work activity that is directly or indirectly charged to sponsored agreements will occur or has occurred, the change will be documented over the signature of a responsible official and entered into the system.

(e) At least annually a statement will be signed by the employee, principal investigator, or responsible official(s) using suitable means of verification that the work was performed, stating that salaries and wages charged to sponsored agreements as direct charges, and to residual, F&A cost or other categories are reasonable in relation to work performed.

(f) The system will provide for independent internal evaluation to ensure the system's integrity and compliance with the above standards.

(g) In the use of this method, an institution shall not be required to provide additional support or documentation for the effort actually performed.

12-32 The Department of Social and Health Services, Children's Administration, is not ensuring the eligibility of clients receiving Adoption Assistance payments.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.659 Adoption Assistance
Federal Award Number:	Unknown
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	$ 79,590
Projected Cost Amount:	$1,762,637

Background

The Children's Administration of the Department of Social and Health Services administers the Adoption Assistance Program. The Department paid approximately $49 million in federal dollars for adoption assistance in fiscal year 2012, for support of almost 12,000 children.

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

State law allows a child who is a least 18, but less than 21 years old, to continue receiving adoption assistance benefits if it is confirmed the child is a full-time high school student or working full time toward the completion of a GED (high school equivalency) certificate and continues to receive financial support from the adoptive parent(s). Under no circumstances may benefits extend beyond the adoptive child's 21st birthday.

During the last three audits (fiscal years 2009, 2010 and 2011) 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. In response to the audit 2011 finding, the Department stated it would provide training for staff and conduct quarterly spot checks of payments. The Department also added controls to their case management system to suspend benefit payments of children who turn 18, only allowing payments to resume after staff has confirmed the child warrants continuation of the benefits.

Description of Condition

We reviewed the Department's process to ensure the eligibility of clients receiving Adoption Assistance payments. We focused on new applicants, children who reached the age of 18, and children who reached the age of 21. We found:

New Applicants

The Department staff did not always complete the required Special Needs Determination and Certification portion of the application and ensure the child met the eligibility requirements.

Children Age 18

The Department lacks the necessary internal controls to ensure recipients who reach the age of 18 are still eligible to receive monthly benefit payments. During this review we found the Department still does not have system or

manual controls to identify children turning age 18 in order to proactively establish continued eligibility or cancel benefits.

Children Age 21

The Department does not have system or manual controls in place to effectively end benefits of children turning age 21.

Cause of Condition

New Applicants

The Department stated all the regions experienced significant staffing issues during fiscal year 2012 and they were in the middle of changing the eligibility determination process to a computerized, paperless entry. We found the regions lacked a secondary review process to ensure documentation of eligibility is complete and on file prior to payments being processed.

Children Age 18

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

Children Age 21

The Department does not have an automated process to ensure payments are not issued for recipients over the age of 21. It relies on manual identification of adoptees aging out of the program and has no Division-wide policies or procedures to guide this process. However, there are no internal controls established to guide the manual identification process.

The Department stated they have added automated controls to identify and flag children age 18 and to stop payments for children age 21. However these automated controls were added in December 2012, after the audit period. We will review the changes to the system during our next audit of the program.

Effect of Condition and Questioned Costs

Without proper controls in place, the Department is paying benefits for children who are not eligible.

New Recipients

We tested documentation for 59 randomly selected children to determine if the Department was adequately documenting each child's eligibility. We found the Special Needs Determination section was not completed in four of the 59 cases. We found no evidence the review for special needs was completed by the Program Consultant for these four cases. Payment should not be processed unless the Special Needs Determination is completed in full. As a result, we cannot be assured that these children were properly assessed as program eligible. We are questioning the costs for these four children in the amount $31,020. We consider these exceptions as isolated to the test group and are not projecting questioned costs to this population.

Children Age 18

To follow up on the concerns noted in prior audits, we performed testing of randomly selected recipient benefits to determine if the Department collected appropriate supporting documentation for children over 18 years of age. To be eligible to continue receiving program benefits, there must be school verification the adopted child (over 18) is enrolled.

Regions 1-5
We found four of 51 children over the age of 18 did not have current documentation on file to prove continued eligibility for adoption assistance benefits. As a result we are questioning costs of $9,003. We also noted one child whose case was closed just after the month cut off, resulting in one extra payment of $460. Based on a projection of our sample testing results, we project an estimated $678,010 in questioned costs.

Region 6
We also performed follow up testing at a regional office where we found a higher noncompliance rate during our fiscal year 2011 audit. We determined seven of 33 children over the age of 18 did not have current documentation on file proving continued eligibility for adoption assistance benefits. As a result we are questioning costs of $24,834. We also found that eight children whose benefits should have ended on the month of graduation, continued to receive benefits of $6,048 through the end of the fiscal year. Based on a projection of our sample testing results, we project an estimated $1,084,627 in questioned costs.

Children Age 21

State law prohibits support payments for any adoptee once they reach age 21. We reviewed all adoption payments for fiscal year 2012 and found five adoptees over 21 who received payments totaling $8,225 during the year. Any person over 21 is not eligible to receive federal funds; therefore we are questioning this entire amount.

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

Recommendation

We recommend the Department:

- Establish 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.
- We recommend the Department perform a secondary review confirming documentation supporting eligibility is completed and on file, and data entries are accurate for Adoption Assistance payments.
- Communicate with the federal grantor to determine whether questioned costs need to be repaid.

Department's Response

The Department concurs with the findings.

In early December 2012 the Children's Administration implemented an automated process within FamLink, the Department's child welfare and payment system, to pend all payments for children at the age of 18. The social worker must have the appropriate documentation in the file which will allow payment beyond age 18, the continuation of payments is then processed by a fiduciary as a secondary review that the appropriate documentation is in place and payment is appropriate. Quarterly reviews for payments over age 18 are also in place to help reduce the potential for an overpayment.

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

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

The auditee shall:

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

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

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

(10) The department and supervising agencies shall have authority to provide continued extended foster care services to youth ages eighteen to twenty-one years to participate in or complete a secondary education program or a secondary education equivalency program, or a postsecondary academic or postsecondary vocational education program. The department shall develop and implement rules regarding youth eligibility requirements.

(11) The department shall have authority to provide adoption support benefits, or relative guardianship subsidies on behalf of youth ages eighteen to twenty-one years who achieved permanency through adoption or a relative guardianship at age sixteen or older and who meet the criteria described in subsection (10) of this section.

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

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

(1) Be less than eighteen years old when the department and the adoptive parents sign the adoption support agreement;

(2) Be legally free for adoption;

(3) Have a "special needs" factor or condition according to the definition in this rule (see WAC 388-27-0140); and

(4) Meet at least one of the following criteria:

(a) Is in state-funded foster care or child caring institution or was determined by the department to be eligible for and likely to be so placed (For a child to be considered "eligible for and likely to be placed in foster care" the department must have opened a case and determined that removal from the home was in the child's best interest.); or

(b) Is eligible for federally funded adoption assistance as defined in Title IV-E of the Social Security Act, the Code of Federal Regulations, the U.S. Department of Health and Human Services establishing guidelines for states to use in determining a child's eligibility for Title IV-E adoption assistance.

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

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

(1) The child reaches eighteen years of age; (if a child is at least eighteen but less than twenty-one years old and is a full-time high school student or working full time toward the completion of a GED (high school equivalency) certificate and continues to receive financial support from the adoptive parent(s), the department may extend the terms of the adoption support agreement until the child completes high school or achieves a GED. Under no circumstances may the department extend the agreement beyond the child's twenty first birthday.) Adoption support benefits will automatically stop on the child's eighteenth birthday unless the parent(s) requests continuation per

this rule and have provided documentation of the child's continuation in school. To prevent disruption in services the parent should contact the adoption support program at least ninety days prior to the child's eighteenth birthday if continued services are to be requested.

(2) The adoptive parents no longer have legal responsibility for the child;
(3) The adoptive parents are no longer providing financial support for the child;
(4) The child dies; or
(5) The adoptive parents die. (A child who met federal Title IV-E eligibility criteria for adoption assistance will be eligible for adoption assistance in a subsequent adoption.)

Children's Administration Operations Manual

13100. Records Management And Security

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

CA will maintain these records in two formats:

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

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.

12-33 The Department of Health did not survey all hospitals and ambulatory surgical centers in accordance with the frequency stipulated by state and federal laws, which could increase the risk of Medicaid clients receiving substandard care.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Provider Health and Safety Standards	
Questioned Cost Amount:	None	

Background

The state has 100 active hospitals in three categories: acute care/general hospitals, chemical dependency hospitals, and psychiatric hospitals. State regulations require the Department of Health or an accreditation agency such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to survey all hospitals on average at least every eighteen months. 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.

The state has 225 ambulatory surgical centers. Federal regulations require the Department of Health to re-perform surveys of ambulatory surgical centers completed by other accreditation organizations. Federal regulations also require the Department to perform surveys for the ambulatory surgical centers not surveyed by other accreditation organizations on a four year cycle.

Hospitals and ambulatory surgical centers statewide received more than $1.1 billion and $5.3 million respectively in state and federal funds in fiscal year 2012 for services provided to Medicaid clients. Federal regulations require states to ensure health-care facilities such as hospitals and ambulatory surgical centers meet prescribed health and safety standards in order to be eligible for federal reimbursement.

Description of Condition

During fiscal year 2012, the Department of Health did not perform hospital and ambulatory surgical centers surveys as required by state and federal laws.

Of the state's 100 current hospitals, 52 were evaluated by the Department. Of that group 33 (63 percent) did not receive the required survey within the 18-month average interval.

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

Time exceeding the 18-month survey period	Number of Hospitals
One Month	6
Two Months	6
Three Months	12
Four Months or Greater	9
Total	33

Federal regulations require the Department to perform surveys each year on 25% of the ambulatory surgical centers which are not surveyed by other accreditation organizations. During fiscal year 2012 the Department completed only 38 of the required 41 ambulatory surgical center surveys.

Cause of Condition

The Department states it does not have a sufficient number of staff to perform surveys in a timely manner as required by state and federal laws. The Department stated it recognized a need for at least one more surveyor but had been unable to hire due to a shortage of qualified candidates.

Effect of Condition

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

Recommendation

We recommend the Department conduct hospital and ambulatory surgical center surveys as required by state and federal laws.

Department's Response

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

We are committed to improving our frequency rate for inspecting health care facilities in Washington as we believe it goes a long way in fulfilling our commitment to patient safety. We join with the auditor's office in seeking to perform at a 100% compliance rate.

With regard to hospital inspections, from June 2012 to the present, we have engaged the hospital inspection team in an extensive review of our inspection methodology using LEAN process improvement principles. This has resulted in a new inspection approach we are taking to the field in 2013. We anticipate this new approach will ultimately result in less inspectors needed for the larger hospitals; thus freeing up staff to run concurrent inspections at other facilities. In this way, more facilities will be inspected over the current year and our frequency rates will catch up and improve.

With regard to ambulatory survey centers, our compliance rate of 93% is significant in light of the unique challenges we face in regulating this facility type. Changes in regulatory standards and inspection methodology for the centers have significantly raised the bar in the regulation of outpatient surgery. Of the 38 we inspected, 87% (32) of the centers required multiple onsite inspections to resolve significant deficiencies identified. This reduced the overall proficiency of this team. Nevertheless, this team is fully dedicated to obtaining and maintaining a 100% inspection frequency compliance rate.

We've focused efforts on recruitment and training, which will benefit all inspection activities. However, our office still has several unfilled inspector positions and hiring nurses for these roles remains challenging in general. We have expanded and overhauled our recruitment efforts and criteria and are starting to see a better pool for hiring develop.

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

Quality Assurance for the Medicare & Medicaid Programs: FY2012 Mission and Priority Document (MPD) – *Survey and Certification;* Department of Health & Human Services, Centers for Medicare and Medicaid Services, Survey and Certification Group, states in part:

D. Ambulatory Surgical Centers (ASCs):
In FY 2012 all States that have non-deemed ASCs are required to survey at least 25% of their non-deemed ASCs using the enhanced survey process. States that have only 4 or fewer non-deemed ASCs must survey at least 1 facility in FY 2012 unless all such ASCs were surveyed in FY 2010 and FY 2011. Beginning in FY2012, Tier 3 survey frequency is a 5.0 year interval (60.9 months) such that no more than 5 years elapses between surveys of any ASC.
States must also continue to send to a CMS contractor the completed Infection Control Surveyor Worksheet for each survey to enable CMS and CDC to analyze the nationwide findings. See Section Four for more details.

P. Ambulatory Surgical Centers (ASCs)
In FY2012 States must survey at least 25% of the non-deemed ASCs in each State (subject to minor adjustments). In addition to the Tier 3 requirements, we emphasize the following:
1. *Tier 2 Targeted 25% Sample Surveys for Non-Deemed ASCs:* States will perform surveys totaling 25% of all non-accredited, non-deemed ASCs, or at least 1, whichever is greater, unless all non-deemed ASCs were surveyed in FY2010 and FY 2011. States must convey to CMS' contractor a copy of the completed Surveyor Infection Control Worksheet for each survey, to permit a national analysis of infection control issues that can inform education and training efforts. States will select ASCs for survey, focusing on ASCs that have not been surveyed in more than 6 years and/or ASCs that represent a greater risk of having quality problems, based on their recent compliance history and any other important factors known to the State.

Note: In contrast to other Tier 2 targeted surveys, the Tier 2 targeted sample requirement for ASCs does apply to a State that has fewer than 7 ASCs.

Deemed ASCs - SAs will perform validation surveys on a 5% - 10% sample of accredited, deemed ASCs. Appendix 3 provides a projection of the ASC validation workload for each SA. SAs will receive a supplemental allocation for these validation surveys. The ASCs to be surveyed will be selected by CMS

based on the accreditation survey schedule of deemed ASCs that are surveyed by accreditation organizations (AOs) in FY2012. Surveys must be completed within 60 days of completion of the AO survey.

Ambulatory Surgical Centers (ASCs)			
Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
Validations- Deemed ASCs: 5% - 10% of deemed ASCs: States conduct validation surveys of deemed ASCs, assigned by CMS based on AO survey schedules. *(Budgeted separately via supplemental allocation)*	**Targeted Surveys (25%):** The State performs surveys totaling 25% of all non-accredited, non-deemed ASCs in the State (or at least 1, whichever is greater), based on State judgment for those providers more at risk of quality problems. Some of the targeted surveys may qualify to count toward the Tier 3 priority. States with fewer than 7 ASCs must survey at least 1 ASC unless all non-deemed ASCs were surveyed in FY 2010 and FY 2011.	**6.0-Year Interval**: Additional surveys are done to ensure that no more than 6.0 years elapses between surveys for any one particular non-deemed ASC.	**N/A for FY2012**

12-34 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	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 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 their clients that they received the services billed to Medicaid by providers. This process is intended to identify potential abuse of Medicaid, a program that pays for some health care for low-income individuals.

Medicaid 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 is responsible for instituting a Quality Assurance system to ensure compliance with federal requirements.

This Administration used more than $649 million in Medicaid funds to pay for in-home services during fiscal year 2012.

Description of Condition

In the past four 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.

In response to our findings, the Department developed procedures to contact recipients of home and community-based services and to verify if the services billed by providers were received. Under the procedures, clients receiving services, or their representative, would be selected at random and contacted by telephone to verify that authorized services have been received.

The new procedures were not put in place in fiscal year 2012.

Cause of Condition

The Department stated the new verification procedures are scheduled to be operational in fiscal year 2013.

Effect of Condition

By not obtaining evidence that Medicaid recipients have received the services which were billed to Medicaid, there is an increased risk that fraudulent provider claims will be paid and not detected in a timely manner, if at all.

Recommendation

We recommend the Department follow the procedures for verifying directly with recipients that they have received the services for which Medicaid is being billed.

Department's Response

The Department implemented the client services verification survey in October 2012 as planned and outlined in the corrective action plan developed in February 2012. The service verification survey was incorporated into the annual Quality Assurance monitoring cycle to be conducted at the end of the cycle as a focused review activity. The survey will be repeated annually until ProviderOne phase two is implemented. The client services verification survey is supplemental to provider timesheet audits which have been part of the annual QA cycle since 2011.

Auditor's Remarks

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

Applicable Laws and Regulations

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

The auditee shall:

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

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

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 beneficiaries.

(b) Subpart B implements sections 1124, 1126, 1902(a)(36), 1903(i)(2), and 1903(n) of the Act. It requires that providers and fiscal agents must agree to disclose ownership and control information to the Medicaid State agency.

(c) Subpart C implements section 1936 of the Act. It establishes the Medicaid Integrity Program under which the Secretary will promote the integrity of the program by entering into contracts with eligible entities to carry out the activities of subpart C.

§455.20 Recipient verification procedure.

(a) The agency must have a method for verifying with beneficiaries whether services billed by providers were received.

(b) In States receiving Federal matching funds for a mechanized claims processing and information

retrieval system under part 433, subpart C, of this subchapter, the agency must provide prompt written notice as required by §433.116 (e) and (f).

12-35 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 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	ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 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 Service, 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). The COPES program provides aged or disabled individuals with the option to remain at home or in alternate living facilities instead of nursing facilities. Services offered under this program include 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, and Home and Community Services (HCS) Offices across the state determine initial eligibility. After the initial eligibility determination, local Area Agencies on Aging perform most of the functional assessments and monitor ongoing 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 the task of auditing the determinations made by financial workers to ensure they are obtaining all appropriate information and using that information to make an accurate determination. Each region can determine the cases that will be reviewed.

During fiscal year 2012, more than 27,800 clients received COPES services and the Department paid approximately $528 million for the services.

Description of Condition

In our prior audit we reported on the Department's inadequate controls over financial eligibility determinations. Four out of seven HCS offices we reviewed did not perform regular audits to ensure the accuracy of financial eligibility determination. In response to our audit, the Department implemented a statewide policy requiring a minimum number of audits be performed for each financial worker to monitor the accuracy of financial eligibility determinations.

During our current audit, we reviewed four of the state's 28 HCS offices to determine whether the offices performed audits on a regular basis to ensure the accuracy of financial eligibility determinations. We found that none of the four offices performed supervisory audits on a regular basis throughout the audit period.

Therefore, the weaknesses we identified during our prior audit still exist.

Cause of Condition

The Department stated the new policy is not scheduled to be operational until fiscal year 2013.

Effect of Condition

Without performing routine audits, the Department is not in compliance with the applicable laws and cannot ensure client eligibility determinations are complete and accurate.

Recommendation

We recommend the Department implement and follow its new policy and perform formal audits to ensure the accuracy of financial eligibility determinations.

Department's Response

The Department concurs with this finding as we did with the original finding (finding 11-35 from the FY11 single audit).

We have now taken the measures we described in the Corrective Action Plan. The quarterly audit reports are available upon request.

Home and Community Services (HCS) Headquarters provided an update to the State Auditor (SAO) about our auditing plan on 7/12/2012 within the document "S11-13 Client Eligibility CAP 7-12-2012". The Management Bulletin referenced in that document was published on 8/2/2012 after reviews by our field staff and upper management. The document can be found at this link identified as H12-054 as the MB number on the left side of the page: http://adsaweb.dshs.wa.gov/docufind/MB/displayHCS.aspx?year=2012

The statewide requirement became effective on that date. This finding was made during the last half of FY 2012 and does not reflect audits conducted on or after 8/2/12. It took HCS some additional time to deliver this product because of the unexpected need to negotiate the requirements with the Health Care Authority (HCA) for our medical audits.

We are now required to provide quarterly reports to HCA. Region 3 did not meet the minimum requirements for the third quarter, but the first month of that quarter was before our offices knew what the exact requirements are. Regions 1 and 2 met the minimum requirements. All regions met the requirements for the fourth quarter, the first full quarter during which the expectations were in place. This includes the subset of offices the SAO inquired to.

Auditor's Remarks

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

Applicable Laws and Regulations

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

> The auditee shall:

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

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 beneficiary. 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 beneficiaries 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 beneficiaries 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 beneficiary that reports a loss of employment, at the time the beneficiary reports that loss and for at least each of the three subsequent months.
    (iii) For an applicant or a beneficiary 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 beneficiary, the requirements of this section do not apply to that applicant or beneficiary.

§ 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 beneficiaries whose coverage is required or allowed under this part.

(b) FFP is available in expenditures for services provided to beneficiaries who were eligible for Medicaid in the month in which the medical care or services were provided except that, for beneficiaries who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the beneficiary's liability. (See §§435.914 and 436.901 of this subchapter for regulations on retroactive eligibility for Medicaid.)

(c) FFP is available in expenditures for services covered under the plan that are furnished—

(1) To children who are determined by a qualified entity to be presumptively eligible;

(2) During a period of presumptive eligibility;

(3) By a provider that is eligible for payment under the plan; and

(4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

§ 435.916 Periodic redeterminations of Medicaid eligibility.

(a) The agency must redetermine the eligibility of Medicaid beneficiaries, 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 beneficiary'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 beneficiary'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 beneficiaries 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 beneficiary's circumstances that may affect his eligibility.

(2) If the agency has information about anticipated changes in a beneficiary'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.

12-36 The Department of Social and Health Services does not have an adequate process to identify ineligible Medicaid expenditures for nonqualified aliens, resulting in $77,352.13 in questioned costs.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed or Unallowed and Allowable Costs/Cost Principles	
Questioned Cost Amount:	$77,352.13	

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 $7.9 billion during fiscal year 2012, more than $4.2 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 medical emergencies for nonqualified aliens who meet all Medicaid program requirements with the exception of immigration status. This program covers low-income families, children and adults who are aged, blind or disabled.

The program defines emergency medical conditions as the sudden onset of a medical condition (including labor and delivery) whose symptoms are acute and severe (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

The state can choose to pay for non-emergency services for nonqualified aliens. The federal government will not share the cost of these services.

Description of Condition

In our current audit, we identified non-emergency services provided to 50 nonqualified aliens totaling $396,988.90. We reviewed detailed payments associated with those services and found the Department had refunded the federal portion of the payments, totaling $242,284.66. The federal share of the remaining payments, totaling $77,352.13, for non-emergency services provided to 29 nonqualified aliens has not been refunded to the federal government.

The table below summarizes our findings:

Service Description	Unallowable Expenditures	Expenditures Refunded	Remaining Amount	Federal Share	State Share
Behavioral rehabilitative services	$91,872.25	$0.00	$91,872.25	$45,936.12	$45,936.13
Long-term care	$305,116.65	$242,284.66	$62,831.99	$31,416.01	$31,415.98
Total	**$396,988.90**	**$242,284.66**	**$154,704.24**	**$77,352.13**	**$77,352.11**

Cause of Condition

Staff did not always follow established procedures to identify non-emergency services for nonqualified aliens charged to the Medicaid program.

Effect of Condition and Questioned Costs

The Department paid $154,704.24 for services that are not eligible for federal reimbursement. We are questioning $77,352.13, 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 procedures to ensure that Medicaid services provided to nonqualified aliens are restricted to emergency services.
- Follow up on the non-emergency services provided to 29 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

This finding involved two administrations within the Department, the Aging and Disability Administration and the Children's Administration. Both administrations concur with the finding.

Aging and Disability Services Administration

Medicaid funds were used to serve non-qualified alien clients. Procedures were previously developed and new SSPS codes were established for these clients but due to the timing of the new codes and staff error, some were missed. All questioned costs have been reimbursed.

Children's Administration

Of the 29 exceptions identified, 3 pertained to CA children. CA will work to correct the process that allowed these children to be allocated to a Medicaid funding source.

The federal funds for these clients will be returned and we will communicate the information to the Centers for Medicaid Services (CMS).

Auditor's Remarks

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

Applicable Laws and Regulations

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

The auditee shall:

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

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

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

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 beneficiary is an alien in a satisfactory immigration status.
(ii) The eligibility of qualified aliens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.
(b) The agency must provide payment for the services described in §440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified aliens subject to the 5-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria, except non-qualified aliens need not present a social security number or document immigration status.

Washington Administrative Code (WAC) 388-500-0030, 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.

12-37 The Department of Social and Health Services does not have adequate internal controls to ensure daily rates paid to supported living providers for Medicaid clients are accurate and properly authorized.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles	
Questioned Cost Amount:	$10,624	
Projected Questioned Cost Amount:	$2,989,952	

Background

The Department of Social and Health Services, Aging and Disability Services Administration, administers the Home and Community Based Services program for people with developmental disabilities through its Division of Developmental Disabilities (DDD). Supported living is a core service this program offers through staff of contracted supported living providers. The instruction and support staff assist clients in activities of daily living, such as maintaining their home, preparing meals, and shopping to help the clients learn, improve, or retain the social and adaptive skills necessary to live in the community and avoid institutionalization.

The Department pays the supported living provider a daily rate for each day of service provided to a client. The total daily rate paid for each client is individualized and adjusted as frequently as necessary, based on changes to the client's support needs and changes to the administrative component of the rate. To ensure the accuracy and proper authorization of each rate, the Department established a rate review and approval process. After each rate goes through the review and approval process, the rate is entered for payment in the Social Service Payment System.

The steps below describe the established rate review and approval process and subsequent transfer of the approved rate to the Social Service Payment System:

1. Rate is first reviewed and approved by the Division of Developmental Disabilities' Regional Administrator or designee, then
2. Rate is reviewed by the Department's Rates Manager, then
3. Rate is reviewed by the Division of Developmental Disabilities' Residential Program Manager, then
4. Rate is approved for payment by the Division of Developmental Disabilities Director or designee, then
5. Approved rate is manually transferred from the approval document into an Excel rate file spreadsheet, where the administrative component of the rate is adjusted, if necessary, then
6. Approved rate is manually transferred from the rate file to the Social Service Payment System

Description of Condition

The Department's internal controls are not adequate to ensure daily rates are calculated correctly and properly authorized for payment in the Social Service Payment System. We selected a random sample of 154 client rates from a total population of 43,342 client rates to verify that each rate was reviewed and approved by the staff member

designated in the process and approved rates were correctly transferred to the Social Service Payment system. We found that 45 percent (69 out of 154) of the rates sampled were not properly authorized.

We also found that the Department did not have internal controls to ensure additional administrative adjustments applied to approved rates and the approved rates transferred to the Social Service Payment system are accurate.

Cause of Condition

The rate review and approval process was not formalized and was not followed consistently across all of the Department's regions.

The rate review and approval process did not include examining the accuracy of additional administrative adjustments applied to approved rates and monitoring of the transfer of approved rates to the Social Service Payment system.

Effect of Condition

Weaknesses in the Department's rate review and approval process resulted in $21,247 of unallowable payments. We are questioning $10,624, which is the federal portion[1] of unallowable payments.

By projecting sample results to the entire Home and Community Based supported living program, we estimate the amount of potential unallowable payments the Department made to supported living providers could be $5,979,904.

The table below summarizes the results of our work:

Population	Sample Size	Exceptions				* Projected Unallowable Payments
		Description	Number of exceptions	Percentage of exceptions	Unallowable payments	Point Estimate
43,342	154	Payment Errors	64	42%	$1,773[2]	$5,979,904
		Unauthorized payments	3	2%	$19,474	
		Total	67	44%	$21,247	

Recommendation

We recommend the Department:

- Follow the established review and approval process to ensure all rates are calculated correctly and properly authorized.
- Monitor data entry processes to the Social Service Payment System to ensure approved rates are used for payments to the provider.
- Consult with its grantor to determine if any questioned costs must be repaid to the federal government.

Department's Response

The Department concurs with this finding.

[1] The federal share is calculated using the state's 2012 FMAP rate of 50 percent.
[2] Unallowable payment errors are the net amount of overpayments minus underpayments.

Regarding the first two recommendations the Department is implementing an electronic rate approval process which will ensure that all the reviewers have approved the rate request. The electronic rate requests must be approved by each reviewer before they can be forwarded to the next reviewer. The approvals will automatically be saved with the date and time to ensure that they are not misplaced.

The electronic rate requests will also reduce errors that can result from calculating the different parts of the rates.

For recommendation three any overpayments as a result of rate adjustments will be identified and repaid to the federal government through the financial recovery process.

Auditor's Concluding Remarks

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

Sample Design
The sample size consisted of 154 client month rates from a total population of 43,342 client month rates for payments the Department made during the period of July 1, 2011 to June 30, 2012.

Estimation Methodology
We used the U.S. Department of Health and Human Services, Office of Inspector General RAT-STATS appraisal program to estimate the amount of unallowable payments made to supported living providers.

***Sampling Results:**

The table below shows the value of our universe, sampling frame and questioned costs:

Payments In Universe	Value of Universe	Sample Size	Value of Sample	Unallowable payments	Questioned Costs (federal share)
43,342	$289,050,293	154	$1,102,995	$21,247	$10,624

Projection of Sampling Results
Projecting our results to the entire Home and Community Based supported living program, we estimate the amount of unallowable payments to supported living providers could range from ($32,098) to $11,991,898.

Precision at the 90-Percent Confidence Level	
	Variable Appraisal
Midpoint	$5,979,904
Lower Limit	($32,089)
Upper Limit	$11,991,898

Applicable Laws and Regulations

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

The auditee shall:

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

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

OMB Circular A-87: Cost Principles for State, Local and Indian Tribal Governments (2 CFR Part 225); Appendix A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

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

OMB Circular A-133 Compliance Supplement, Part 4 (June 2012)- Department of Health and Human Services (HHS), Medicaid Cluster, III. Compliance Requirements, states in part:

> To be allowable, Medicaid costs for medical services must be: (1) covered by the State plan and waivers; (2) for an allowable service rendered (including supported by medical records or other evidence indicating that the service was actually provided and consistent with the medical diagnosis); (3) properly coded; and (4) paid at the rate allowed by the State plan. Additionally, Medicaid costs must be net of applicable credits (e.g., insurance, recoveries from other third parties who are responsible for covering the Medicaid costs, and drug rebates), paid to eligible providers, and only provided on behalf of eligible individuals.

Title 42, Code of Federal Regulations, Section 435.1002 FFP for services, states:

(a) Except for the limitations and conditions specified in §§435.1007, 35.1008, 435.1009, and 438.814 of this chapter, FFP is available in expenditures for Medicaid services for all beneficiaries whose coverage is required or allowed under this part.
(b) FFP is available in expenditures for services provided to beneficiaries who were eligible for Medicaid in the month in which the medical care or services were provided except that, for beneficiaries who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the beneficiary's liability. (See §§435.914 and 436.901 of this subchapter for regulations on retroactive eligibility for Medicaid.)
(c) FFP is available in expenditures for services covered under the plan that are furnished—
   (1) To children who are determined by a qualified entity to be presumptively eligible;
   (2) During a period of presumptive eligibility;
   (3) By a provider that is eligible for payment under the plan; and
   (4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

12-38 The Department of Social and Health Services, Economic Services Administration, does not have adequate controls in place to ensure all individuals who receive Medicaid benefits are financially eligible.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA-State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Eligibility	
Questioned Cost Amount:	None	

Background

The Medicaid program pays for medical assistance for certain individuals and families with low incomes and limited financial resources. Federal and State laws, regulations, and other requirements establish Medicaid eligibility. To be eligible, an individual must, among other things, meet citizenship requirements; submit an application for Medicaid benefits; furnish his or her Social Security number; be eligible for the specific services received; and not exceed income and financial resource levels established in state regulation. Information to support the eligibility determination must be included in each applicant's case file.

The Department must include all household members when calculating income and resource eligibility. People who live together, such as families, whose income or resources are counted to decide eligibility, are termed an Assistance Unit (AU). More than 900,000 Assistance Units in Washington receive Medicaid benefits. Income and resource thresholds, which are subject to yearly adjustments, vary based on eligibility category and the number of family members in the Unit.

Once the Department initially determines an applicant is eligible, it must annually re-verify information such as income to determine whether the individual is still eligible for benefits. Staff is required to document the results of the eligibility determinations.

The state Medicaid program spent more than $7.9 billion during fiscal year 2012; approximately $4.2 billion was paid with federal funds.

Description of Condition

We performed testing to determine if the Department has adequate internal controls to ensure only individuals who are financially eligible received Medicaid benefits.

We selected the Medical Coverage Group for Categorically Needy Children for testing because it is the largest coverage group. More than 259,000 Assistance Units in this category received Medicaid benefits during the period July 1, 2011 through March 31, 2012.

We selected 188 AUs and performed tests to determine if there was:

- Evidence the Department did a review to account for all income generated by the Unit.
- Sufficient documents to support the Department's eligibility determination.

- Evidence the Department correctly calculated income in determining eligibility.

We determined that exceptions to any of the above three criteria could affect the eligibility of the AU.

We found the Department did not have adequate controls to ensure all individuals who receive Medicaid benefits are financially eligible. We found net income used to determine income eligibility was not accurate in many instances. For example, the Department relied on a client's income declaration without verification and staff incorrectly deducted unallowable expenditures such as meals and home mortgage interest from gross income. The following table summarizes the sample[1] we selected and the results of our testing.

Assistance unit income type	Population	Sample size	Exceptions		
			Total	% of sample	Projected sample errors (projected quantity in universe)[1]
Self-employed	20,019	112	35	31.25%	6,256
All other types	239,234	76	1	1.32%	3,148

Cause of Condition

Department policies do not provide clear guidelines of determining income eligibility and staff have not been adequately trained to review information, calculate income and determine eligibility.

Effect of Condition

Due to the lack of adequate controls, there is an increased risk ineligible individuals will receive Medicaid benefits.

Recommendation

We recommend the Department establish adequate internal controls, such as providing the guidance, resources, and training needed, to ensure staff can determine which documents are required to determine Assistance Unit income and calculate income eligibility, especially situations when income cannot be independently verified (e.g. self-employment income).

Department's Response

The Department partially concurs with the audit findings.

Unlike cash and food programs where the income budgeted directly impacts the amount of benefits a household is eligible to receive, most Medicaid programs work on a pass/fail eligibility system. For the Categorically Needy Children's Medical program, the household is eligible as long as the income is below the program limits for the household size. The Department can be less precise in income verification but still result in a correct eligibility determination. In ten of the exception cases, the household remains eligible for Medicaid.

The Department recognizes that income rules for Medicaid programs, specifically around self-employment cases, don't always align with income rules for other programs. This can create confusion for eligibility workers. Community Services Division will ensure eligibility workers have the information and guidance they need to correctly verify and calculate income when determining eligibility for the Children's Medical program.

Please note: Effective October 1, 2013, applications/renewals for pregnant women, children, and families will be processed through the Health Benefit Exchange web portal. Eligibility will be determined through an automated data-match process.

Auditor's Remarks

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

[1]Sampling Method

We used the U.S. Department of Health and Human Services, Office of Inspector General – Office of Audit Services appraisal programs to estimate the total number of Assistance Units for which Medicaid income eligibility determinations made by the Department were not reliable. In our risk analysis, we determined AUs with self-employment income ran a higher risk for error than those with other types. We obtained income and eligibility data from the Department. We separated the AUs with Categorically Needy Children coverage designation into two groups by income type (self-employed or all other types of income) to direct more audit effort towards the group which contained the greatest potential risk for error.

Self employed clients

Projection of Sample Results: Self-Employed	
Precision at the 90-Percent Confidence Level	
Attributes Appraisal	
Midpoint	6,256
Lower limit	4,817
Upper limit	7,847

Extrapolating the results of our statistical sample to the entire Categorically Needy Children program for self-employed clients, we estimate the number of possible Assistance Units that Medicaid income eligibility determinations made by the Department might not be reliable could range between the lower limit of our projected results (4,817) and the upper limit (7,847).

Non Self employed clients

Projection of Sample Results – Non Self-Employed	
Precision at the 90-Percent Confidence Level	
Attributes Appraisal	
Midpoint	3,148
Lower limit	162
Upper limit	14,568

Extrapolating the results of our statistical sample to the entire Categorically Needy Children program for non self-employed clients, we estimate the number of possible Assistance Units that Medicaid income eligibility determinations made by the Department might not be reliable could range between the lower limit of our projected results (162) and the upper limit (14,568).

Applicable Laws and Regulations

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

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

Title 42, code of Federal Regulations, Section 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 beneficiary. 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 beneficiaries 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 beneficiaries 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 beneficiary that reports a loss of employment, at the time the beneficiary reports that loss and for at least each of the three subsequent months.
    (iii) For an applicant or a beneficiary 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;
    (iv) Unemployment compensation;
    (v) 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.

§ 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 beneficiaries whose coverage is required or allowed under this part.
(b) FFP is available in expenditures for services provided to beneficiaries who were eligible for Medicaid in the month in which the medical care or services were provided except that, for beneficiaries who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the beneficiary's liability. (See §§ 435.914 and 436.901 of this subchapter for regulations on retroactive eligibility for Medicaid.)
(c) FFP is available in expenditures for services covered under the plan that are furnished—
   (1) To children who are determined by a qualified entity to be presumptively eligible;
   (2) During a period of presumptive eligibility;
   (3) By a provider that is eligible for payment under the plan; and
   (4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

§ 435.916 Periodic redeterminations of Medicaid eligibility.

(a) The agency must redetermine the eligibility of Medicaid beneficiaries, 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 beneficiary'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 beneficiary'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 beneficiaries 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 beneficiary's circumstances that may affect his eligibility.
   (2) If the agency has information about anticipated changes in a beneficiary's circumstances, it must redetermine eligibility at the appropriate time based on those changes.

WAC 388-450-0215 states:

How does the department estimate my assistance unit's income to determine my eligibility and benefits?

(1) We decide if your assistance unit (AU) is eligible for benefits and calculate your monthly benefits based on an estimate of your AU's gross monthly income and expenses. This is known as prospective budgeting.
(2) We use your current, past, and future circumstances for a representative estimate of your monthly income.
(3) We may need proof of your circumstances to ensure our estimate is reasonable. This may include documents, statements from other people, or other proof as explained in WAC 388-490-0005.
(4) We use one of two methods to estimate income:

(a) Anticipating monthly income (AM): With this method, we base the estimate on the actual income we expect your AU to receive in the month (see subsection (6)); and
(b) Averaging income (CA): With this method, we add the total income we expect your AU to receive for a period of time and divide by the number of months in the period (see subsection (7)).

(5) When determining eligibility for apple health for kids programs as listed in WAC 388-505-0210 or pregnancy medical as listed in WAC 388-462-0015, we can use the method most beneficial to your AU.

(6) Anticipating monthly income: We must use the anticipating monthly method:
(a) When we estimate income for anyone in your AU, if you or anyone in your AU receive SSI-related medical benefits under chapter 388-475 WAC.
(b) When we must allocate income to someone who is receiving SSI-related medical benefits under chapter 388-475 WAC.
(c) In the month of application, when you are a destitute migrant or destitute seasonal farmworker under WAC 388-406-0021. In this situation, we must use anticipating monthly (AM) for all your AU's income.
(d) To budget SSI or Social Security benefits even if we average other sources of income your AU receives.

(7) Averaging income: When we average your income, we consider changes we expect for your AU's income. We determine a monthly amount of your income based on how often you are paid:
(a) If you are paid weekly, we multiply your expected income by 4.3;
(b) If you are paid every other week, we multiply your expected income by 2.15;
(c) In most cases if you receive your income other than weekly or every other week, we estimate your income over your certification period by:
(i) Adding the total income for representative period of time;
(ii) Dividing by the number of months in the time frame; and
(iii) Using the result as a monthly average.
(d) If you receive your yearly income over less than a year because you are self employed or work under a contract, we average this income over the year unless you are:
(i) Paid on an hourly or piecework basis; or
(ii) A migrant or seasonal farmworker under WAC 388-406-0021.

(8) We use the same method for each month in your certification period, including the month of application, unless:
(a) A full month's income is not anticipated in the month of application. In this situation, we budget your income in the month of application using the anticipated monthly (AM) method and average your income (CA) for the rest of the months in your certification.
(b) You are a destitute migrant or destitute seasonal farmworker. We must budget your income in the month of application using the anticipated monthly method, as required by subsection (6). We may average your income for the rest of the months in your certification period.

(9) If you report a change in your AU's income, and we expect the change to last through the end of the next month after you reported it, we update the estimate of your AU's income based on this change.

(10) If your actual income is different than the income we estimated, we don't make you repay an overpayment under chapter 388-410 WAC or increase your benefits unless you meet one of the following conditions:
(a) You provided incomplete or false information; or
(b) We made an error in calculating your benefits.

WAC 388-503-0505 General eligibility requirements for medical programs.

1. Persons applying for benefits under the medical coverage programs established under chapter 74.09 RCW must meet the eligibility criteria established by the department in chapters 388-400 through 388-555 WAC.
2. Persons applying for medical coverage are considered first for federally funded or federally matched programs. State-funded programs are considered after federally funded programs and are not available

to the client except for brief periods when the state-funded programs offer a broad scope of care which meet a specific client need.

3. Unless otherwise specified in program specific WAC, the eligibility criteria for each medical program is as follows:
   a. Verification of age and identity (chapters 388-404, 388-406, and 388-490 WAC); and
   b. Residence in Washington state (chapter 388-468 WAC); and
   c. Citizenship or immigration status in the United States (chapter 388-424 WAC); and
   d. Possession of a valid Social Security Account Number (chapter 388-476 WAC); and
   e. Assignment of medical support rights to the state of Washington (388-505-0540); and
   f. Cooperation in securing medical support (chapter 388-422 WAC); and
   g. Application for Medicare and enrollment into Medicare's prescription drug program if:
      i. It is likely that the individual is entitled to Medicare; and
      ii. The state has authority to pay Medicare cost sharing as described in chapter 388-517 WAC.
   h. Countable resources within program limits (chapters 388-470 and 388-475 and 388-478 WAC); and
   i. Countable income within program limits (chapters 388-450 and 388-475 and 388-478 WAC).
4. In addition to the general eligibility requirements in subsection (3) of this section, each program has specific eligibility requirements as described in applicable WAC.

WAC 388-505-0210 Apple Health for kids and other children's medical assistance programs.

Funding for coverage under the apple health for kids program may come through Title XIX (medicaid), Title XXI (CHIP), or through state-funded programs. There are no resource limits for the apple health for kids programs. Apple health for kids coverage is free to children in households with incomes of no more than two-hundred percent of the federal poverty level (FPL), and available on a premium basis to children in households with incomes of no more than three-hundred percent FPL.

1. Newborns are eligible for federally matched categorically needy (CN) coverage through their first birthday when:
   a. The newborn is a resident of the state of Washington.
   b. The newborn's mother is eligible for medical assistance:
      i. On the date of the newborn's birth, including a retroactive eligibility determination; or
      ii. Based on meeting a medically needy (MN) spenddown liability with expenses incurred on, or prior to, the date of the newborn's birth.
2. Children under the age of nineteen who are U.S. citizens, U.S. nationals, or lawfully present qualified or nonqualified aliens as described in WAC 388-424-0001, WAC 388-424-0010 (4), and WAC 388-424-0006 (1), (4) and (5) are eligible for free federally matched CN coverage when they meet the following criteria:
   a. State residence as described in chapter 388-468 WAC;
   b. A social security number or application as described in chapter 388-476 WAC;
   c. Proof of citizenship or immigrant status and identity as required by WAC 388-490-0005 (11);
   d. Family income is at or below two-hundred percent Federal Poverty Level (FPL) as described in WAC 388-478-0075 at each application or review; or
   e. They received supplemental security income (SSI) cash payments in August 1996 and would continue to be eligible for those payments except for the August 1996 passage of amendments to federal disability definitions; or
   f. They are currently eligible for SSI.
3. Non-citizen children under the age of nineteen, who are not lawfully present qualified or nonqualified aliens as described in WAC 388-424-0001, WAC 388-424-0010 (4), and WAC 388-424-0006 (1), (4), and (5), are eligible for free state-funded coverage when they meet the following criteria:
   a. State residence as described in chapter 388-468 WAC; and
   b. Family income is at or below two hundred percent FPL at each application or review.
4. Children under the age of nineteen who are U.S. citizens, U.S. nationals, or lawfully present qualified or nonqualified aliens as described in WAC 388-424-0001, WAC 388-424-0010 (4), and WAC 388-424-0006 (1), (4), and (5) are eligible for premium-based federally-matched CN coverage as described in chapter 388-542 WAC when they meet the following criteria:

a. State residence as described in chapter 388-468 WAC;
b. Proof of citizenship or immigrant status and identity as required by WAC 388-490-0005 (11);
c. Family income is over two-hundred percent FPL, as described in WAC 388-478-0075, but not over three-hundred percent FPL at each application or review;
d. They do not have other creditable health insurance as described in WAC 388-542-0050; and
e. They pay the required monthly premiums as described in WAC 388-505-0211.

5. Noncitizen children under the age of nineteen, who are not lawfully present qualified or nonqualified aliens as described in WAC 388-424-0001, 388-424-0010 (4), and 388-424-0006 (1), (4), and (5), are eligible for premium-based state-funded coverage when they meet the following criteria:
   a. State residence as described in chapter 388-468 WAC;
   b. Family income is over two-hundred percent FPL, as described in WAC 388-478-0075, but not over three-hundred percent FPL at each application or review;
   c. They do not have other creditable health insurance as described in WAC 388-542-0050; and
   d. They pay the required monthly premium as described in WAC 388-505-0211.
6. Children under age nineteen are eligible for the medically needy (MN) medicaid program when they meet the following criteria:
   a. Citizenship or immigrant status, state residence, and Social Security number requirements as described in subsection (2) (a), (b), and (c) of this section;
   b. Are ineligible for other federally-matched CN programs;
   c. Have income that exceeds three hundred percent FPL; or
   d. Have income less than three hundred percent FPL, but do not qualify for premium-based coverage as described in subsection (4) of this section because of creditable coverage; and
   e. Meet their spenddown liability as described in WAC 388-519-0100 and WAC 388-519-0110.
7. Children under the age of nineteen who reside or are expected to reside in a medical institution, intermediate care facility for the mentally retarded (ICF/MR), hospice care center, nursing home, institution for mental diseases (IMD) or inpatient psychiatric facility may be eligible for apple health for kids healthcare coverage based upon institutional rules described in WAC 388-505-0260. Individuals between the age of nineteen and twenty-one may still be eligible for healthcare coverage but not under the apple health for kids programs. See WAC 388-505-0230 "Family related institutional medical" and WAC 388-513-1320 "Determining institutional status for long-term care" for more information.
8. Children who are in foster care under the legal responsibility of the state, or a federally recognized tribe located within the state, and who meet eligibility requirements for residency, Social Security number, and citizenship as described in subsection (2)(a), (b), and (c) of this section are eligible for federally-matched CN medicaid coverage through the month of their:
   a. Eighteenth birthday;
   b. Twenty-first birthday if the children's administration determines they remain eligible for continued foster care services; or
   c. Twenty-first birthday if they were in foster care on their eighteenth birthday and that birthday was on or after July 22, 2007.
9. Children are eligible for state-funded CN coverage through the month of their eighteenth birthday if they:
   a. Are in foster care under the legal responsibility of the state or a federally-recognized tribe located within the state; and
   b. Do not meet social security number and citizenship requirements in subsection (2) (b) and (c) of this section.
10. Children who receive subsidized adoption services are eligible for federally-matched CN coverage.
11. Children under the age of nineteen not eligible for apple health for kids programs listed above may be eligible for one of the following medical assistance programs not included in apple health for kids:
    a. Family medical as described in WAC 388-505-0220;
    b. Medical extensions as described in WAC 388-523-0100; or
    c. SSI-related MN if they:
       i. Meet the blind and/or disability criteria of the federal SSI program, or the condition of subsection (2) (e) of this section; and
       ii. Have countable income above the level described in WAC 388-478-0070 (1).
    d. Home and community based waiver programs as described in chapter 388-515 WAC; or

e. Alien medical as described in WAC 388-438-0110, if they:
   i. Have a documented emergency medical condition as defined in WAC 388-500-0005;
   ii. Have income more than three hundred percent FPL; or
   iii. Have income less than three hundred percent FPL, but do not qualify for premium-based coverage described in subsection (5) of this section because of creditable coverage.

12-39 The Department of Social and Health Services does not have adequate internal controls to ensure Medicaid payments to supported living 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	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed/Unallowed; Allowable Costs/Cost Principles	
Questioned Cost Amount:	$20,376	
Projected Questioned Cost Amount:	$5,628,969	

Background

The Department of Social and Health Services, Aging and Disability Services Administration, administers the Home and Community Based Services program for people with developmental disabilities through its Division of Developmental Disabilities. Supported living is a core service this program offers through staff of contracted supported living providers. The instruction and support staff assist clients in activities of daily living, such as maintaining the home, preparing meals, and shopping to help the client learn, improve, or retain the social and adaptive skills necessary to live in the community and avoid institutionalization.

The Department pays the supported living provider a daily rate for each day of service provided to a client. The amount and type of instruction and support services a client receives are based on the client's assessed needs and may vary from a few hours per month up to 24 hours per day of one-on-one support. The majority of clients receiving supported living services require daily staff support to maintain their health and safety. In fiscal year 2012, the Department paid approximately $289 million for supported living services to assist 3,714 developmentally disabled clients.

Providers are required to maintain adequate payroll records including staff time sheets, work schedules, and payroll vouchers to support payment claims. The Department's Residential Care Service Division inspectors review the supported living provider's payroll records as part of their regular provider-certification process every two years.

Description of Condition

To be allowable, Medicaid payments made on behalf of developmentally disabled clients must be adequately documented. We found the Department lacked internal controls to ensure supported living providers maintain adequate documentation to support payments claimed for each day of service billed.

We selected a random sample of 150 client months from a total population of 41,439 client months to verify that payments the Department made for each client month were adequately supported. A client month consisted of all payments made to a provider for a specific client on a single month.

Of the 150 client month payments sampled, providers didn't supply staff time records or other adequate documentation to support payment claims for six clients. We also found three clients for whom staff records did not support claims for specific days the provider said the client was served.

Cause of Condition

The review by Residential Care Service Division inspectors was not designed to verify payroll records to payments for services.

Effect of Condition and Questioned Costs

Of the 150 client months reviewed, we identified nine that were not adequately supported:

Population	Sample size	Exceptions			Projected sample error range*	
		Description	Number of exceptions	Questioned costs	Low	High
41,439	150	Not supported	3	$1,694.65		
		Inadequate documents	6	$39,056.59		
		Total	9	$40,751.24	$4,795,724	$17,720,151

The Department made payments of $40,751.24 that were not fully supported with adequate documentation. We are questioning $20,375.62, which is the federal portion[1] of the unallowable expenditures.

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

Projecting our results to the entire Home and Community Based supported living program, we estimate the amount of unallowable payments to supported living providers could range from $4,795,724 to $17,720,151.

Recommendation

We recommend the Department:

- Improve internal controls by strengthening its monitoring of providers' payroll records to ensure payments to providers are legitimate and supported.
- Seek recovery of the funds paid to providers who were unable to adequately support payment claims.
- Consult with its grantor to determine if any questioned costs must be repaid to the federal government.

Department's Response

The Department concurs with this finding.

To address it, we plan to add a new schedule to the residential programs cost report, which will enable reconciliation of reported Instruction and Support Services (ISS) hours and costs to the provider's actual payroll records. We will also determine which providers and clients did not have adequate documentation and verify whether overpayments have already been processed through the Office of Financial Recovery or whether they still need to be sent to OFR. This should be completed by September, 2013 as part of the 2012 cost report review. Finally, we will determine the extent of the overpayments above before projecting the total costs in question.

Auditor's 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.

[1] The federal share is calculated using the state's 2012 FMAP rate of 50 percent.

Sample Unit

The sampling unit was a client month. A client month consisted of all payments the Department made to a provider for a specific client on a single month during the period of July 1, 2011 to June 30, 2012.

Estimation Methodology

We used the U.S. Department of Health and Human Services, Office of Inspector General RAT-STATS appraisal program to estimate the amount of unallowable payments the Department made to Supported Living Providers.

***Sampling Results**

The table below shows the value of our universe, sampling frame and questioned costs:

Table 1: Value of universe, sampling frame and questioned costs

Payments In Universe	Value of Universe	Sample Size	Value of Sample	Questioned Costs	Value of Questioned Costs (federal share)
41,439	$289,050,293.18	150	$1,102,995.37	$40,751.24	$20,375.62

Projection of Sampling Results

By projecting the results of our statistical sample to the entire Home and Community Based supported living program payments reviewed, we estimate the amount of possible unallowable payments to supported living providers could range between the lower limit of our projected results ($4,795,724) and the upper limit ($17,720,151).

Table 2: Projected value of questioned costs

Precision at the 90-Percent Confidence Level	
	Variables Appraisal
Midpoint	$11,257,938
Lower Limit	$4,795,724
Upper Limit	$17,720,151

Applicable Laws and Regulations

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

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

OMB Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments* (2 CFR 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.

The Department's *Division of Developmental Disabilities' Community Residential Service Contract, Section 11* states in part:

> The Contractor shall maintain records relating to this Contract and the performance of the services described herein. The records include, but are not limited to, accounting procedures and practices, which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this Contract. All records and other materials relevant to this Contract shall be retained for six years after expiration or termination of this Contract.

12-40 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	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Eligibility	
Questioned Cost Amount:	$9,926.70	

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 Services. 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 $7.9 billion during fiscal year 2012, more than $4.2 billion of which was federal dollars.

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

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

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

Description of Condition

We reviewed Medicaid beneficiaries in the Department's payment system (Social Service Payment System) and performed tests to determine if the Medicaid beneficiaries have valid Social Security numbers.

Our testing found 12 individuals who did not have a valid Social Security number. The table below summarizes the results of our work:

Description	Number of clients	Payments	Federal Share[1]	State Share
Invalid Social Security number	6	$19,448.49	$9,724.25	$9,724.24
No Social Security number	5	$374.89	$187.45	$187.44
Number belongs to deceased person	1	$30.00	$15.00	$15.00
Total	**12**	**$19,853.38**	**$9,926.70**	**$9,926.68**

Cause of Condition

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

Effect of Condition and Questioned Costs

The Department paid $19,853.38 to providers for services for ineligible individuals.

Federal regulations require us to report known questioned costs when likely questioned costs are greater than $10,000 for each type of compliance requirement. The federal portion of the known questioned costs is $9,926.70; however, we believe that it is likely that questioned costs exceed $10,000 in the population.

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 12 clients for whom the Department could not provide evidence of correct Social Security numbers and re-determine their Medicaid eligibility.
- Establish internal control procedures to (1) ensure all staff involved in the verification process follow the Department's Social Security number verification procedures and (2) review applicant information for missing or invalid SSNs.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Department's Response

This finding involved two administrations within the Department, the Economic Services Administration and the Aging and Disability Services Administration. Each administration provided individual responses.

Economic Services Administration

Economic Services Administration (ESA) concurs with the findings for the 8 Community Services Division (CSD) cases identified as exceptions. CSD will review these cases and take appropriate action as necessary.

Over the last several years, ESA has made significant improvements in its Social Security number verification procedures, automated systems and trainings. ESA will continue to pursue enhancements to verification procedures that promote Social Security Number accuracy.

[1] The federal share is calculated using the state's 2012 FMAP rate of 50 percent.

Aging and Disability Services Administration

The Aging and Disability Services Administration concurs with this finding.

Medicaid funds were used to serve non-qualified clients. Procedures were previously developed and new SSPS codes were established for these clients but to the timing of the new codes and staff error, corrections for four clients were missed. All questioned costs have been reimbursed.

The Department would like to point out that this finding is specific to 12 cases out of 60,000 and equal to $20,000 out of a the Long Term Care annual budget of $1.7B dollars. While this finding represents 0.02% of the cases and 0.001% of the funding, the Department remains committed to pursuing the goal of matching 100% of the clients and SSNs.

Auditor's Remarks

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

Applicable Laws and Regulations

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

The auditee shall:

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

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

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

Section 510 - Audit findings.

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

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

Title 42, Code of Federal Regulations, Section 435.910 (a) 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 social security numbers (SSNs). . . .

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

The agency must verify each SSN of each applicant and beneficiary 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 an applicant cannot recall his SSN or SSNs or has not been issued a SSN the agency must:

(1) Assist the applicant in completing an application for an SSN;
(2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and
(3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

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

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

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

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

12-41 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	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Provider Eligibility	
Questioned Cost Amount:	$91,001	

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 2012, the Department paid approximately $126 million to more than 17,000 in-home service individual providers for their services.

All individual providers must meet basic qualifications to provide services to Medicaid clients. They must be at least 18 years old, authorized to work in the United States and meet the minimum training requirement.

Individual providers also must successfully complete 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

During the previous audit, we reported the Department did not ensure providers completed background checks before rendering services to Medicaid clients.

We reviewed all 17,398 providers who provided services in fiscal year 2012 to ensure they have cleared a background check as required by state regulation.

We found the Department did not conduct background checks for 27 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, the Department did not confirm that provider background checks were complete before allowing providers to render services to Medicaid clients. The Department stated most late background checks related to

typos in its background check monitoring database and untimely communication between the Department and providers.

Effect of Condition

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	State Share
One to four months	12	$36,481.41	$18,240.71	$18,240.70
Five to nine months	6	$33,817.93	$16,908.96	$16,908.97
More than10 months	9	$111,702.94	$ 55,851.47	$55,851.47
Total	27	$182,002.28	$91,001.14	$91,001.14

The Department paid a total of $182,002.28 to the 27 providers who did not complete a required background check at the time of the services. We are questioning $91,001.14, 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:

- Improve its internal controls to ensure all providers have cleared background checks prior to providing services to Medicaid clients.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Department's Response

The Department concurs with this finding.

We 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.

- *The Department will develop individual corrective action plans with three local offices where the most significant deficiencies were noted.*
- *The Department will provide reminders to staff of policies related to background checks through a management bulletin.*
- *The Department will terminate payments to any providers who do not have current background checks and terminate the contracts of providers who fail to comply with requests to have current background checks completed.*

Auditor's 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.

[1] The federal share is calculated using the state's 2012 FMAP rate of 50 percent.

Applicable Laws and Regulations

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

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

OMB Circular A-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:
> a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
> b. Be allocable to Federal awards under the provisions of 2 CFR part 225, Appendix A.
> c. Be authorized or not prohibited under State or local laws or regulations.
> d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
> e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

RCW 74.39A.056 (prior to 2012 amendments effective 3/29/2012) 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.

12-42 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	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed or 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-service 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-service 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 $400 million to pharmacies for services to Medicaid clients in fiscal year 2012. Of that, more than $11.3 million was paid for claims using override codes.

Description of Condition

In our audits for fiscal years 2006 through 2011, we reported a lack of adequate controls over use of other coverage codes to ensure Medicaid is the payer of last resort. Pharmacies can enter either accurate third-party liability coverage information or override codes into the point-of-service system to bypass the controls in place. Due to this significant inherent control weakness, claims for pharmaceutical payments are susceptible to errors or abuse.

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 not implemented either of these recommendations.

Cause of Condition

The Authority stated that the resources needed to increase post-payment audits were better used in other areas and has not made changes to the pharmacy data entry controls.

Effect of Condition

The Medicaid program could pay claims that should have been paid in whole or in part by third parties.

Recommendation

We again recommend the Department:

- 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.

Authority's Response

The agency disagrees with this finding and maintains that adequate controls are in place to assure that Medicaid is the payer of last resort. The following items demonstrate the priority of the work and items that HCA has put in place to strengthen third-party liability controls.

1. *The Office of Program Integrity continues to dedicate two full-time auditors to reviewing pharmacy third-party liability claims for inappropriate use of override codes. The data retrieval has been improved with a better data query (SQL), which has reduced the audit time required.*
2. *HCA has also strengthened Coordination of Benefits controls by contracting with Health Management Systems (HMS) to provide supplemental third-party liability recoveries for the Health Care Authority. The agency is tracking the effectiveness of the HMS work.*
3. *The Office of Payment Integrity has analyzed other potential changes to the system, including an edit that would require a valid date in the OTHER PAYER DATE field if an override code is present on the claim. But since these fields are contained in different segments of the claim transaction, they are not easily configurable, and this system edit is not considered cost effective at this time. However, the Office of Program Integrity will continue to look for ways to enhance third-party liability controls.*

Auditor's Remarks

We thank the Authority for its response. The Authority has not implemented controls directly related to the weaknesses we identified. Due to the weaknesses, the Medicaid program could pay claims that should have been paid in whole or in part by third parties. We reaffirm our finding.

Applicable Laws and Regulations

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

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

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 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.

12-43 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	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 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 $7.9 billion during fiscal year 2012. More than $4.8 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.

Description of Condition

We reported a finding in our fiscal year 2011 audit regarding a lack of controls to ensure providers meet initial and ongoing Medicaid eligibility requirements.

The Provider Enrollment Unit ensures durable medical equipment providers meet eligibility requirements for their field of service. One of the requirements for equipment providers is to maintain a physical location and the Office of Program Integrity's Medical and Hospital Audit Unit performs drive-by verifications to verify the locations of these providers. However, the Medical and Hospital Audit Unit completed only one drive-by verification of a durable medical equipment site during state fiscal year 2012. There are nearly 1,500 durable medical equipment locations active in the state's Medicaid program.

The Affordable Care Act identifies durable medical equipment providers as moderate to high-risk providers and require the state to perform unscheduled and unannounced site visits. The Authority has been creating procedures to be in compliance with these requirements, but these were not in place during the audit period.

Cause of Condition

In recent fiscal years, budget constraints limited the number of staff assigned to field audits within the Office of Program Integrity. As such, the audit unit did not concentrate on drive-bys of durable medical equipment providers.

Requirements related to the Affordable Care Act were more recently put in place and require new policies and procedures to meet those requirements. The Authority has stated they expect implementation of these new policies and procedures in state fiscal year 2013.

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:

- Durable medical equipment providers maintain an appropriate physical location for providing services.
- Affordable Care Act requirements are met.

Authority's Response

- *As of March 25, 2011, the Patient Protection and Affordable Care Act (ACA) introduced new screening procedures for providers and suppliers. The Act identifies Durable Medical Equipment providers as moderate to high-risk business partners who require unscheduled, unannounced site visits.*

- *The Health Care Authority is finalizing written policies and procedures to comply with the Act. The Health Care Authority plans to be compliant with the site visit as well as the other ACA screening requirements in January 2013.*

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

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

> The auditee shall:

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

Title 42, Code of Federal Regulations, Section 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:
(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)(1) Except for orthotic and prosthetic personnel described in paragraph (c)(7)(i)(A)(2) of this section,, maintains a practice location that is at least 200 square feet beginning—
(i) September 27, 2010 for a prospective DMEPOS supplier;
(ii) 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
(iii) September 27, 2013, for an existing DMEPOS supplier with a lease that expires on or after September 27, 2013.
(2) Orthotic and prosthetic personnel providing custom fabricated orthotics or prosthetics in private practice do not have to meet the practice location requirements in paragraph (c)(7)(i)(A)(1) of this section if the orthotic and prosthetic personnel are—
(i) State-licensed; or
(ii) Practicing in a State that does not offer State licensure for orthotic and prosthetic personnel.
(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.

Title 42, Code of Federal Regulations, Section 455.432 states -

The State Medicaid agency—

(a) Must conduct pre-enrollment and post-enrollment site visits of providers who are designated as ‘‘moderate’’ or ‘‘high’’ categorical risks to the Medicaid program. The purpose of the site visit will be to verify that the information submitted to the State Medicaid agency is accurate and to determine compliance with Federal and State enrollment requirements.

(b) Must require any enrolled provider to permit CMS, its agents, its designated contractors, or the State Medicaid agency to conduct unannounced on-site inspections of any and all provider locations.

12-44 The Health Care Authority did not have adequate controls to ensure violations of Medicaid laws and regulations by providers are identified and 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	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 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 $7.9 billion during fiscal year 2012. More than $4.8 billion of that amount 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 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). The Authority must report information about its preliminary investigations to the Department of Health and Human Services.

Cases requiring a preliminary investigation come from a number of sources. Staff within the Authority may identify cases based on data mining, submitted claims, or communication with clients. In addition, OPI handles client verification notices and an 800-number fraud line, which allow clients and citizens to notify the Authority of suspicious activities. Staff may also identify cases during the course of their work. Cases are documented and tracked in staff work plans or the Authority's Case Tracking system for those cases requiring additional review. The SURS Unit is responsible for referring any cases determined to require a full investigation to MFCU.

Description of Condition

In order for cases of Medicaid provider fraud to be identified, the Authority's SURS Unit must first review any complaints received. If provider fraud is occurring, it is important for SURS to identify this as quickly as possible.
In our prior audit we reported a finding regarding the Authority's inadequate controls to ensure cases involving violations of Medicaid laws and regulations were identified and referred to MFCU in a timely manner.

At the beginning of fiscal year 2012, SURS had a total of 279 cases open in the Case Tracking system. During fiscal year 2012 SURS opened an additional 275 cases and closed 335 cases. The remaining 219 cases remained open and required additional review at year end.

We further analyzed the open cases and the table below summarizes the results.

Total Time in System	Open/Pending Cases	Percentage of Open/Pending Cases
0-30 days	36	16%
31-60 days	6	3%
61-90 days	19	9%
91-120 days	7	3%
121-150 days	5	2%
151-180 days	17	8%
181-360 days	38	17%
361-720 days	50	23%
More than 720 days	41	19%
Total	**219**	100%

The results of our testing showed that 59 percent of the cases remained in the system beyond 180 days, and 42 percent remained in the system beyond 360 days. The internal control weaknesses we identified during our prior audit still exist. The Authority did not have adequate controls to ensure cases involving violations of Medicaid laws and regulations were identified and referred to MFCU in a timely manner.

We also found the Authority did not report to the Department of Health and Human Services the number of fraud and abuse complaints that warranted a preliminary investigation.

Cause of Condition

The Authority has a limited number of staff assigned to review cases. These staff investigators also have other responsibilities, in addition to performing these reviews.

Effect of Condition

By not performing timely investigations, referrals to MFCU have been delayed and Medicaid fraud may go undetected, resulting in the loss of public resources. We identified one case during testing where two years passed between receiving the case and conducting a review. When the review occurred the original accusations could not be identified because the data was lost, so the case was closed.

Recommendation

We recommend the Authority establish adequate internal controls to:

- Complete a timely review of all suspected cases of provider fraud to determine if sufficient evidence exists to warrant a full investigation.
- Comply with reporting requirements regarding fraud and abuse complaints that warranted a preliminary investigation.

Authority's Response

The Health Care Authority (HCA) does not concur with this finding. The agency maintains that adequate controls are in place to ensure that violations of Medicaid laws and regulations are identified and referred to the Medicaid Fraud Control Unit (MFCU) in a timely manner. The analysis completed by SAO focused on "cases" that are entered and tracked through HCA's Case Tracking System and assigned to Surveillance and Utilization Review (SUR) staff.

- *The entry of cases into the Case Tracking System should not be considered, by itself, to be a suspicion of fraud or abuse. Rather, the system is used to track a variety of cases, with appropriate timeframes for each type of case.*
- *Sixty (60) percent of the cases identified by SAO as open more than 180 days are Medical Service Verification (MSV) receipts. As noted in a separate SAO Finding related to MSV, there are no federal timeline requirements for MSV reviews. They are assigned a lower priority based on a historically low return on investment.*
- *Some cases are entered in the case tracking system as placeholders and reminders for staff to follow up with additional review. In addition, there has historically been no consistent criteria for utilization of the Drop Down Labeling in the system so the categories may not be consistent.*

HCA complies with the provisions of 42 CFR 455.14 regarding preliminary investigations and 42 CFR 455.15 regarding full investigations. HCA complies with all federal reporting requirements related to numbers of investigations and detailed processes for conducting each type.

In short, this finding identifies inconsistencies in HCA's use of its Case Tracking System rather than any actual deficiency in identification of fraud or referral to MFCU. SAO's scrutiny assisted HCA in identifying the need for more consistency in our use of the Case Tracking System. However, it is wrong to conclude that HCA does not have control of its caseload and does not refer all appropriate cases to MFCU, based upon the length of time a case has been open in our Case Tracking System. Processes are in place to prioritize the work of SURS investigators, ensuring that HCA is addressing those cases with the highest potential for fraud, waste and abuse and properly utilizing our resources to focus on cases that yield the highest return on investment.

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 would also like to note that our analysis of cases within the Case Tracking System included all cases other than Medical Service Verification (MSV) cases. Those cases labeled as MSV in the system were removed from consideration and only included during our separate MSV review.

Additionally, we confirmed with the Centers for Medicare and Medicaid Services that a report, as required by 42 CFR 455.17, had not been received from the Authority.

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

Title 42, code of Federal Regulations, Section 455 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 beneficiaries.
(b) Subpart B implements sections 1124, 1126, 1902(a)(36), 1903(i)(2), and 1903(n) of the Act. It requires that providers and fiscal agents must agree to disclose ownership and control information to the Medicaid State agency.
(c) Subpart C implements section 1936 of the Act. It establishes the Medicaid Integrity Program under which the Secretary will promote the integrity of the program by entering into contracts with eligible entities to carry out the activities of subpart C.

§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 beneficiary has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.
(c) If there is reason to believe that a beneficiary has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

§ 455.16 Resolution of full investigation.

A full investigation must continue until—

(a) Appropriate legal action is initiated;
(b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or
(c) The matter is resolved between the agency and the provider or beneficiary. This resolution may include but is not limited to—

(1) Sending a warning letter to the provider or beneficiary, giving notice that continuation of the activity in question will result in further action;
(2) Suspending or terminating the provider from participation in the Medicaid program;
(3) Seeking recovery of payments made to the provider; or
(4) Imposing other sanctions provided under the State plan.

§ 455.17 Reporting requirements.

The agency must report the following fraud or abuse information to the appropriate Department officials at intervals prescribed in instructions.

(a) The number of complaints of fraud and abuse made to the agency that warrant preliminary investigation.
(b) For each case of suspected provider fraud and abuse that warrants a full investigation—
  (1) The provider's name and number;
  (2) The source of the complaint;
  (3) The type of provider;
  (4) The nature of the complaint;
  (5) The approximate range of dollars involved; and
  (6) The legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred.

§ 455.21 Cooperation with State Medicaid fraud control units.

In a State with a Medicaid fraud control unit established and certified under subpart C of this part,

(a) The agency must—
  (1) Refer all cases of suspected provider fraud to the unit;
  (2) If the unit determines that it may be useful in carrying out the unit's responsibilities, promptly comply with a request from the unit for—
    (i) Access to, and free copies of, any records or information kept by the agency or its contractors;
    (ii) Computerized data stored by the agency or its contractors. These data must be supplied without charge and in the form requested by the unit; and
    (iii) Access to any information kept by providers to which the agency is authorized access by section 1902(a)(27) of the Act and § 431.107 of this subchapter. In using this information, the unit must protect the privacy rights of beneficiaries; and
  (3) On referral from the unit, initiate any available administrative or judicial action to recover improper payments to a provider.
(b) The agency need not comply with specific requirements under this subpart that are the same as the responsibilities placed on the unit under subpart D of this part.

12-45 The Health Care Authority's inadequate internal controls over claims from Federally Qualified Health Centers led to payments of more than $1.4 million for charges improperly calculated and claimed.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed and Allowable Costs/Cost Principles	
Questioned Cost Amount:	$727,690	

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 $7.9 billion during fiscal year 2012. More than $4.8 billion of that relates to activities of the Health Care Authority (Authority), of which more than $4.4 billion was paid directly to providers.

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

With few exceptions, FQHCs are paid based on a client encounter with a provider regardless of the number or type of procedures provided during the encounter. An encounter is a face-to-face visit between a client and a qualified FQHC provider who exercises independent judgment when providing services that qualify for an encounter rate. Washington Administrative Code 182-548-1400 describes how encounter rates are determined.

Incidental services are factored into the encounter rates and should not be paid separately by the Authority. Examples include when the services are:

- Furnished as an incidental, although integral, part of the practitioner's professional services (e.g. professional component of a x-ray or lab);
- Of a type commonly furnished either without charge or included in the FQHC bill;
- Of a type commonly furnished in a provider's office (e.g. tongue depressors, bandages, etc.);
- Provided by center employees under the direct, personal supervision of encounter-level practitioners; and
- Furnished by a member of the center's staff who is an employee of the center (e.g. nurse, therapist, technician or other aide).

Description of Condition

The Medicaid claim adjudication and payment process is highly automated. The Authority relies heavily on internal controls within the ProviderOne payment system to identify and deny claims when charges are unallowable or billed improperly by FQHC providers. During our testing we found the internal controls within the system were not effective to prevent improperly billed claims from being paid. Additionally, the controls within the system were not

effectively designed to identify and deny unallowable claims when FQHCs billed for incidental services that should have been included in their client encounter fee.

Cause of Condition

The Authority was aware of the weakness and developed a monthly report to capture claims when FQHC providers did not bill the Authority based on a client encounter. Because of complications in building the report, the Authority used estimates based on historical data for each FQHC to determine how much to recoup. Since the Provider One system was launched in May 2010, reconciliations to actual improper payments have not been performed.

The Authority did not implement controls within ProviderOne due to the complexity of identifying claims for incidental services that should have been included in their client encounter fee.

Effect of Condition

Due to the internal control weaknesses described above, we performed tests to determine if the Authority improperly paid or overpaid FQHC providers.

We selected 59 providers paid in fiscal year 2012 and determined if they were improperly paid for claims on a fee-for-service basis rather than for an encounter rate. For these providers we determined the Authority made improper payments totaling $1,256,235.

When the FQHC's were paid for their encounter rate, we performed an additional procedure to identify any claims for services that were paid separately for the same client on the same date of service. We found the Authority overpaid FQHC providers $199,145 for incidental services that should have been included in their encounter fees.

One-half of these payments are considered paid from federal grant resources, resulting in total questioned costs of $727,690. 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 Health Care Authority:

- Develop adequate internal controls within its ProviderOne system to detect and prevent improper and unallowable claims submitted by FQHC providers.
- Recoup $199,145 in overbilled amounts from the FQHC providers.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Authority's Response

The Health Care Authority agrees with this finding.

Currently, the internal controls for FQHC overpayments and improper billings rely more heavily on post-pay claims review and recoupment rather than denial at the point of claim submission.

The agency will make the appropriate updates to the system and billing guides for FQHCs so that the system edits will prevent overpayments and improper billings at the point of claim submission with an estimated date of completion of January 2014. This will include denial of claims without a qualifying encounter service being billed for the same client on the same day, as well as multiple billings for one client for the same day that should be included in one encounter billing. The Health Care Authority will work with our internal audit staff to recoup the improperly paid claims.

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

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

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

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

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

Washington Administrative Code 182-548-1400 states in part:

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

12-46 The Health Care Authority improperly claimed $48,365.31 in federal reimbursement for the Medicaid program.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Allowable Costs/Cost Principles	
Questioned Cost Amount:	$48,365.31	

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 $7.9 billion during fiscal year 2012, more than $4.2 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.

The state can elect to pay for non-emergency services for nonqualified aliens. The federal government will not share the cost of those services.

Federal regulations state that an overpayment is the amount that a Medicaid agency paid to a provider in excess of the amount allowable for furnished services. Because services cannot be provided after a beneficiary's death, no medical services are allowable after a beneficiary's death. Accordingly, payments for services claimed to have been provided after a Medicaid beneficiary's death are overpayments.

The Health Care Authority, Washington state Medicaid agency, receives quarterly death data from the Department of Health, and uses the data to identify a deceased Medicaid client and terminates Medicaid eligibility from Medicaid eligibility file. The Department also runs an algorithm that identifies Medicaid services paid after a client's date of death and processes a recoupment of the payments made after the client's date of death.

Description of Condition

During our audit, we noted the Authority claimed the following unallowable or unsupported expenditures for federal reimbursement:

Medicaid payments for unallowable services

We found 881 non-emergency services provided to 75 nonqualified aliens. The table below summarizes the results of our work:

Description	Number of claims	Payments	Federal Share[1]	State Share
Non emergency services provided to nonqualified aliens.	881	$53,693.29	$26,846.65	$26,846.64

Medicaid payments for unsupported services

We found 162 services provided after a client's death. The table below summarizes the results of our work:

Description	Number of claims	Payments	Federal Share[1]	State Share
Services provided after date of death	162	$43,037.32	$21,518.66	$21,518.66

Cause of Condition

The Authority performs reviews to detect unallowable Medicaid payments for services provided to nonqualified aliens and payments for services provided after a client's death. However, it is still not preventing or catching all unallowable payments.

Effect of Condition and Questioned Costs

When the state provides services to ineligible individuals, or the services are unallowable and/or unsupported, the service cannot be claimed for federal reimbursement. The Authority paid $96,730.61 to providers for services for unallowable activities. We are questioning $48,365.31, 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:

- Strengthen internal control procedures to ensure that Medicaid services provided to nonqualified aliens are restricted to emergency services.
- Strengthen internal control procedures for identifying deceased beneficiaries to prevent overpayments.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

[1] The federal share is calculated using the state's 2012 FMAP rate of 50 percent.

Authority's Response

The agency agrees with this finding and concurs that 162 claims were erroneously paid after the client's date of death.

- *The Health Care Authority has reviewed and recouped all the payments identified by the State Auditor's Office as paid to deceased persons.*
- *Health Care Authority continues to strengthen procedures to improve the immediate documentation of a client's death. For managed care and fee-for-service payments, ProviderOne does capture and recoup paid claims when we become aware of a date of death through the Automated Client Eligibility System (ACES), the eligibility source system. For many claims not previously recouped, the case was closed in ACES prior to identification of date of death information, preventing the information from being entered or transferred to ProviderOne. In addition, the HCA will continue to receive death data from the Department of Health to assist with the proper identification of client death information. Health Care Authority will continue to refine post payment processes to capture this information for timely recoveries.*
- *Health Care Authority has reviewed all payments cited by the State Auditor's Office to ineligible people and concurs with the auditor's findings. Health Care Authority will arrange repayment of any federal funds received in error by Sept. 30, 2013.*
- *The agency has reviewed all transactions listed by the SAO and corrected any case errors.*
- *HCA will strengthen training processes already in place by sending a SSN verification reminder memo to CSD staff. HCA will continue to pursue enhancements to verification procedures that promote SSN accuracy. HCA anticipates SSN accuracy will improve under health care reform because clients will input their own SSNs and will get instant feedback if an input error was made.*

Auditor's Remarks

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

Applicable Laws and Regulations

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

> Section 300, states in part:
>
> The auditee shall:
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.
>
> (c) Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its Federal programs.
>
> Section 510, states in part:
>
> (c) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
>
> …(3) Known questioned costs which are greater than $10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

Title 42, Code of Federal Regulations, Section 435.139 Coverage for certain aliens states:

> The agency must provide services necessary for the treatment of an emergency medical condition, as defined in §440.255(c) of this chapter, to those aliens described in §435.406(c) of this subpart.

Title 42, Code of Federal Regulations, Section 440.255, Limited services available to certain aliens states:

(a) FFP for services. FFP is available for services provided to aliens described in this section which are necessary to treat an emergency medical condition as defined in paragraphs (b)(1) and (c) or services for pregnant women described in paragraph (b)(2).
(b) Legalized aliens eligible only for emergency services and services for pregnant women. Aliens granted lawful temporary resident status, or lawful permanent resident status under sections 245A, 210 or 210A of the Immigration and Nationality Act, who are not in one of the exempt groups described in §§435.406(a)(3) and 436.406(a)(3) and who meet all other requirements for Medicaid will be eligible for the following services—
    (1) Emergency services required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
        (i) Placing the patient's health in serious jeopardy;
        (ii) Serious impairment to bodily functions; or
        (iii) Serious dysfunction of any bodily organ or part.
    (2) Services for pregnant women which are included in the approved State plan. These services include routine prenatal care, labor and delivery, and routine post-partum care. States, at their option, may provide additional plan services for the treatment of conditions which may complicate the pregnancy or delivery.
(c) Effective January 1, 1987, aliens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of law must receive the services necessary to treat the condition defined in paragraph (1) of this section if—
    (1) The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
        (i) Placing the patient's health in serious jeopardy;
        (ii) Serious impairment to bodily functions; or
        (iii) Serious dysfunction of any bodily organ or part, and
    (2) The alien otherwise meets the requirements in §§435.406(c) and 436.406(c) of this subpart.

Title 42, Code of Federal Regulations, Section 435.406, Citizenship and alienage states:

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

(D) Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are beneficiaries of foster care maintenance or adoption assistance payments under Title IV–E of the Act.

(2) (i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified aliens), qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified aliens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or recipient is an alien in a satisfactory immigration status.

(ii) The eligibility of qualified aliens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.

(d) 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:

(11) 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:

(d) 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

(e) The person's qualifying emergency medical condition is treated in one of the following hospital settings:

(iii) Inpatient;
(ii) Outpatient surgery;
(iv) Emergency room services, which must include an evaluation and management (E&M) visit by a physician; or

(f) 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).

(12) 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:

(c) 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

(d) During the specific emergency room visit, outpatient surgery or inpatient admission. These services include, but are not limited to:

(viii) Medications;
(ix) Laboratory, X ray, and other diagnostics and the professional interpretations;
(x) Medical equipment and supplies;
(xi) Anesthesia, surgical, and recovery services;
(xii) Physician consultation, treatment, surgery, or evaluation services;
(xiii) Therapy services;

(xiv) 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.

(13) The department will cover admissions to an LTAC facility or an inpatient PM&R unit if:

(d) The original admission to the hospital meets the criteria as described in subsection (1) of this section;

(e) The person is transferred directly to this facility from the hospital; and

(f) 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).

(14) 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.

(15) 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.

(16) 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.

(17) 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.

(c) 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.

(d) 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.

(18) 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:

(e) 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:

(iv) Laboratory X ray, or other diagnostic procedures;

(ii) Physical, occupational, speech therapy, or audiology services;

(v) Hospital clinic services; or

(vi) Emergency room visits, surgery, or hospital admissions.

(f) 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;

(g) Organ transplants, including preevaluations, post operative care, and anti-rejection medication;

(h) Services provided outside the hospital settings described in subsection (1) of this section, including but not limited to:

(vi) Office or clinic-based services rendered by a physician, an ARNP, or any other licensed practitioner;

(vii) 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).

(19) 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.

(20) 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.

12-47 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	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed or Unallowed and Allowable Costs/Cost Principles	
Questioned Cost Amount:	None	

Background

From July 2011 through June 2012, the state paid more than $1.37 billion to managed care organizations, an increase of more than $34 million over the previous year. During this period, the number of Medicaid clients enrolled in managed care programs increased by more than 15,000 *and the average premium paid was $169.10.*

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 which include more seriously ill people.

In a report dated August 4, 2010, CMS's Oversight of States' Rate Setting Needs Improvement, the U.S. Government Accountability Office stated the accuracy and completeness of data used to set managed care rates is a critical component to ensure rates are appropriate. In fiscal years 2003 through 2011, we reported concerns regarding the Authority's lack of review of the accuracy of data received from providers that it uses 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 underlying 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 controls at managed healthcare providers and third parties 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.
- Fraud and abuse controls at the healthcare providers to prevent fraud.

- Centers for Medicare and Medicaid Services (CMS) rate-setting process 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.

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.

Authority's Response

The Authority continues to disagree with this finding but will take the following actions in an effort to resolve the repeat findings on this issue.

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

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.

Applicable Laws and Regulations

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

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

Title 42, Code of Federal Regulations, Section 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.

12-48 The Health Care Authority did not complete the required automatic data processing (ADP) risk analysis and system security reviews of ProviderOne, the new Medicaid Management Information System, risking the loss of Medicaid program assets and jeopardizing Medicaid program integrity.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	ADP Risk Analysis and System Security Review	
Questioned Cost Amount:	None	

Background

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

The ProviderOne system, the State of Washington new Medicaid Management Information System, went live in May 2010. It replaces a 32-year-old payment system for Medicaid, a shared state-federal health program that serves low-income parents, children, seniors and people with disabilities. The new system software, built by Rockville, Md.-based CNSI, handles millions in payments for medical and nursing home care to thousands of health care providers, including doctors and pharmacies. The federal government is paying for 90 percent of the cost of implementing the system and is expected to pick up roughly 75 percent of its operating costs.

The state Medicaid program spent more than $7.9 billion during fiscal year 2012, more than $4.2 billion of which was federal dollars.

Description of Condition

We performed general and application control review of the ProviderOne system to determine if the Authority maintained adequate controls to:

- Provide assurance that data input and processed is valid, accurate and complete.
- Limit individuals to only the electronic access necessary to perform their assigned job duties.
- Reduce risk of damage, loss and unauthorized use or modification of resources.

During our testing we identified the following significant deficiencies that could affect the state's ability to safeguard Medicaid program assets. These deficiencies also increase the risk of misuse, loss or misappropriation of related funds:

- The Authority does not have assurance the vendor has effective controls to protect the ProviderOne system from unauthorized changes.

- The Authority does not have assurance the vendor has effective controls to safeguard ProviderOne data files.
- User access privileges were not restricted to ensure separation of incompatible duties.
- Disaster recovery procedures have not been tested in more than three years.

Cause of Condition

The Authority did not complete an ADP risk analysis and system security reviews of the ProviderOne system as required by federal law.

Effect of Condition

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

Recommendation

We recommend the Authority:

- Conduct the required ADP risk analysis and system security reviews of the ProviderOne system**.**

We also recommend the Authority take immediate action and:

- Obtain assurance the vendor has effective controls to protect the ProviderOne system from unauthorized changes.
- Establish controls to ensure all program changes promoted to production are authorized.
- Obtain assurance the vendor has effective controls to safeguard data files.
- Perform a thorough review of user access privileges to ensure separation of incompatible duties.
- Continuously monitor user access privileges to ensure access remains restricted to only those functions needed by users to perform their assigned duties.
- Perform annual testing of disaster recovery procedures.

Authority's Response

The Health Care Authority partially agrees with this finding. The agency considers the safeguarding of personally identifiable and protected health information a top priority and has the required controls in place. However, HCA agrees that additional independent review will strengthen the agency's ability to ensure that its vendor has effective controls in place.

Per OMB Circular A-133, Compliance Supplement, the agency is required to perform the following: States are required to establish a security plan for ADP systems that includes policies and procedures to address:

(1) physical security of ADP resources,
(2) equipment security to protect equipment from theft and unauthorized use,
(3) software and data security;
(4) telecommunications security;
(5) personnel security;
(6) contingency plans to meet critical processing needs in the event of short or long-term interruption of service;
(7) emergency preparedness;
(8) designation of an agency ADP security manager.

State agencies must establish and maintain a program for conducting periodic risk analyses to ensure appropriate, cost-effective safeguards are incorporated into new and existing systems.

For ADP assets under its direct control, the Health Care Authority has implemented security controls consistent with the Washington State Office of the Chief Information Officer (OCIO) Security Standard 141.10, OMB Circular A-133, the HIPAA Security Rule, and other guiding and regulatory documents.

Examples of controls include, but are not limited to the following:

- *Utilizing CTS services to secure its network perimeter;*
- *Implementing user device endpoint protection to guard against malware and other threats;*
- *Encrypting confidential data where appropriate;*
- *Developing applications which protect against common exploits;*
- *Actively managing user access controls;*
- *Implementing password standards consistent with OCIO requirements;*
- *Responding appropriately to security incidents.*

For assets not under direct HCA control, such as those managed by the ProviderOne vendor, the Health Care Authority has received verbal and written documentation that indicates compliance with the above requirements. Examples of controls include, but are not limited to:

- *Vendor conducts both internal and third-party security assessments annually;*
- *Extensive background checks are conducted on employees;*
- *Employees attend mandatory HIPAA, ePHI and security awareness training;*
- *Data entering or exiting the vendor facility is encrypted using SSL or SFTP;*
- *HCA hardware and data are physically segregated from other customers.*
- *The ProviderOne Technical Library provides extensive documentation of ProviderOne design and operations, including security components.*

In the Description of Condition section, SAO notes the identification of four significant deficiencies that could affect the state's ability to safeguard Medicaid program assets. HCA previously provided a response to these four findings. The responses may be found in the Washington State Auditor's Special Audit Report "Health Care Authority ProviderOne" number 1008984. For easy reference, the findings and HCA responses are copied below.

Previous audit findings and the agency's responses:

1. ***PREVIOUS FINDING: The Authority does not have assurance the vendor has effective controls to protect the ProviderOne system from unauthorized changes.***

Agency's Response

The Health Care Authority does not concur with the finding statement but agrees that additional independent review will strengthen the agency's ability to ensure that the vendor has effective controls in place.

HCA recognizes the significance and the priority of internal controls and takes its responsibility seriously. HCA has a robust set of Change Control processes in place that control both internal system changes and vendor changes. HCA believes that the Change Control processes in place minimize the likelihood of unauthorized alterations and errors and adequately provide for the analysis, implementation and testing of all changes requested and implemented. The HCA asserts that the Change Control processes in place meet Best Practice standards and are effective in the prevention of unauthorized changes to ProviderOne production programs. The processes include control of documentation and authorization of all change requests, impact assessments, change logs, release management, configuration management and version control.

HCA believes that the Certification process conducted by the federal Centers for Medicare and Medicaid Services (CMS) documented that sufficient internal controls are in place. ProviderOne was implemented in May 2010 and was successfully certified by the federal Centers for Medicare and Medicaid Services (CMS) in July 2011, with no weaknesses cited. The CMS Certification Review is a comprehensive review of system criteria that includes over 600 Review Criteria, including a review of financial and internal application control

components. In addition to state-prepared documentation for each of the Review Criteria, a team of 7 CMS reviewers with expertise on specific system components were on-site for a week to conduct the review. The On-site Certification Team reviewed prepared documentation prior to their arrival, interviewed staff, and performed additional verification by actual system interaction and testing. The federal certification process is very comprehensive in nature, using proven, standardized testing methodologies that allow the federal government to validate their 90% funding of the development and implementation of the system and 75% of operational funding. Washington's ProviderOne certification was the first in the country to achieve federal certification without a single finding from the federal certification team.

While robust change control processes are in place, HCA also recognizes the value of an independent audit of internal system controls. While neither expected nor required by the federal government for any Medicaid payment system, to strengthen HCA's ability to monitor vendor controls, Washington State has now added a requirement for external audit to the ProviderOne vendor contract. This will be implemented in phases and once complete, will provide HCA with additional independent assurance of effective vendor controls.

2. PREVIOUS FINDING: The Authority does not have assurance the vendor has effective controls to safeguard ProviderOne data files.

Agency's Response

The Health Care Authority does not concur with the finding statement but agrees that additional independent review will strengthen HCA's ability to ensure that its vendor has effective controls in place to safeguard ProviderOne data files.

The HCA recognizes the necessity of effective data file safeguards. During ProviderOne implementation, the State reviewed and approved CNSI's Database Security Procedures, and conducted a physical inspection of the Data Center to ensure that system software, application and data files met all security standards. In addition, audit trails maintain a record of all system and database activity to ensure that the database has not been modified outside of authorized processes. The HCA asserts that the Database procedures in place meet Best Practice standards.

HCA believes that the Certification process conducted by the federal Centers for Medicare and Medicaid Services (CMS) documented that sufficient internal controls are in place. ProviderOne was implemented in May 2010 and was successfully certified by the federal Centers for Medicare and Medicaid Services (CMS) in July 2011, with no weaknesses cited. The CMS Certification Review is a comprehensive review of system criteria that includes over 600 Review Criteria, including a review of financial and internal application control components. In addition to state-prepared documentation for each of the Review Criteria, a team of 7 CMS reviewers with expertise on specific system components were on-site for a week to conduct the review. The On-site Certification Team reviewed prepared documentation prior to their arrival, interviewed staff, and performed additional verification by actual system interaction and testing. The federal certification process is very comprehensive in nature, using proven, standardized testing methodologies that allow the federal government to validate their 90% funding of the development and implementation of the system and 75% of operational funding. Washington's ProviderOne certification was the first in the country to achieve federal certification without a single finding from the federal certification team.

While robust change control processes are in place, HCA also recognizes the value of an independent audit of internal system controls. While neither expected nor required by the federal government for any Medicaid payment system, to strengthen HCA's ability to monitor vendor controls, Washington State has now added a requirement for external audit to the ProviderOne vendor contract. This will be implemented in phases and once complete, will provide HCA with additional independent assurance of effective vendor controls.

3. PREVIOUS FINDING: User access privileges were not restricted to ensure separation of incompatible duties.

Agency's Response

The Health Care Authority partially concurs with this finding. While ProviderOne user security profiles were established and thoroughly reviewed prior to implementation, we agree that assessing the compliance and operating effectiveness of existing controls are necessary on an ongoing basis. HCA is currently outlining a set of Enterprise Security Principles on which to base decisions related to separation of duties and will follow with development of an internal annual process for review of user security profiles.

It should be noted that SAO provided HCA with the same recommendation and associated details at the conclusion of a 2011 ProviderOne Review. HCA reviewed all of the profile combinations that were noted as incompatible, and provided SAO with a list of completed resolutions in the spring of 2012. HCA believes that the establishment of appropriate balance between user needs and security requires a careful analysis of the criticality and sensitivity of information resources available and the tasks performed by users. There are some combinations of user security profiles that have been assessed by HCA as low risk and due to resource constraints, are impractical to maintain a separation of duties.

4. PREVIOUS FINDING: Disaster recovery procedures have not been tested in more than three years.

Agency's Response

The Health Care Authority concurs with the finding and notes that annual Disaster Recovery testing was completed prior to HCA's receipt of this finding. The agency will continue to take corrective actions to ensure that ongoing annual Disaster Recovery testing timelines are monitored and met.

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

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

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

Title 45 CFR 95.621 ADP reviews, states in part:

> The Department will conduct periodic onsite surveys and reviews of State and local agency ADP methods and practices to determine the adequacy of such methods and practices and to assure that ADP equipment and services are utilized for the purposes consistent with proper and efficient administration under the Act. Where practical, the Department will develop a mutually acceptable schedule between the Department and State or local agencies prior to conducting such surveys or reviews, which may include but are not limited to:
>
> (a) *Pre-installation readiness.* A pre-installation survey including an onsite evaluation of the physical site and the agency's readiness to productively use the proposed ADP services, equipment or system when installed and operational.
> (b) *Post-installation.* A review conducted after installation of ADP equipment or systems to assure that the objectives for which FFP was approved are being accomplished.
> (c) *Utilization.* A continuing review of ADP facilities to determine whether or not the ADP equipment or services are being efficiently utilized in support of approved programs or projects.

(d) *Acquisitions not subject to prior approval.* Reviews will be conducted on an audit basis to assure that system and equipment acquisitions costing less than $200,000 or acquisitions exempted from prior approval were made in accordance with Part 92 and the conditions of this subpart and to determine the efficiency, economy and effectiveness of the equipment or service.

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

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

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

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

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

(A) Physical security of ADP resources;

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

(C) Software and data security;

(D) Telecommunications security;

(E) Personnel security;

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

(G) Emergency preparedness; and,

(H) Designation of an Agency ADP Security Manager.

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

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

(4) Costs incurred in complying with provisions of paragraphs (f)(1)–(3) of this section are considered regular administrative costs which are funded at the regular match rate.

(5) The security requirements of this section apply to all ADP systems used by State and local governments to administer programs covered under 45 CFR part 95, subpart F.

(6) The State agency shall maintain reports of their biennial ADP system security reviews, together with pertinent supporting documentation, for HHS on-site review.

The Office of Financial Management's *State Administrative and Accounting Manual* (SAAM), states in part:
Section 20.10.20 Authority for these policies:

> The Budget and Accounting Act is found in Chapter 43.88 RCW. Section 43.88.160 (4) requires that the director of the Office of Financial Management (OFM), as an agent of the governor:
>
> Develop and maintain a system of internal controls and internal audits comprising methods and procedures to be adopted by each agency that will safeguard its assets, check the accuracy and reliability of its accounting data, promote operational efficiency, and encourage adherence to prescribed managerial policies for accounting and financial controls. The system developed by the director shall include criteria for determining the scope and comprehensiveness of internal controls required by the classes of agencies, depending on the level of resources at risk. Each agency head or authorized designee shall be assigned the responsibility and authority for establishing and maintaining internal audits following the standards of internal auditing of the Institute of Internal Auditors . . . .

Section 20.15.40.e Monitoring:

An agency's internal control is most effective when there is a proper monitoring control environment, results are prioritized and communicated, and weaknesses are corrected and followed up on as necessary.

12-49 The Health Care Authority does not comply with the data-sharing requirements of State law and the federal Deficit Reduction Act of 2005, thereby increasing the likelihood that the state is paying claims that should have been paid by liable third parties.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed or Unallowed and Allowable Costs/Cost Principles	
Questioned Cost Amount:	None	

Background

Medicaid is the "payer of last resort", meaning the Health Care Authority (Authority) should identify other payment sources prior to submitting claims to Medicaid. Third-party liability refers to the legal obligation of third-party resources, usually insurance companies, to pay medical and pharmaceutical claims of Medicaid recipients prior to Medicaid coverage. The function of third-party liability within the Medicaid program is to ensure non-Medicaid resources are the primary source of payment. Federal regulations require states to have processes to identify third parties liable for payment of services before Medicaid dollars are used.

The federal Deficit Reduction Act of 2005 requires health insurers to provide states with eligibility and coverage information that will enable Medicaid agencies to determine whether Medicaid recipients have third-party coverage. The Act directs states, as a condition of receiving Medicaid money, to have laws requiring health insurers doing business in that state to provide the eligibility and coverage information upon the request of the state.

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, in turn, are required to use that information to identify Medicaid clients with third-party coverage, and provide those results to the Authority. The law requires this process to be performed no less than twice per year. The law, if followed, would provide a comprehensive identification of potential third-party payers and save scarce public resources.

In our past four audits, 2008 through 2011, we reported findings regarding the Authority's noncompliance with the federal Deficit Reduction Act of 2005 and the state law.

The state had Medicaid expenditures of approximately $7.9 billion in fiscal year 2012.

Description of Condition

The Authority has not performed the semi-annual data share with insurers as required by the federal Deficit Reduction Act of 2005 and State law.

Cause of Condition

The Authority does not have a process in place to share data on a semi-annual basis with insurers as required by the federal Deficit Reduction Act of 2005 and State law. The Authority believed it met the intent of the requirements of state law and federal regulation through work it performed.

Effect of Condition

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

Recommendation

We again recommend the Authority complete all necessary steps to establish processes 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.

Agency's Response

The Authority continues to disagree with this finding.

The Authority maintains that it is in compliance with the Deficit Reduction Act of 2005 (DRA) and applicable state law. The Authority 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 Authority 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 Authority will implement the change request based on prioritization against all other system change requests in their order of importance.*

- *The Authority'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 Authority could explore to enhance its cost avoidance and recovery. As a result of this review, the Authority entered into a contract with HMS to strengthen and improve its 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 the Authority.*

Although the Authority has been in compliance with the DRA since it was passed into law in April 2007, the above actions demonstrate how the Authority continues to improve ways to share Medicaid information with health insurers so the state is not paying for claims that should have been paid by a liable third party.

The condition noted in this finding was previously reported in finding 10-40

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 reaffirm our finding.

Applicable Laws and Regulations

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

The auditee shall:

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

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

Title 42, United States Code, Part 1396a(a)(25) indicates that a State plan for medical assistance must "provide":

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 1167(1) of U.S.C. Title 29), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including--

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396*o* of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396*o* of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396*o* of this title), exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall--

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall--

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation

to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)], a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this subchapter for such State, or any other State;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to--

(i) provide, with respect to individuals who are eligible (and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with section 1396a(e)(13)(D) of this title) for, or are provided, medical assistance under the State plan under this subchapter (and, at State option, child health assistance under subchapter XXI), upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if-

(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

Revised Code of Washington (RCW) 74.09A.005 states:

The legislature finds that:

(1) Simplification in the administration of payment of health benefits is important for the state, providers, and health insurers;

(2) The state, providers, and health insurers should take advantage of all opportunities to streamline operations through automation and the use of common computer standards;

(3) It is in the best interests of the state, providers, and health insurers to identify all third parties that are obligated to cover the cost of health care coverage of joint beneficiaries; and

(4) Health insurers, as a condition of doing business in Washington, must increase their effort to share information with the authority and accept the authority’s timely claims consistent with 42 U.S.C. 1396a(a)(25).

Therefore, the legislature declares that to improve the coordination of benefits between the health care authority and health insurers to ensure that medical insurance benefits are properly utilized, a transfer of information between the authority and health insurers should be instituted, and the process for submitting requests for information and claims should be simplified.

RCW 74.09A.020 states:

Computerized information — Provision to health insurers.

1. The authority shall provide routine and periodic computerized information to health insurers regarding client eligibility and coverage information. Health insurers shall use this information to identify joint beneficiaries. Identification of joint beneficiaries shall be transmitted to the authority. The authority shall use this information to improve accuracy and currency of health insurance coverage and promote improved coordination of benefits.
2. To the maximum extent possible, necessary data elements and a compatible database shall be developed by affected health insurers and the authority. The authority shall establish a representative group of health insurers and state agency representatives to develop necessary technical and file specifications to promote a standardized database. The database shall include elements essential to the authority and its population's health insurance coverage information.
3. If the state and health insurers enter into other agreements regarding the use of common computer standards, the database identified in this section shall be replaced by the new common computer standards.
4. The information provided will be of sufficient detail to promote reliable and accurate benefit coordination and identification of individuals who are also eligible for authority programs.
5. The frequency of updates will be mutually agreed to by each health insurer and the authority based on frequency of change and operational limitations. In no event shall the computerized data be provided less than semiannually.
6. The health insurers and the authority shall safeguard and properly use the information to protect records as provided by law, including but not limited to chapters 42.48, 74.09, 74.04, 70.02, and 42.56 RCW, and 42 U.S.C. Sec. 1396a and 42 C.F.R. Sec. 43 et seq. The purpose of this exchange of information is to improve coordination and administration of benefits and ensure that medical insurance benefits are properly utilized.
7. The authority shall target implementation of this section to those health insurers with the highest probability of joint beneficiaries.

12-50 The Health Care Authority did not adequately monitor subrecipients to ensure Medicaid Administrative Match expenditures are allowable and subrecipients obtained federal compliance audits.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Subrecipient 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. HCA operates the Medicaid Administrative Match (MAM) program, which contracts with governmental entities across the state, such as school districts and local health jurisdictions, to conduct activities to support program goals. These activities include Medicaid outreach and education, identifying children and families who may be eligible and helping people with the application process.

HCA reimburses school districts and local health jurisdictions for staff costs associated with these activities. These entities participate in time studies to determine the amount to be charged to Medicaid. The Centers for Medicare and Medicaid Services (CMS) approves the time study methodology used by school districts and local health jurisdictions.

When grant funds are passed through to school districts and local health jurisdictions, HCA is required to ensure school districts and local health jurisdictions that spend $500,000 or more in federal awards during the fiscal year receive an audit in accordance with the federal requirements (U.S. Office of Management and Budget Circular A-133). HCA also is required to follow up on audit findings within six months of receipt of the audit report and monitor school districts and local health jurisdictions to ensure that they take appropriate and timely corrective action on all audit findings.

The state Medicaid program paid more than $69 million in federal funding to subrecipients during fiscal year 2012, approximately $36 million of which went directly to participants of the MAM program. Sixty-eight school districts and 15 local health jurisdictions spent the majority of the funds, $16.8 million and $19.2 million respectively.

Description of Condition

The accuracy of Medicaid Administrative Match (MAM) claims depends on the accuracy of the expenditures reported and time study results. In our prior audit, we found the Authority did not adequately monitor subrecipients to ensure MAM expenditures are allowable and supported. To improve oversight, the Authority added a fiscal component to its on-site subrecipient monitoring activities of schools and local health jurisdictions. In our current audit, however, we noted that the weakness we identified during our prior audit still exists.

Additionally, the Authority did not verify whether subrecipients obtained federal compliance audits during fiscal year 2012.

Cause of Condition

The new fiscal monitoring procedures were not fully in place during fiscal year 2012.

Also, prior to fiscal year 2012, the Department of Social and Health Services administered the Medicaid program and verified completion of federal compliance audits centrally for all its subrecipients. The Authority does not yet have a verification process.

Effect of Condition

By not verifying the allowability and accuracy of the expenditures, the Authority risks reimbursing subrecipients for expenditures that may be unsupported and unallowable.

The failure to verify the audit status of subrecipients increases the risk that subrecipients may not obtain required audits or that the Authority would not take timely and appropriate corrective action on audit findings.

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.

We also recommend the Authority verify the completion of federal compliance audits for all its subrecipients.

Authority's Response

HCA agrees with the finding and is implementing the following corrective actions.

To improve oversight, the Medicaid Administrative Match program added a fiscal component to its monitoring of school districts and local health jurisdictions. Beginning June 1, 2012 the fiscal monitoring activity includes the following: For the timeframe monitored, HCA uses a random sampling process to select time study participants. HCA compares the actual salaries and benefits of those selected through this process to salaries and benefits claimed for those participants. HCA also reviews direct and indirect claimed costs for the same period monitored.

HCA agrees with the finding related to obtaining required audits and taking needed appropriate corrective action on audit findings.

Effective November 2012 all contract monitoring tools have been updated to include this requirement as part of the HCA onsite/desk monitoring process. Additionally, one staff member has been assigned the task of tracking receipt of needed audits from subrecipients, reviewing and ensuring audit findings are addressed.

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

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

> The auditee shall:

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

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.

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

Section M. Subrecipient Monitoring:
Compliance Requirements
A pass-through entity is responsible for: …

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

- *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.

Monitoring activities normally occur throughout the year and may take various forms, such as:

- Reporting – Reviewing financial and performance reports submitted by the subrecipient.
- Site Visits – Performing site visits at the subrecipient to review financial and programmatic records and observe operations.
- Regular Contact – Regular contacts with subrecipients and appropriate inquiries concerning program activities.

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

8. Compensation for personal services.
   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) 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.

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.

12-51 The Health Care Authority does not perform the federally required retrospective drug use review of pharmaceutical claims data to identify patterns of fraud or abuse.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
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	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Utilization Control and Program Integrity	
Questioned Cost Amount:	None	

Background

Medicaid is a state and federal partnership that provides health insurance for certain low–income individuals who might otherwise go without medical care. This coverage includes paying for prescription drugs. The Authority paid more than $422 million to pharmacies for services to Medicaid clients in fiscal year 2012.

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. As a Medicaid administrator, 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. This requirement may be satisfied by activities completed within the federally required surveillance and utilization review program.

Description of Condition

In our audits for fiscal years 2008 through 2011, we reported concerns regarding the Authority's noncompliance with federal law that requires a retrospective drug use review of pharmaceutical claims data at least quarterly.

During our current audit, we requested any review and analysis of pharmaceutical claims data performed by the Authority during fiscal year 2012. The Authority performed one analysis related to pharmacy claims in March 2012. The analysis identified duplicate payments occurring days apart, which resulted in overpayments totaling $308,362.14 to 286 providers.

This analysis is the only retrospective drug use review of pharmaceutical claims data the Authority performed in fiscal year 2012. The federal law requires the state Medicaid program to perform a retrospective drug use review of pharmaceutical claims data at least quarterly.

Cause of Condition

Authority management believes that its Office of Program Integrity has performed ongoing, periodic reviews of pharmaceutical claims data to identify potential Medicaid fraud, waste or abuse. However, the Office of Program Integrity did not analyze pharmaceutical claims data quarterly, as required.

Effect of Condition

The Authority did not comply with the requirement. Because the Authority is not analyzing pharmaceutical claim data and other records on a regular basis to identify patterns of fraud, abuse, or misuse of Medicaid funds, there is an increased risk these situations could occur and not be detected in a timely manner, if at all.

Recommendation

We again recommend the Authority comply with federal law and perform a retrospective drug use review of pharmaceutical claims data at least quarterly.

Authority's Response

The agency continues to disagree with this finding.

The Health Care Authority performs ongoing periodic review of pharmaceutical claims data to identify fraud, waste, or abuse which satisfies federal requirements. The agency performs claim review and analysis in multiple offices including but ***not*** *limited to the Office of Program Integrity (OPI) mentioned in Description and Cause of Condition. Health Care Authority does not assert that the claims analysis performed by OPI satisfies federal conditions on its own. Analysis performed in OPI, by the Quality Management Team, and the Patient Review and Coordination program work together to satisfy federal requirements.*

The State Auditor's Office (SAO) was provided with information in October 2012 detailing three claim review and analysis algorithms performed by OPI during SFY 2012. Two of these three are not mentioned in this finding despite their details having been submitted to SAO. Additional analyses were performed by OPI during SFY 2012 that were not detailed for the SAO, because they did not result in opportunities for recoupment (i.e., additional reviews were performed which looked for, but did not find significant fraud, waste, abuse, or billing errors).

In addition to the work of OPI, the agency's Quality Management Team performed 175 claim analyses of individual prescribers in FFY 2012, and the Patient Review and Coordination program performed 4,249 individual client claim analyses.

The Health Care Authority is very interested in working with the SAO to provide additional information or clarification so as to eliminate this repeat audit finding in the future.

Auditor's Remarks

We thank the Authority for its response.

We received information in October 2012 regarding claim reviews and analysis algorithms performed by OPI. A total of five algorithms were received but only one analysis algorithm occurred during SFY 2012. Of the remaining four analysis algorithms received, three were completed after SFY 2012 and one was completed prior to SFY 2012.

We will continue to work with and discuss this finding with the Authority during our next audit period.

Applicable Laws and Regulations

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

The auditee shall:

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

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

Title 42, Code of Federal Regulations, Section 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 456.714 states:

(a) The retrospective DUR requirements in this subpart parallel a portion of the surveillance and utilization review (SUR) requirements in subpart A of this part and in part 455 of this chapter.

(b) A State agency may direct DUR staffs to limit review activities to those that focus on what constitutes appropriate and medically necessary care to avoid duplication of activities relating to fraud and abuse under the SUR program.

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 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 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, states:

A full investigation must continue until—

(a) Appropriate legal action is initiated;
(b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or
(c) The matter is resolved between the agency and the provider or beneficiary. This resolution may include but is not limited to—
  (1) Sending a warning letter to the provider or beneficiary, giving notice that continuation of the activity in question will result in further action;
  (2) Suspending or terminating the provider from participation in the Medicaid program;
  (3) Seeking recovery of payments made to the provider; or
  (4) Imposing other sanctions provided under the State plan.

Washington Administrative Code (WAC) 182-530-4050, 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).

12-52 The Health Care Authority cannot be sure it is properly claiming Children's 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	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed or Unallowed and Allowable Costs/Cost Principles	
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 spent approximately $7.9 billion for the Medicaid program and $106 million for the Children's Health Insurance Program during fiscal year 2012. The state is reimbursed for approximately 65 percent of its CHIP expenditures and 50 percent of Medicaid expenditures.

Medicaid expenditures for children who reside in households with income between 133 percent and 200 percent of the Federal Poverty Level are eligible for additional CHIP funding. If the Medicaid costs already have been claimed and reimbursed, the state still can claim and be paid for up to the CHIP allotment the difference between the Medicaid and CHIP rates.

In state fiscal year 2012, the Authority claimed $10.5 million in CHIP money based on the eligibility of children in the Medicaid program.

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 additional CHIP funds. The Authority uses net income to determine eligibility for the Medicaid program.

In our audits for fiscal years 2010 and 2011, we recommended the Authority develop and follow adequate controls to correctly identify Medicaid expenditures that are eligible for CHIP. During the current audit, we found the Authority still incorrectly used gross income rather than net income to determine CHIP eligible Medicaid clients.

Cause of Condition

The Authority has not taken action to address this recommendation from our previous audits.

Effect of Condition

When incorrect income criteria is used, the Authority cannot ensure Medicaid expenditures it used to claim $10.5 million CHIP allotment were eligible for the higher reimbursement rate.

Recommendation

We again recommend the Authority:

- Ensure correct income criteria is used in determining Medicaid children who are eligible for additional CHIP funds.
- 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.

Authority's Response

The Health Care Authority agrees with the finding and is taking the following corrective actions:

The agency has developed a report using data from the Medicaid Management Information System to identify claims by Recipient Aid Category (RAC) and Federal Poverty Level (FPL) based on net income. The report will be implemented for SFY13 beginning with the quarterly transfer for July-September 2012, which will be processed in January 2013.

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

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

The auditee shall:

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

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

Sec. 2105. [42 U.S.C. 1397ee] Payments states in part:

(g) Authority for qualifying states to use certain funds for Medicaid expenditures.—

(1) State option.—

(A) In general.—Notwithstanding any other provision of law subject to paragraph (4), a qualifying State (as defined in paragraph (2)) may elect to use not more than 20 percent of any allotment under section 1397dd of this title for fiscal year 1998, 1999, 2000, 2001, 2004, 2005, 2006, 2007, or 2008 (insofar as it is available under subsections (e) and (g) of such section) for payments under subchapter XIX of this chapter in accordance with subparagraph (B), instead of for expenditures under this subchapter .

(B) Payments to states.—

(i) In general.—In the case of a qualifying State that has elected the option described in subparagraph (A), subject to the availability of funds under such subparagraph with respect to the State, the Secretary shall pay the State an amount each quarter equal to the additional amount that would have been paid to the State under subchapter XIX of this chapter with respect to expenditures described in clause (ii) if the enhanced FMAP (as determined under subsection (b) of this section) had been substituted for the Federal medical assistance percentage (as defined in section 1396d(b) of this title).

(ii) Expenditures described.—For purposes of this subparagraph, the expenditures described in this clause are expenditures, made after August 15, 2003, and during the period in which funds are available to the qualifying State for use under subparagraph (A), for

medical assistance under subchapter XIX of this chapter to individuals who have not attained age 19 and whose family income exceeds 150 percent of the poverty line.

(iii) No impact on determination of budget neutrality for waivers.—In the case of a qualifying State that uses amounts paid under this subsection for expenditures described in clause (ii) that are incurred under a waiver approved for the State, any budget neutrality determinations with respect to such waiver shall be determined without regard to such amounts paid.

(2) Qualifying state.—In this subsection, the term "qualifying State" means a State that, on and after April 15, 1997, has an income eligibility standard that is at least 184 percent of the poverty line with respect to any 1 or more categories of children (other than infants) who are eligible for medical assistance under section 1396a(a)(10)(A) of this title or, in the case of a State that has a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that was first implemented on August 1, 1994, or July 1, 1995, has an income eligibility standard under such waiver for children that is at least 185 percent of the poverty line, or, in the case of a State that has a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that was first implemented on January 1, 1994, has an income eligibility standard under such waiver for children who lack health insurance that is at least 185 percent of the poverty line, or, in the case of a State that had a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that was first implemented on October 1, 1993, had an income eligibility standard under such waiver for children that was at least 185 percent of the poverty line and on and after July 1, 1998, has an income eligibility standard for children under section 1396a(a)(10)(A) of this title or a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that is at least 185 percent of the poverty line.

(3) Construction.—Nothing in paragraphs (1) and (2) shall be construed as modifying the requirements applicable to States implementing State child health plans under this subchapter.

(4) Option for allotments for fiscal years 2009 through 2015.—

(A) Payment of enhanced portion of matching rate for certain expenditures.—In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State's allotment made under section 1397dd of this title for any of fiscal years 2009 through 2015 (insofar as the allotment is available to the State under subsections (e) and (m) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under subchapter XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1396d(b) of this title).

(B) Expenditures described.—For purposesgraph (A), the expenditures described in this subparagraph are expenditures made after February 4, 2009, and during the period in which funds are available to the qualifying State for use under subparagraph (A), for the provision of medical assistance to individuals residing in the State who are eligible for medical assistance under the State plan under subchapter XIX or under a waiver of such plan and who have not attained age 19 (or, if a State has so elected under the State plan under subchapter XIX, age 20 or 21), and whose family income equals or exceeds 133 percent of the poverty line but does not exceed the Medicaid applicable income level.

12-53 The Health Care Authority's inadequate internal controls over claims for dental services led to more than $648,000 in overpayments to providers.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed and Allowable Costs/Cost Principles	
Questioned Cost Amount:	$324,237	

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 $7.9 billion during fiscal year 2012. More than $4.8 billion of that relates to activities of the Health Care Authority (Authority), of which more than $4.4 billion was paid directly to providers.

States are required to provide dental benefits to children covered by Medicaid, but states choose whether to provide dental benefits for adults. The State of Washington only provides non-emergency dental care for Medicaid-eligible adults with developmental disabilities, long-term care patients, and pregnant women.

In fiscal year 2012, the Authority paid approximately $237 million for dental services.

Description of Condition

The Medicaid claim adjudication and payment process is highly automated. The Authority relies heavily on internal controls within the ProviderOne payment system to identify and deny claims when charges are unallowable or billed improperly by dental providers. During our testing we found the internal controls within the system were not effective to prevent unallowable claims from being paid.

Cause of Condition

For some dental services, we found the covered amount was not consistent between Washington Administrative Code (Code) and the Authority's Medicaid provider guide. For example:

- Section 182-535-1082(2)(b) of the Code states that the Authority will cover up to two topical fluoride treatments for clients from seven to eighteen years of age in a twelve month period.
- In contrast, the Medicaid provider guide states it will cover up to two topical fluoride treatments for clients from seven to eighteen years of age in a twelve month period, **per provider or clinic**.

This difference, while subtle, is significant because the internal controls the Authority has designed within the ProviderOne system to detect and prevent unallowable payments apply the coverage limitations of the provider guide and not the Code.

We also found instances when the automated controls within the ProviderOne system did not prevent unallowable payments described in both the Code and the Authority's provider guide. For example, when providers billed for

some claims with expedited authorization numbers, the system's controls were overridden and resulted in unallowable claims being paid.

Effect of Condition

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

Fluoride Treatments for Children
Medicaid covers up to three applications of fluoride in a year for clients six years of age. For clients between seven and 18 years of age, Medicaid covers up to two applications in a year, unless the client is developmentally disabled. For these clients the program covers up to three applications per client in a year. In fiscal year 2012, claims totaling $9.7 million were paid for these treatments.

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

	Clients 6 years of age or less	**Clients between 7 and 18 years of age**	**Totals**
Number of clients who received more treatments than covered by Medicaid	5,252	7,387	**12,639**
Total overpaid to providers	$155,419	$125,332	**$280,751**

Dental Cleanings (prophylaxis)
Medicaid covers dental cleanings (prophylaxis) once every six-months for clients eighteen years of age or younger and once every twelve months for clients nineteen years of age and older. If the client is developmentally disabled, Medicaid covers up to three cleanings in a twelve month period, regardless of the client's age. In fiscal year 2012, nearly $14 million in claims were paid to providers for these treatments.

We identified 1,725 claims totaling $62,214 paid to providers for cleanings that exceeded the allowed number covered by Medicaid.

Dental X-rays
Medicaid covers dental x-rays for children and some adults. Depending on the type of x-ray, the number covered per client per year varies. We reviewed claims for the following types of x-rays:

- Intraoral complete series
- Intraoral occlusal films
- Cephalometric films
- Bitewings

We identified 1,982 claims totaling $29,890 for x-rays that exceeded more than the allowed number covered by Medicaid.

Oral Evaluation Services
Medicaid covers oral evaluation services, with some restrictions. We reviewed claims for the following services:

- Comprehensive oral evaluations – covered once per client, per provider. In fiscal year 2012, Medicaid paid providers approximately $5.1 million for these evaluations.
- Periodic oral evaluations – covered once every six months. Also, six months must lapse between the client's comprehensive oral evaluation and first periodic oral evaluation. In fiscal year 2012, Medicaid paid providers approximately $12 million for these evaluations.

We identified claims totaling $228,645 where providers were paid for oral evaluation services that exceeded the allowed number covered by Medicaid.

Family Oral Health Education and Limited Visual Oral Assessments
Family oral health education is covered by Medicaid. The Access to Baby and Child Dentistry (ABCD) program has been established (WAC 182-535-1245) to increase access to dental services for Medicaid-eligible clients through the age of five. Claims for family oral health education is limited to one visit per day, per family, up to two visits per child in a 12-month period, per billing provider.

Providers are allowed to bill Medicaid for limited visual oral assessments, up to two per client, per year, per billing provider when the following conditions are met:

- Not performed in conjunction with other clinical oral evaluation services.
- Performed by a licensed dentist or dental hygienist to determine the need for sealants or fluoride treatment and/or when triage services are provided in a setting other than a dental office or dental clinic (school, alternative living facility, etc.).

We found Medicaid made payments for:

- 218 claims, totaling $2,210 that exceeded the number of limited oral assessments allowed per client, per year, per provider.
- 173 claims, totaling $1,794 for limited oral assessments that were performed in conjunction with other clinical oral evaluation services.
- 1,558 claims, totaling $42,970 for family oral health education that was paid for more than twice for the same client by the same provider in fiscal year 2012.

In total, the Authority made payments of $648,474 for services that were not allowable for reimbursement. We are questioning $324,237, which is the federal portion[1] of the unallowable payments.

Recommendation

We recommend the Authority:

- Ensure the Medicaid provider guide is consistent with the Code.
- Develop adequate internal controls within its ProviderOne system to detect and prevent improper and unallowable claims submitted by dental providers.
- Recover the $648,474 in unallowable claims paid to the dental providers.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Authority's Response

1. *Fluoride treatment for children. The agency agrees that the billing guide, Washington Administrative Code (WAC) and the ProviderOne system are not aligned. It is the agency's intent to allow fluoride with applicable age/annual limits, per client, per provider. The WAC needs to be corrected and no recovery is necessary.*
2. *Dental Cleanings. The agency found system issues that have been corrected, and the agency's Division of Program and Payment Integrity will recoup the overpayments.*
3. *Dental X-rays. The agency agrees that the billing guide and WAC are not aligned with the ProviderOne payment system. It is the agency's intent to pay for necessary diagnostic X-rays per client, per provider. The agency will update the WAC and billing guides, and any payments made outside of these limitations will be identified and recouped by the agency.*

[1] The federal share is calculated using the state's 2012 FMAP rate of 50 percent.

4. *Oral Evaluation Services. The agency agrees that there were system issues for most of the overpayments. The agency will update the WAC and billing guide to allow for additional evaluations for clients managed by the Department of Social and Health Services' Aging and Disability Services Administration. (We allow three cleanings per year, thus we should allow a limited evaluation at the same time.)*
5. *Limited Visual Evaluations and Family Oral Health Education. The agency paid both services with a miscellaneous code, and we were unable to set up automated system limitations. However, we now have new codes with edits for the Limited Visual Evaluation as of January 1, 2013, and have set up system limits for both services. The agency has submitted requests to the Office of Payment Integrity to identify overpayments and recoup funds.*
6. *In total, the agency will recoup roughly $337,833 of overpayments. All other services were paid correctly based on agency intent.*

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

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

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

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

> Improper Payments
>
> Under OMB guidance, Public Law (Pub. L.) No. 107-300, the Improper Payments Information Act of 2002, as amended by Pub. L. No. 111-204, the Improper Payments Elimination and Recovery Act, Executive Order 13520 on reducing improper payments, and the June 18, 2010 Presidential memorandum to enhance payment accuracy, Federal agencies are required to take actions to prevent improper payments, review Federal awards for such payments, and, as applicable, reclaim improper payments. Improper payment means:
>
> 5. Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements.
> 6. Incorrect amounts are overpayments or underpayments that are made to eligible recipients (including inappropriate denials of payment or service, any payment that does not account for credit for applicable discounts, payments that are for the incorrect amount, and duplicate payments).
> 7. Any payment that was made to an ineligible recipient or for an ineligible good or service, or payments for goods or services not received (except for such payments where authorized by law).
> 8. Any payment that an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation.

Washington Administrative Code 182-535-1079 states in part:

> The agency pays for dental-related services and procedures provided to eligible clients when the services and procedures states in part:
> (a) Are part of the client's dental benefit package;
> (b) Are within the scope of an eligible client's medical care program;

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

Washington Administrative Code 182-535-1080 states in part:

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

(1) **Clinical oral evaluations.** The agency covers:
(a) Oral health evaluations and assessments.
(b) Periodic oral evaluations as defined in WAC 182-535-1050, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.
(c) Limited oral evaluations as defined in WAC 182-535-1050, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client. . . .
(d) Comprehensive oral evaluations as defined in WAC 182-535-1050, once per client, per provider or clinic, as an initial examination. The agency covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.
(e) Limited visual oral assessments as defined in WAC 182-535-1050, up to two per client, per year, per provider only when the assessment is:
(i) Not performed in conjunction with other clinical oral evaluation services;
(ii) Performed by a licensed dentist or dental hygienist to determine the need for sealants or fluoride treatment and/or when triage services are provided in settings other than dental offices or clinics; and
(iii) Provided by a licensed dentist or licensed dental hygienist.

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

Washington Administrative Code 182-535-1082 states in part:

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

(1) **Dental prophylaxis.** The agency covers prophylaxis as follows. Prophylaxis:
(a) Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary or permanent dentition.

(b) Is limited to once every:
  (i) Six months for clients eighteen years of age and younger; and
  (ii) Twelve months for clients nineteen years of age and older.
(c) Is reimbursed only when the service is performed:
  (i) At least six months after periodontal scaling and root planing, or periodontal maintenance services, for clients from thirteen to eighteen years of age; and
  (ii) At least twelve months after periodontal scaling and root planing, periodontal maintenance services, for clients nineteen years of age and older.
(d) Is not reimbursed separately when performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy, or gingivoplasty.
(e) Is covered for clients of the division of developmental disabilities according to (a), (c), and (d) of this subsection and WAC 182-535-1099.

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

Washington Administrative Code 182-535-1099 states in part:

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

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

Washington Administrative Code 182-535-1245 states in part:

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

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

12-54 The Health Care Authority does not have adequate controls in place to verify services billed by providers with Medicaid beneficiaries in accordance with federal laws, risking the loss of Medicaid resources.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 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 the Authority to follow up for surveys in which clients indicate they did not receive the service and/or paid for the service listed and conduct a preliminary investigation, if necessary to determine if it has sufficient basis to warrant a full investigation.

If follow-through identifies credible suspicions of fraud or abuse, the Authority is to forward that information to the State Attorney General's Office Medicaid Fraud Control Unit. The Centers for Medicare and Medicaid Services (CMS), which is the federal agency that oversees Medicaid, estimated that improper Medicaid payments were $19.2 billion across the nation in fiscal year 2012.

The state had Medicaid expenditures of approximately $7.9 billion in fiscal year 2012, more than $4.2 billion of which was federal dollars.

Description of Condition

In our prior audit, we reported concerns regarding the Authority's lack of follow-up over medical service verifications. During fiscal year 2011, the Authority sent 34,662 surveys to clients but the number of surveys was substantially reduced to 8,401 in fiscal year 2012. This reduction was intended to enable the Authority to follow-up on returned surveys more effectively.

In 2012 a total of 2,590 (31 percent) were returned to the Authority, 94 of those containing negative responses. During our review of 94 negative responses we found the following:

MSV Conclusions	Adequate follow-ups performed	Investigation Pending	Claims that should be excluded from the survey	Survey forms are not clear	Lack of adequate Follow-Up	Total
Number of MSVs	17	12	20	19	30	98*
Percent of total	17.35%	12.24%	20.41%	19.39%	30.61%	100%

*Four surveys reviewed applied to multiple categories.

We found 17 cases (17 percent) were properly reviewed by staff and 12 cases (12 percent) remained pending at fiscal year end. However, we noted the following related to the remaining 71 percent of cases:

- Twenty surveys were sent to clients containing claims that should have been excluded. Types of excluded claims include those covered by Medicare, confidential claims, and those where Medicaid did not cover any amount of the service.
- *Nineteen surveys were misinterpreted by the client as the surveys did not provide all pertinent information. Surveys were addressed to head of household, but the services listed were related to another beneficiary in the survey household. The head of household then responded that services had not been received since the survey form did not specify the beneficiary of the services listed.*
- The Authority did not perform sufficient follow-up on 30 surveys.
    - Thirteen of these cases were not reviewed due to the survey being written in a foreign language, and no translation services are available to staff.
    - Six were not reviewed as the client could not be contacted immediately.
    - Ten were closed before collecting sufficient information to make a determination.
    - One survey was missing.

Cause of Condition

The Authority management considers the medical service verification process to have limited value. This has resulted in a lack of oversight to ensure survey forms are adequately designed and only appropriate claims are included.

Also, the Authority did not allocate adequate resources to perform a thorough follow-up.

Effect of Condition

When a survey form is improperly designed, responses from beneficiaries could be inaccurate causing unnecessary follow-ups and use of limited resources that could be used on more credible cases.

Sending surveys to those with confidential claims puts the privacy of certain clients at risk and is not in compliance with federal laws.

The lack of adequate follow-ups on returned surveys increases the risk Medicaid fraud may go undetected and take away Medicaid resources that would otherwise be directed to the truly needy citizens of Washington.

Recommendation

We recommend the Authority improve its internal controls by:

- Strengthening its oversight to ensure survey forms are properly designed.
- Improving its processes to ensure only relevant claims are included for medical service verification.

- Performing a thorough follow-up on all negative responses.

Authority's Response

The Health Care Authority does not agree with the finding and disagrees that the Medical Service Verification (MSV) process lacks adequate controls.

- *Historically, the MSV process has proven to have no value in detecting fraud. The agency prioritizes its resources for program integrity and surveillance and utilization in areas that have been proven to yield a higher return on investment. The agency maintains that resources spent on MSV processing actually reduce our ability to focus on program integrity activities that increase controls.*

- *Of the 30 MSVs noted as "lacking follow-up" the agency maintains that resources dedicated to these MSVs were appropriate given the process and the dollar values at stake:*
  - *Thirteen (13) were not followed up because the amounts paid did not warrant the purchase of translation services (average cost of $68 per MSV, including three that were paid at zero and a fourth with 39 cents at risk)*
  - *Another 6 - an average of less than $12 per MSV—were not followed-up because the clients could not be located*
  - *Of the 11 remaining, 10 —with an average paid amount of $28—received no follow-up when clients checked every box, checked no boxes, or completed the form when the service in question was provided to another member of the household*
  - *Claims for confidential services are now appropriately excluded from inclusion in the MSV process.*

HCA will continue to refine its selection process for MSV reviews and will continue to meet federal MSV requirements.

Auditor's Remarks

We thank the Authority for its response.

The MSV process is very unique as it is one of the processes where the Authority has direct contact with clients to verify paid services. When fraudulent activity occurs, it is typically not a single, large payment that covers all the activities, but numerous small payments that may add up to a large amount. The identification of one fraudulent payment will most likely lead to uncovering many additional fraudulent payments, which highlights the importance of the MSV process.

Not having a process to verify receipt of services billed is considered non-compliance of federal regulations by the Centers for Medicare and Medicaid Services as demonstrated by its findings in its Annual Summary Report of Comprehensive Program Integrity Review issued in June 2012.

We will review this area during our next audit.

Applicable Laws and Regulations

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

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

Title 42, Code of Federal Regulations, Section 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 beneficiaries.
(b) Subpart B implements sections 1124, 1126, 1902(a)(36), 1903(i)(2), and 1903(n) of the Act. It requires that providers and fiscal agents must agree to disclose ownership and control information to the Medicaid State agency.
(c) Subpart C implements section 1936 of the Act. It establishes the Medicaid Integrity Program under which the Secretary will promote the integrity of the program by entering into contracts with eligible entities to carry out the activities of subpart C.

§ 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 beneficiary has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.
(c) If there is reason to believe that a beneficiary has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

§455.20 Beneficiary verification procedure.

(a) The agency must have a method for verifying with beneficiaries whether services billed by providers were received.
(b) In States receiving Federal matching funds for a mechanized claims processing and information retrieval system under part 433, subpart C, of this subchapter, the agency must provide prompt written notice as required by §433.116 (e) and (f).

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 paragraph (j) of this section, FFP is available at 75 percent of expenditures for operation of a mechanized claims processing and information retrieval system approved by CMS, from the first day of the calendar quarter after the date the system met the conditions of initial approval, as established by CMS (including a retroactive adjustment of FFP if necessary to provide the 75

percent rate beginning on the first day of that calendar quarter). Subject to 45 CFR 95.611(a), the State shall obtain prior written approval from CMS when it plans to acquire ADP equipment or services, when it anticipates the total acquisition costs will exceed thresholds, and meets other conditions of the subpart.

(b) CMS will approve the system operation if the conditions specified in paragraphs (c) through (i) of this section are met.

(c) The conditions of §433.112(b) (1) through (4) and (7) through (9), as periodically modified under §433.112(b)(2), must be met.

(d) The system must have been operating continuously during the period for which FFP is claimed.

(e) The system must provide individual notices, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the plan.

(f) The notice required by paragraph (e) of this section—

(1) Must specify—

(i) The service furnished;

(ii) The name of the provider furnishing the service;

(iii) The date on which the service was furnished; and

(iv) The amount of the payment made under the plan for the service; and

(2) Must not specify confidential services (as defined by the State) and must not be sent if the only service furnished was confidential.

(g) The system must provide both patient and provider profiles for program management and utilization review purposes.

(h) If the State has a Medicaid fraud control unit certified under section 1903(q) of the Act and §455.300 of this chapter, the Medicaid agency must have procedures to assure that information on probable fraud or abuse that is obtained from, or developed by, the system is made available to that unit. (See §455.21 of this chapter for State plan requirements.)

12-55 The Health Care Authority did not ensure that all individuals who received Medicaid benefits had valid Social Security numbers.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Eligibility	
Questioned Cost Amount:	$61,267.23	

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 $7.9 billion during fiscal year 2012, more than $4.2 billion of which was federal dollars.

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

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

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

Description of Condition

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

We found 206 individuals who did not have a valid Social Security number.

The table below summarizes the results of our work:

Description	Number of clients	Payments	Federal Share[1]	State Share
Invalid Social Security number	6	$1,354.42	$677.21	$677.21
No Social Security number	194	$115,541.46	$57,770.73	$57,770.73
Number belongs to deceased person	6	$5,638.58	$2,819.29	$2,819.29
Total	**206**	**$122,534.46**	**$61,267.23**	**$61,267.23**

Cause of Condition

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

Effect of Condition and Questioned Costs

When the state provides services to ineligible individuals, or the services are unallowable and/or unsupported, the service cannot be claimed for federal reimbursement. Payments for services for these 206 clients were $122,534.46. We are questioning $61,267.23, which is the federal portion of the unallowable costs.

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

Recommendation

We recommend the Department:

- Follow up on the 206 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.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

Authority's Response

HCA will continue to send monthly "NO SSN" reports to CSD for correction. Many of these clients with no SSN have had their Medicaid terminated or they received Medicaid for services for which a SSN is not required such as labor and delivery or alien emergency medical services.
HCA will continue to pursue enhancements to verification procedures that promote SSN accuracy. HCA anticipates SSN accuracy improving under Health Care Reform due to the client inputting their own SSN and getting instant feedback if an input error was made.

HCA's foster care medical team has changed processes to add the SSN for children in adoption support. Of the 14,000 children in adoption support, approximately 90% now have a SSN listed in ACES. Before this change, the SSN had been verified but it was not input on the DEM1 screen in ACES.

HCA will pay back the federal share for any payments made on ineligible persons before the end of the federal fiscal year.

Auditor's Remarks

[1] The federal share is calculated using the state's 2012 FMAP rate of 50 percent.

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

Applicable Laws and Regulations

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

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

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

> Section 510 - Audit findings.
>
> (b) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
> … (3) Known questioned costs which are greater than $10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than $10,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor shall include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Title 42, Code of Federal Regulations, Section 435.910 (a) 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 social security numbers (SSNs) . . . .

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

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

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

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

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

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

12-56 The Health Care Authority did not have adequate controls to ensure the federal share of overpayments to Medicaid providers is refunded to the federal government in a timely manner.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.720	ARRA - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
	93.775	State Medicaid Fraud Controls
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
	93.778A	Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
Federal Award Number:	5-1205WA5MAP; 5-1205WA5ADM; 5-1105WAARRA	
Applicable Compliance Component:	Activities Allowed or Unallowed and Allowable Costs/Cost Principles	
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. Most Medicaid expenditures are payments to providers of medical treatment, prescriptions, medical equipment, home health care, long-term care, and other services. The state Medicaid program spent more than $7.9 billion during fiscal year 2012. More than $7.1 billion was paid directly to providers.

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

An overpayment resulting from a situation other than fraud is discovered on the earliest of the date on which any Medicaid agency official or other state official first notifies a provider in writing of an overpayment and specifies a dollar amount subject to recovery; the date on which a provider initially acknowledges a specific overpayment in writing to the Medicaid agency; or the date on which any state official or fiscal agent initiates formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing. An overpayment that results from fraud is shown as discovered on the date of the final written notice of the state's overpayment determination.

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.

Description of Condition

Overpayments identified by the Authority are reported to the Office of Financial Recovery (OFR), a division of the Department of Social and Health Services, which tracks them to ensure the federal share of the overpayments is refunded within a year from the date of discovery.

When OFR receives overpayment information, it establishes accounts receivable and the one-year clock starts. If an overpayment is paid by providers within a year, the federal share of the overpayment is refunded through cash-receipting procedures. If a provider balance remains after a year, the Collections and Accounts Receivable System runs a Medicaid Overpayment Management System report that is forwarded to the Authority Accounting Services to

process a refund for any amount still owed to the federal government. The accuracy of this refunding process depends upon accuracy of overpayment information OFR receives from the Authority.

During our review, we found that the Authority did not have adequate internal controls to ensure the federal share of overpayments is refunded to the federal government in a timely manner. The Authority did not communicate information on overpayments to OFR when they were discovered. We selected 20 out of 138 overpayments the Authority discovered in fiscal year 2012 and found 15, totaling $3,492,910.49, were not communicated to OFR when discovered. This amount included federal funds.

Cause of Condition

The Authority did not believe that it should refund the federal share of overpayments to the federal government within a year from the date of discovery unless a final determination had been made on the amount.

Effect of Condition

Without adequate procedures for overpayment reporting to OFR, the Authority cannot ensure the federal share of overpayments is refunded to the federal government in a timely manner. The federal share of two overpayments, totaling $16,559.82, was returned to the federal government more than one year from the date of discovery.

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

Recommendation

We recommend the Authority implement appropriate procedures to ensure the federal portion of overpayments is reported to OFR. We further recommend the Authority refund all overpayments to the federal government in a timely manner.

Authority's Response

Because draft audit reports are considered part of the audit process, are preliminary to any final identifications of recoverable funds, and subject to modification based upon provider responses to the draft report, HCA did not consider preliminary recovery amounts in draft audit reports to be "discovery," and was not sending draft audit reports to OFR. The Office of Program Integrity contacted OFR to let them know the HCA would be adding the date of the draft letter to the account allocation code sheet, effective January 16, 2013. This met with OFR's approval and this action has been completed.

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

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

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

Section 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.

Title 42, Code of Federal Regulations, Section 433.312 - Basic requirements for refunds.

(a) Basic rules.
  (1) Except as provided in paragraph (b) of this section, the State Medicaid agency has 1 year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.
  (2) The State Medicaid agency must refund the Federal share of overpayments at the end of the 1 year period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider.
(b) Exception.
  The agency is not required to refund the Federal share of an overpayment made to a provider when the State is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business in accordance with Sec. 433.318.
(c) Applicability.
  (1) The requirements of this subpart apply to overpayments made to Medicaid providers that occur and are discovered in any quarter that begins on or after October 1, 1985.
  (2) The date upon which an overpayment occurs is the date upon which a State, using its normal method of reimbursement for a particular class of provider (e.g., check, interfund transfer), makes the payment involving unallowable costs to a provider.

Title 42, Code of Federal Regulations, Section 433.316 - When discovery of overpayment occurs and its significance.

(a) General rule. The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.
(b) Requirements for notification. Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.
(c) Overpayments resulting from situations other than fraud. An overpayment resulting from a situation other than fraud is discovered on the earliest of—-
  (1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;
  (2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or
  (3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.
(d) Overpayments resulting from fraud.
  (1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in §433.304 of this subchapter) of the State's overpayment determination.
  (2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made 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 any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by §455.15, §455.21, or §455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

(e) Overpayments identified through Federal reviews. If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) Effect of changes in overpayment amount. Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) Effect of partial collection by State. A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

(h) Effect of administrative or judicial appeals. Any appeal rights extended to a provider do not extend the date of discovery.

Title 42, Code of Federal Regulations, Section 433.318 - Overpayments involving providers who are bankrupt or out of business.

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

(b) Overpayment debts that the State need not refund. Overpayments are considered debts that the State is unable to recover within the 1-year period following discovery if the following criteria are met:

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

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

(e) Circumstances requiring refunds. If the 1-year recovery period has expired before an overpayment is found to be uncollectible under the provisions of this section, if the State recovers an overpayment amount under a court-approved discharge of bankruptcy, or if a bankruptcy petition is denied, the agency must refund the Federal share of the overpayment in accordance with the procedures specified in Sec. 433.320 of this subpart.

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 agency must credit CMS with the Federal share of overpayments subject to recovery on the earlier of –

  (i) The Form CMS-64 submission due to CMS for the quarter in which the State recovers the overpayment from the provider; or

  (ii) The Form CMS-64 due to CMS for the quarter in which the 1-year period following discovery, established in accordance with section 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 at the end of the 1-year period if the State has already reported a collection or submitted an expenditure claim reduced by a discrete amount to recover the overpayment prior to the end of the 1-year 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...

12-57 The Department of Health did not maintain federally required documentation for $140,468 in payroll costs charged to the National Bioterrorism Hospital Preparedness Program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.889 National Bioterrorism Hospital Preparedness Program
Federal Award Number:	U3REP090228
Applicable Compliance Component:	Allowable Costs / Cost Principles
Questioned Cost Amount:	$ 140,468.09

Background

The Washington State Department of Health administers the National Bioterrorism Hospital Preparedness Program. This federal grant enhances 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, tribes, health centers, emergency management services and other healthcare partners. These entities oversee training, meetings, purchasing of supplies and equipment, and create and update emergency response plans. The Department spent $6.6 million in Hospital Preparedness Program funds in fiscal year 2012.

Recipients may use grant money only for costs that are allowable and related to the grant's purpose. Federal regulations specify the documentation they 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, 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, so long as the estimate is reconciled to actual work activity at least quarterly.

We reported a finding in our fiscal year 2010 and 2011 audits that the Department did not comply with documentation regulations for employee compensation charged to federal grants. We questioned approximately $448,000 of payroll costs in 2010 and $189,000 in 2011.

Description of Condition

During fiscal year 2012, the Department charged 100 percent of the payroll costs for two employees to the National Bioterrorism Hospital Preparedness Program grant. Although these employees filled out the proper certifications to support charging 100 percent to the grant, we determined they actually worked on multiple federal grant programs. Because they completed certifications, they did not maintain time records or other personnel activity reports as required when working on multiple federal grants.

Cause of Condition

The Department created the positions for the two staff members to support the National Bioterrorism Hospital Preparedness Program grant. Over time, the program became aligned with another federal grant program and these

staff members began performing work related to both. When this happened the Department did not require the staff to start keeping timesheets as is required.

Effect of Condition and Questioned Costs

We identified $140,468.09 in direct payroll and benefits incorrectly charged to the National Bioterrorism Hospital Preparedness Program grants because they 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 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 finding that the Department charged two employees 100% to one grant, although the employees worked less than 100% on that grant. Our corrective action have both employees using positive time and attendance record keeping, effective July 1, 2012.

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.

12-58 The Department of Health did not obtain a Data Universal Numbering System (DUNS) number from subrecipients prior to awarding federal dollars under the HIV Care Formula Grant Program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.917 HIV Care Formula Grants
Federal Award Number:	2X07HA00083-22-00
Applicable Compliance Component:	Subrecipient monitoring
Questioned Cost Amount:	None

Background

The Washington State Department of Health administers the HIV Care Formula Grants. The objective of the program is to provide limited medical care, prescription drugs, and health insurance premium assistance for low to moderate-income people living with Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS). The HIV Client Services unit awards sub-grants to public and nonprofit organizations to plan and deliver services. The program is partly funded by state funds and rebates from pharmaceutical manufacturers.

In fiscal year 2012, the program spent $15.2 million in federal grant funds. Of this amount, $10.9 million was passed through to subrecipients.

Federal law requires state agencies to obtain a Data Universal Numbering System (DUNS) number from a subrecipient before making a sub-award. DUNS numbers are used to identify organizations receiving funding under grants and cooperative agreements and to provide consistent name and address data for electronic grant application systems.

The Department's Grants Management division is responsible for ensuring compliance with this requirement.

Description of Condition

The DUNS number was required by the grant in fiscal year 2012. The Department did not have internal controls in place to ensure it obtained these numbers from subrecipients prior to awarding federal funds.

Cause of Condition

Department management did not follow their own policies and procedures for obtaining DUNS numbers. Department staff did not give subrecipients the form used to collect DUNS numbers as part of the grant contract or inform subrecipients of the requirement to provide a DUNS number.

Effect of Condition

During our audit, we reviewed all of the applicable contracts with subrecipients for fiscal year 2012 and noted that the Department did not obtain a DUNS number from any of its subrecipients.

Therefore, the Department has not complied with this requirement. By not obtaining DUNS numbers from subrecipients prior to awarding federal funds, the Department cannot ensure the public transparency of the money it provides.

Recommendation

We recommend the Department develop internal controls, including appropriate monitoring of its processes by management, to ensure adherence to established policies and procedures for obtaining DUNS number from its subrecipients.

Department's Response

The Department concurs with the State Auditor's Office finding. Upon notification of the issue by the auditor, the program immediately collected DUNS numbers from all current subrecipients. In December 2012, the Department clarified the requirement with staff that the DUNS number will be collected for all sub-contractors by using the Federal Funding Accountability and Transparency Act form. Management will not approve a contract for routing for approval if this form is not attached.

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.

CFR 25.200: Requirements for program announcements, regulations, and application instructions.

(a) Each agency that awards types of Federal financial assistance included in the definition of "award" in §25.305 must include the requirements described in paragraph (b) of this section in each program announcement, regulation, or other issuance containing instructions for applicants that either:
  (1) Is issued on or after the effective date of this part; or
  (2) Has application or plan due dates after October 1, 2010.
(b) The program announcement, regulation, or other issuance must require each entity that applies and does not have an exemption under §25.110 to:
  (1) Be registered in the CCR prior to submitting an application or plan;
  (2) Maintain an active CCR registration with current information at all times during which it has an active Federal award or an application or plan under consideration by an agency; and
  (3) Provide its DUNS number in each application or plan it submits to the agency.
(c) For purposes of this policy:
  (1) The applicant is the entity that meets the agency's or program's eligibility criteria and has the legal authority to apply and to receive the award. For example, if a consortium applies for an award to be made to the consortium as the recipient, the consortium must have a DUNS number. If a consortium is eligible to receive funding under an agency program but the agency's policy is to make the award to a lead entity for the consortium, the DUNS number of the lead entity will be used.
  (2) A "program announcement" is any paper or electronic issuance that an agency uses to announce a funding opportunity, whether it is called a "program announcement," "notice of funding availability," "broad agency announcement," "research announcement," "solicitation," or some other term.

(3) To remain registered in the CCR database after the initial registration, the applicant is required to review and update on an annual basis from the date of initial registration or subsequent updates its information in the CCR database to ensure it is current, accurate and complete.

12-59 The Military Department does not have sufficient internal controls to ensure all of its subrecipients receive audits for the Disaster Grants-Public Assistance program when required.

Federal Awarding Agencies:	U.S. Department of Homeland Security
Pass-Through Entity:	None
CFDA Number and Title:	97.036 Disaster Grants-Public Assistance
Federal Award Number:	FEMA-1499-DR-WA; FEMA-1641-DR-WA; FEMA-1671-DR-WA; FEMA-1682-DR-WA; FEMA-1734-DR-WA; FEMA-1817-DR-WA; FEMA-1825-DR-WA; FEMA-1963-DR-WA; FEMA-4056-DR-WA
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

The Washington Military Department administers the Disaster Grants-Public Assistance program that provides federal assistance with response to and recovery from disasters.

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

The Department and a subrecipient sign an agreement that includes standard terms and conditions, including the audit requirement. It also notifies the subrecipient that it must provide the Department's Finance Division with either a copy of the audit report or a letter explaining why it is exempt from having an audit, no later than nine months after the subrecipient's fiscal year end. The Department also has a written policy and procedures to ensure all subrecipient audits are received and reviewed. The policy and procedures specify that the Finance Division is responsible for receiving, tracking and reviewing all audits. The Finance Division is also responsible for contacting the subrecipient if any audit reports are missing.

Once the audit reports have been received and reviewed they are to be forwarded to the program manager. The program manager is to review the audit reports. If any findings were reported the program manager is responsible for requesting corrective action from the subrecipient and for ensuring the corrective actions are performed.

Description of Condition

The Department does not follow its internal policies and procedures and lacks internal controls to ensure all subrecipients receive an audit.

The Department does not have a process to ensure its subrecipients submit audit reports or identify why they did not need an audit. Instead, the Finance Division staff and program managers wait for audit report notifications from the State Auditor's Office and review the reports as they are published. If Department staff is aware that an auditee has not been audited by the State Auditor's Office, they may check the federal audit clearinghouse records. However, this process alone does not allow the Department to identify:

- Subrecipients who were required to have an audit, but did not have one performed.
- Subrecipients who had an audit, but did not file it with the federal audit clearinghouse.
- Subrecipients who had an organization other than the State Auditor's Office perform the audit.

If the Department does not have contact with all subrecipients, it cannot determine they met audit requirements.

Prior to January 1, 2012, Finance Division staff was using a tracking sheet to record audits that had been reviewed and to identify any audit findings requiring additional action by the Department. As of January 1, 2012, the Finance Division stopped tracking any of the subrecipient audit report information. We were not able to verify which audits were reviewed after that date.

Cause of Condition

The Department has a policy and procedures that would ensure compliance with federal requirements, but was not following them. Management said the policy and procedures were outdated but no other written procedures had been implemented to replace them.

The Finance Division stopped tracking the subrecipient audit information because they believed program staff were performing sufficient monitoring to ensure compliance. The program staff may have been sufficiently reviewing the audits but we were not able to verify this because the program did not document their review. Program staff relied on the centralized tracking for documentation of review and were not aware it had been discontinued until our audit was performed.

Effect of Condition

The Department cannot be certain whether all of its subrecipients comply with federal grant requirements, and, therefore, cannot ensure that it has met the monitoring requirement of its federal grantor.

Recommendation

We recommend the Department follow its existing policy and procedures, or design new ones that will ensure it determines the federal audit status of all subrecipients.

Department's Response

The Department concurs with the findings in this audit. A corrective action plan will be developed to review the current process, rescind the old outdated policy and procedure and rewrite a new policy and procedure that addresses these short comings.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

Section 300

The auditee shall:

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

Section 400(d) - Pass-through entity responsibilities.

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

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

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

Section M. Subrecipient Monitoring:

Compliance Requirements

A pass-through entity is responsible for: …

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

12-60 The Military Department did not file reports required by the Federal Funding Accountability and Transparency Act for the Disaster Grants-Public Assistance program.

Federal Awarding Agency:	U.S. Department of Homeland Security
Pass-Through Entity:	None
CFDA Number and Title:	97.036 Disaster Grants-Public Assistance
Federal Award Number:	FEMA-1963-DR-WA; FEMA-4056-DR-WA
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The Washington Military Department administers the Disaster Grants-Public Assistance program that provides federal assistance with response to and recovery from disasters.

In fiscal year 2012, the Department spent $21.3 million in federal Disaster Grants-Public Assistance program funds.

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

The Accountability Act reporting requirement applies to new awards made after October 1, 2010. Although the requirement has been in effect since 2010, guidance given to auditors by the Office of Management and Budget includes a good-faith effort exception. This exception allows Departments who have not filed the required reports to provide emails, phone logs, screen shots, etc. as evidence that they attempted to file when required. If this evidence is provided, the guidance directs auditors to not issue an audit finding.

Description of Condition

During our review, we found the Department did not have internal controls in place to ensure the fiscal year 2012 Accountability Act reports were filed.

Department staff stated the federal electronic reporting system would not allow them to file the required reports. They also stated they were in communication with the federal grantor regarding this issue and had attempted to get it corrected. However, the Department was unable to provide any documentation to show that it attempted to submit the reports or of communication with the federal grantor during the audit period.

Cause of Condition

We cannot determine if attempts were made to file the reports during the audit period and, therefore, cannot apply the good-faith effort exception.

The Department does not have policies and procedures in place to ensure the reports are filed and any issues are addressed and properly documented.

Effect of Condition

We found the Department did not report 76 sub-awards in excess of $25,000, totaling $6,639,942, which were required to be reported.

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

Recommendation

We recommend the Department design and put in place internal controls that include management oversight for ensuring reports are filed and problems encountered are addressed with the grantor in a timely manner. We also recommend the Department submit all required reports for each sub-award of $25,000 or more by the applicable deadline.

Department's Response

The Contracts Office attempted to comply with the new FFATA reporting requirements upon notification of the new reporting requirement in October 2010. Michael Williams, a contracts specialist was assigned to learn and maintain the new federal reporting system in September 2010. Problems prevented us from entering data were identified from the start of the process. We were in communications with federal systems administration since the reporting requirement started in October 2010.

The system problem still exists today. FEMA representatives acknowledge this fact and their responsibility to rectify the situation. The system problem has been demonstrated to SAO staff and has been confirmed by FEMA Region 10 representatives. While we agree that we are unable to provide any documentation to show that we attempted to submit the reports or of communications with the federal grantor during the audit period, we feel it is unfair to suggest that we did not make a good faith effort to resolve this problem in the past.

The contracts office is in the process of developing a FFATA policy and procedures. This will resolve the internal control issues referenced above. We continue to have issues with FAIN numbers not being associated with our DUNS number, which is preventing us from submitting reports. We are continuing to work with FEMA to get this resolved. We intend to have all past reports filed and up to date within 45 days of FEMA resolving the system problem. All other reports have been submitted and are up to date.

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.

2 CFR 170 Appendix A –Award Term

I. Reporting Subawards and Executive Compensation.
   a. Reporting of first-tier subawards.
      1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and

Reinvestment Act of 2009, Pub. L. 111–5) for a subaward to an entity (see definitions in paragraph e. of this award term).

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

OMB Circular A-133, Part 3 Compliance Requirements, Compliance Supplement 2012

Good Faith Effort

In the event that applicable subawards were not properly reported by a recipient pursuant to FFATA, auditors should evaluate compliance with these requirements based on whether a recipient demonstrated a "good faith" effort to comply. Demonstration of a "good faith" effort by a recipient should be evidenced by proper documentation such as: emails or phone logs of communication between a recipient and the awarding agency or the General Services Administration; or computer screen shots that illustrate recipient attempts to upload information into the FFATA Subaward Reporting System (FSRS). Auditors are not required to report audit findings when there is evidence a recipient demonstrated a "good faith" effort. However, auditors are still required to report audit findings for non-compliance with the FFATA reporting requirements that are not supported by a recipient's demonstrated "good faith" effort. Completed audits which reported audit findings or modifications of opinion based solely on Part 3L, steps 10 and 11 do not need to be amended.

12-61 The Military Department did not comply with the Federal Funding Accountability and Transparency Act reporting requirements for the Homeland Security Grant Program.

Federal Awarding Agency:	U.S. Department of Homeland Security
Pass-Through Entity:	None
CFDA Number and Title:	97.067 Homeland Security Grant Program
Federal Award Number:	EMW-2011-SS-0030-S01; EMW-2011-UA-0034
Applicable Compliance Component:	Reporting
Questioned Cost Amount:	None

Background

The Washington Military Department administers the Homeland Security Grant Program. The program is intended to improve and significantly enhance the ability of the Nation to prevent, deter, respond to and recover from, threats and incidents of terrorism and to enhance regional preparedness. The Homeland Security Program provides financial assistance to the States (and through the States to local governments) to support activities such as planning, equipment, training, and exercises to address critical resource gaps identified in the assessments and priorities outlined within each States' Homeland Security Strategy.

The Department spent $26.3 million in Homeland Security Grant funds in fiscal year 2012, of which $24.8 million was distributed to subrecipients.

Federal Funding Accountability and Transparency Act

Under the Federal Funding Accountability and Transparency Act, the Department is required to collect and report information on each sub-award of $25,000 or more in federal funds in the Federal Funding accountability and Transparency Sub-award Reporting System. The reporting must be done by the end of the month following the month in which the sub-award was made. The Federal Funding Accountability and Transparency Act (Accountability Act) reporting requirement was implemented by the Federal Government to increase transparency and improve access to Federal Government information, particularly information on Federal spending. Reports are required to be filed by the prime recipients of funding by the end of the month following the month in which the funding is awarded to the subrecipient.

Description of Condition

The Washington Military Department was awarded two Homeland Security Grants during the audit period; the primary Homeland Security Grant for $20,018,235 and the Non-Profit Homeland Security Grant for $449,350. Under the requirements of the grant, all funding received under the award is required to be obligated to subrecipients within 45 days of the grant award.

We reviewed the Military Department's records and found that reports for 25 of the grant's 49 subrecipients had not been filed in a timely basis. For reports on 24 subrecipients, the report was filed by the Department anywhere from 25 to 151 days late and for one subrecipient, no report had been filed at all.

Cause of Condition

The Department was aware of the reporting requirement and assigned one person to file the required reports in accordance with the Accountability Act. During the audit period the Department was in the process of establishing internal controls over the reporting process, but had not instituted a requirement for an independent review to verify Accountability Act reports were being filed as required. The Department did not have a process to monitor the activities of that individual to ensure the information was actually submitted. Due to this lack of oversight, the Department was unaware that the employee assigned to file the reports had failed to do so.

The Department did hire a new employee in August 2012 to file overdue Accountability Act reports and has since implemented policies and procedures to ensure it is compliant with the Accountability Act reporting requirements.

Effect of Condition

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

Recommendation

We recommend the Department ensure its policies and procedures are sufficient and operating as designed to ensure all Accountability Act reports are submitted in a timely basis.

Department's Response

The contracts office is in the process of developing a FFATA policy and procedures. This will resolve the internal control issues referenced above. We continue to have issues with FAIN numbers not being associated with our DUNS number, as well as SAM/D&B/FSRS issues which are preventing us from submitting reports. We are continuing to work with FEMA to get this resolved. We intend to have all past reports filed and up to date within 45 days of FEMA resolving the system problem. All other reports have been submitted and are up to date.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

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

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

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

12-62 The Military Department does not have sufficient internal controls to ensure all of its subrecipients receive audits when required and that all subrecipients take timely and appropriate corrective actions for audit findings issued for the Homeland Security Grant Program.

Federal Awarding Agency:	U.S. Department of Homeland Security
Pass-Through Entity:	None
CFDA Number and Title:	97.067 Homeland Security Grant Program
Federal Award Number:	EMW-2008-TU-T8-0004; EMW-2009-SS-T9-0015; EMW-2010-SS-T0-0084; EMW-2011-SS-00030; EMW-2009-UA-T9-0003; EMW-2010-UA-T0-0023; EMW-2011-UA-00034
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

The Washington Military Department administers the Homeland Security Grant Program. The program is intended to improve and significantly enhance the ability of the Nation to prevent, deter, respond to and recover from, threats and incidents of terrorism and to enhance regional preparedness. The Homeland Security Program provides financial assistance to the states (and through the states to local governments) to support activities such as planning, equipment, training, and exercise to address critical resource gaps identified in the assessments and priorities outlined within each state's Homeland Security Strategy.

The majority of the grant funds are distributed to various municipal governments and non-profit organizations. As part of the award process, the Department and each subrecipient sign a contract that includes standard terms and conditions, including the requirement for an audit under U.S. Office of Management and Budget (OMB) Circular A-133 if the subrecipient spends more than $500,000 in federal funding during the year. The agreement also notifies the subrecipient that it must provide the Department's Finance Division with either a copy of their audit report or a letter explaining why it is exempt from having an audit, not later than nine months after the subrecipient's fiscal year end. The Department also has a written policy and procedures to ensure all subrecipient audits are received and reviewed. The policy and procedures specify that the Finance Division is responsible for receiving, tracking and reviewing all audits. The Finance Division is also responsible for contacting the subrecipient if any audit reports are missing.

Once the audit reports have been received and reviewed by the Finance Division, they are to be forwarded to program managers. Program managers are responsible for reviewing the audit reports and determining if the results of the audit affect the Department's grant. If any audit findings were reported and appear to affect grant funds, the program manager is responsible for requesting corrective action from the subrecipient and for ensuring appropriate corrective action is performed.

The Military Department spent $26.3 million in Homeland Security Grant funds in fiscal year 2012, of which $21.8 million was distributed to other governmental entities and non-profit organizations.

Description of Condition

The Department does not follow its internal policies and procedures and lacks effective internal controls to ensure all subrecipients receive an audit. In addition, the Department does not have a consistent method of determining if a finding affects grant funds it awarded and does not consistently follow-up on findings and ensure corrective action is performed by its subrecipients.

The Department does not have a process to ensure its subrecipients submit audit reports or identify why they did not need an audit. Instead, the Finance Division staff and program managers wait for audit report notifications from the State Auditor's Office and review the reports as they are published. If Department staff is aware that an auditee has

not been audited by the State Auditor's Office, they may check the federal audit clearinghouse records. However, this process alone does not allow the Department to identify:

- Subrecipients who were required to have an audit, but did not have one performed.
- Subrecipients who had an audit, but did not file it with the federal audit clearinghouse.
- Subrecipients who had an organization other than the State Auditor's Office perform the audit.

If the Department does not have contact with all subrecipients, it cannot determine they met the Circular A-133 audit requirements.

Prior to January 1, 2012, Finance Division staff was using a tracking sheet to record audit reports that had been reviewed and to identify any audit findings requiring additional action by the Department. As of January 1, 2012, the Finance Division stopped tracking any of the subrecipient audit report information. We were not able to verify which audit reports were reviewed after that date.

The Department is also responsible for issuing management decisions on audit findings within six months after receipt of the subrecipient's audit report, and ensuring the subrecipient takes timely and appropriate corrective action on all audit findings. Our review of the audit reports received by the Department identified five entities with findings in the areas of financial reporting and SEFA preparation. Although these findings were not directly related to the program, the agency did take note of the identified deficiencies and requested follow-up on three of them. Follow-up action for one of the entities had not been performed in a timely manner. The subrecipient was required to provide the Department a report of corrective action by August 2012, but still had not done so by January 2013.

Cause of Condition

The Department has policies and procedures that would ensure compliance with federal requirements, but was not following them. Management said the policies and procedures were outdated but no other written procedures had been implemented to replace them.

The Finance Division stopped tracking the subrecipient audit information because they believed program staff were performing sufficient monitoring to ensure compliance. The program staff may have been sufficiently reviewing the audits but we were not able to verify this because they did not document their review. Program staff relied on the centralized tracking calendar for documentation of review and were not aware it had been discontinued until our audit was performed.

In addition, the Department's policies and procedures did not require assessment of audit findings and requests for corrective action be documented by Program Managers.

Effect of Condition

During our review of the audit report tracking sheets used by the Department, we determined fifteen subrecipients out of 48 reviewed were not listed on the sheet and one subrecipient was listed but no audit report was received. Department personnel confirmed it did not have audit reports from these 16 subrecipients.

The Department cannot be certain whether all of its subrecipients comply with federal grant requirements, and, therefore, cannot ensure that it has met the monitoring requirement of its federal grantor. Furthermore, the Department cannot be certain that its subrecipients respond to and correct deficiencies found in audits in an appropriate and timely manner.

Recommendation

We recommend the Department follow its existing policies and procedures, or design new ones that will ensure all federal requirements are followed.

Department's Response

The Department concurs with the findings in this audit. A corrective action plan will be developed to review the current process, rescind the old outdated policy and procedure and rewrite a new policy and procedure that addresses these short comings.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

Section 300

The auditee shall:

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

Section 400(d) - Pass-through entity responsibilities.

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

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

U.S. Office of Management and Budget Circular A-133, *Compliance Supplement for 2012*, Part 3 – Compliance Requirements states:

Section M. Subrecipient Monitoring:

Compliance Requirements

A pass-through entity is responsible for: …

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

12-63 The Military Department's internal controls over subrecipient monitoring are not working as designed and the Department does not adequately monitor sub-recipients of the Homeland Security Grant Program.

Federal Awarding Agency:	U.S. Department of Homeland Security
Pass-Through Entity:	None
CFDA Number and Title:	97.067 Homeland Security Grant Program
Federal Award Number:	EMW-2008-TU-T8-0004; EMW-2009-SS-T9-0015; EMW-2010-SS-T0-0084; EMW-2011-SS-00030; EMW-2009-UA-T9-0003; EMW-2010-UA-T0-0023; EMW-2011-UA-00034
Applicable Compliance Component:	Sub-recipient Monitoring
Questioned Cost Amount:	None

Background

The Washington Military Department administers the Homeland Security Grant Program. The program is intended to improve and significantly enhance the ability of the Nation to prevent, deter, respond to and recover from, threats and incidents of terrorism and to enhance regional preparedness. The Homeland Security Program provides financial assistance to the states (and through the states to local governments) to support activities such as planning, equipment, training, and exercise to address critical resource gaps identified in the assessments and priorities outlined within each state's Homeland Security Strategy.

The Department spent $26.3 million in Homeland Security Grant funds in fiscal year 2012, of which $24.8 million was distributed to sub-recipients.

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. The Military Department's Subrecipient Monitoring Policy mostly relies on the sub-recipient's risk level, as assessed by program managers, specifically stating, "*the level of monitoring will be dependent on the risk level of subrecipient.*" The Department's policy further directs program staff to use language in the subaward agreement, internal reviews and audits, site visits, and interaction with sub-recipients for monitoring activities. In accordance with these practices, there is little reliance placed on expense reimbursement packages submitted by sub-recipients and the Department requires support *only* for sub-recipient equipment purchases. Monitoring of all other activities and documentation for non-equipment purchases are only required if specifically requested by the Department and/or checked on a sample basis during monitoring activity by Program staff.

The Military Department uses a perpetual calendar to document and schedule monitoring activity for its sub-receipients. The Department suggests a minimum of one formal monitoring activity a year, but at least one every two years. This calendar records dates of all activity, and both previous and future visits. The Department policy requires program managers to maintain reports and documentation of any monitoring activity performed.

Description of Condition

Our review of the Military Department's perpetual submonitoring schedule/calendar found that 17 of the 54 grant sub-recipients had either not been listed on the calendar, never had any documented monitoring activity on the calendar, or had no monitoring activity during fiscal year 2012 or in the two fiscal years prior to our audit.

We requested to see documentation of scheduled submonitoring activity for seven sub-recipients monitored through a site visit or desk audit in the prior two fiscal year periods. The Department could not locate any documentation or reports to support monitoring activity for four of the seven entities.

Cause of Condition

Although the Military Department had designed controls to ensure regular sub-recipient monitoring was scheduled and performed, the calendar used to track this activity was not being used and updated by all staff. In addition, the Department did not have a centralized or uniform manner to document and maintain monitoring reports. In several instances, the Department could not determine if a monitoring activity had actually occurred as shown on the calendar since reports and documents related to the activity could not be located.

Our audit found the Department has no written guidelines in the following areas:

- Establishing minimum monitoring activity for Program staff.
- Requiring or establishing procedures for use and maintenance of the Department calendar as a control.
- Submission and uniform organization and retention of reports and documents related to monitoring activity.
- Documentation of internal risk assessments on sub-recipients and how monitoring activity was affected by the risk assessments.

Effect of Condition

Given the Department does not follow established sub-recipient controls, it cannot validate that its subrecipients are in compliance with required federal requirements and their contract provisions. In addition, the Department cannot validate it is only reimbursing subrecipients for allowable and actual costs.

Recommendation

We recommend the Department establish uniform internal controls and policies and procedures over sub-recipient monitoring activities to ensure sub-recipients comply with required federal and contract provisions. We also recommend the Department only reimburses sub-recipients for actual and allowable costs that are supported by documentation in accordance with federal requirements. We further recommend the Department communicate these expectations to all Program staff and establish procedures to ensure expectations are properly met in a timely manner.

Department's Response

The Department concurs with the findings in this audit. A corrective action plan will be developed to review the current process, rescind the old outdated policy and procedure and rewrite a new policy and procedure that addresses these short comings.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

OMB Circular A-133 Compliance Supplement Subpart C—Auditees

Section 300 - Auditee responsibilities.

The auditee shall: …

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

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

Section 400(d) - Pass-through entity responsibilities.

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

(3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

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

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

(7) Require each subrecipient to permit the pass-through entity and auditors to have access to the records and financial statements as necessary for the pass-through entity to comply with this part.

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

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 for 2012*, Part 3, states in part:

Section M. Subrecipient Monitoring:

Compliance Requirements

A pass-through entity is responsible for:

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