

Schedule of Findings and Questioned Costs

For the Fiscal Year Ended June 30, 2008

Federal Findings and Questioned Costs

08-01 The Department of Social and Health Services does not ensure that retroactive Food Assistance payments to clients are calculated correctly as prescribed by state and federal law.

Federal Awarding Agency:	U.S. Department of Agriculture
Pass-Through Entity:	None
CFDA Number and Title:	10.551, 10.561 Food Stamps
Federal Award Number:	
Applicable Compliance Component:	Activities Allowed/Cost Principles
Questioned Cost Amount:	\$13,995

Background

The Economic Services Administration at the Department of Social and Health Services administers the Food Stamp program for the state. The objective of the program is to help low-income households buy the food they need for good health. The program serves approximately 315,000 households each month and spent more than \$650 million in federal money in fiscal year 2008.

Federal law requires the Department to restore benefits to households that were underpaid or denied due to Department error or court action. The client is eligible for restoration of underpaid benefits for any of the 12 months prior to the month that the client requests restoration or the month that the Department discovers the underpayment. The underpayment is issued in a retroactive allotment equal to the amount of benefits lost during that time regardless of whether the household is eligible or ineligible. Approximately 2,100 retroactive benefit payments totaling \$538,973 were made in fiscal year 2008.

Description of Condition

We initially selected the 20 largest retroactive food assistance benefit payments made during the fiscal year for review. We identified six payments in which caseworkers calculated the total retroactive payment going back further than 12 months, resulting in total unallowable payments of \$5,990.

Based on our results, we expanded our audit work and identified all payments (134) that appeared to have been made for more than 12 months. Of those, we selected the remaining 18 largest for additional review. In each of the 18, we found retroactive benefit payment calculations that included time periods in excess of the 12 months prior as allowed by law. Unallowable payments associated with these totaled \$8,005. The 24 payments we reviewed represent 64 percent of the dollars at risk.

Cause of Condition

Department staff responsible for issuing these types of benefits have not been properly trained in the criterion used to calculate them.

Effect of Condition and Questioned Costs

Some Department clients received food stamp benefits they were not entitled to. Benefit payments related to the files we reviewed totaled \$13,995. Federal auditing requirements state a finding must be reported when the auditor identifies \$10,000 or more in questioned costs for a particular program. We are questioning these costs.

Recommendation

We recommend the Department ensure staff is adequately trained how to calculate retroactive food stamp benefits. Additionally, we recommend the Department consult with the grantor to determine what questioned costs should be repaid.

Department's Response

The Department concurs with the finding.

The Community Services Division (CSD) will re-train field staff on the proper calculation of retroactive payments. Training will focus on both the circumstances when a retroactive payment is indicated and allowed, and the time limitations required by law.

CSD will complete the review of cases cited in this audit to determine the correct supplement amount for which each client was eligible. Nineteen of the cases identified with potential error have been reviewed by headquarters. Nine of the 19 cases required no additional work. Ten of the cases reviewed were sent to the field and have already been corrected. For the remaining cases where the issued amount is incorrect, the Department will continue to follow established rules and policies for establishing an overpayment

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

Auditor's Concluding Remarks

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

Applicable Laws and Regulation

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.

Washington Administrative Code 388-410-0040 states:

“All food assistance benefits underpaid are restored when:

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

08-02 Food Assistance public funds were misappropriated at the Department of Social and Health Services' Economic Services Administration.

Federal Awarding Agency: U.S. Department of Agriculture
Pass-Through Entity: None
CFDA Number and Title: 10.551, 10.561 Food Stamps
Federal Award Number: 2006IS251447
Applicable Compliance Component: Activities Allowed/Cost Principles
Questioned Cost Amount: \$3,795.03

Background

The Department of Social and Health Services, Economic Services Administration, provides cash assistance, work-focused services, food benefits, and social services to help individuals and families meet basic needs and achieve economic independence. The Administration oversees more than 25 federal and state programs aimed at reducing poverty, and promoting parental responsibility and self-sufficiency. Two of these programs are the General Assistance Unemployable (GAU) program and the federal Food Assistance program.

GAU is a state-funded program that provides monthly cash grants to clients who are poor, do not have dependent children and are unable to work because of the effects of a physical or mental disorder. The state pays approximately 50,000 clients a total of approximately \$100 million in general assistance each year. The federal Food Stamp Program provides benefits to individuals and families whose income is below 130 percent of the federal poverty level. The program serves approximately 315,000 households per month and spent more than \$650,000,000 in federal funding in fiscal year 2008. Both of these programs are operated through the Department's 57 Community Services Offices (CSO) located around the state.

In documentation of an investigation done by the Department, we found that in September, 2006, it was reported to Lynnwood CSO management that an employee was conducting illegal activity with former DSHS clients.

The documentation showed CSO management reported the incidents to the Lynnwood Police Department on September 13, 2006. On September 18, 2006, management completed an internal audit of the former clients' cases and found the employee had authorized them to receive financial assistance benefits without requiring documentation to show they were eligible for benefits.

After identifying the questionable activity, management expanded the preliminary investigation to all cases processed by the employee. The original estimate of suspected misappropriations from the expanded investigation was \$68,957 in GAU benefits and \$2,428 in Food Stamp benefits. A more comprehensive review indicated 11 improperly authorized clients were issued \$70,680 in GAU benefits and \$3,919 in Food Stamp benefits in December 2005 through September 2006. The employee was placed on home assignment beginning September 19, 2006 and resigned on November 2, 2006.

The Department of Social and Health Services did not report the suspected loss to the State Auditor's Office as directed by state law (RCW 43.09.185). The State Auditor's Office became aware of the suspected loss through a newspaper article published on April 18, 2008.

Description of Condition

A computer system is used to open benefits' accounts for DSHS clients. The employee manipulated the computer system, making it possible for 11 clients to obtain electronic benefits transfer (EBT) cards and personal identification numbers in order to access those benefits. The employee then used the EBT cards to misappropriate benefits.

We reviewed the Department's investigation and determined the total unauthorized GAU funds deposited on EBT accounts was \$70,680, of which \$70,665.18 was misappropriated through ATM withdrawals, purchases and purchases with cash back. The remaining \$14.82 was left on the EBT account. The employee also authorized \$3,919 in food assistance benefits, of which \$3,795.03 was misappropriated through food purchases. The remaining \$123.97 was left on the EBT account.

The \$70,665.18 in GA benefits was state funds and the \$3,795.03 in food assistance benefits was federal funds.

Cause of Condition

The Department does not have adequate internal controls to ensure all benefits issued to EBT accounts are properly authorized and for legitimate client use.

Effect of Condition and Questioned Costs

Money was misappropriated and the Department was deprived of using it to benefit legitimate recipients. Because this involved federal money, the state may be required to reimburse the federal government its share of the loss.

Recommendation

We recommend the Department establish and follow controls that will ensure all benefits issued to clients are authorized and legitimate. We recommend the Department consult with its grantor to determine what costs need to be repaid.

The Department should seek recovery of \$74,460.21 in misappropriated public funds plus \$4,070.46 in related audit/investigation costs from the former employee. Any compromise or settlement of this claim must be approved in writing by the Attorney General and State Auditor as directed by state law (RCW 43.09.330). Assistant Attorney General Marta DeLeon is the contact person for the Attorney General's Office and she can be reached at 360-753-3168 or martad@atg.wa.gov. The contact for the State Auditor's Office is Jan Jutte, Director of Legal Affairs and she can be reached at 360-902-0363 or juttej@sao.wa.gov.

We further recommend the Department promptly notify the State Auditor's Office of any suspected loss of public funds as directed by state law (RCW 43.09.185).

Insurance coverage for employees is as follows:

Insurance Company:	Traveler's
Policy Number:	104238506
Policy Type:	Commercial Crime Policy
Amount of Coverage:	\$10,000,000
Coverage Period:	August 1, 2004 until cancelled
Deductible Amount:	\$500,000

Department's Response

The Department concurs with the finding that there are not adequate internal controls to ensure all benefits issued to EBT accounts are properly authorized for client use.

To ensure correct issuance of benefits, the Department:

- § *Relies on program requirements that a client must meet in order to be eligible for the benefits*
- § *Trains employees on program requirements, rules, and regulations*

- § *Provides staff with the EAZ manual for guidance on the various program rules and regulations to determine eligibility correctly*
- § *Requires monthly mandatory supervisory audits be completed*
- § *Incorporates stringent design security rules into the system*

Even with all these precautions in place, as with any complex automated business application, there is always a possibility that a worker, intent on engaging in illegal behavior, can work outside the rules to carry out fraudulent activities. In this case, the worker intentionally authorized benefits without going through the proper procedures or following eligibility requirements. To mitigate this incident from happening again, the department has or will take the following actions:

- § *In the initial stages of the internal investigation, the Economic Services Administration (ESA) ran a query that included characteristics of the misappropriated cases. No additional cases were identified from the report.*
- § *ESA will require supervisors to run and review a monthly barcode processed date report to see if there are any questionable timeframes, in addition to mandatory monthly random supervisory audits or the Basic Food Program Management Evaluation audits. The Alderwood Community Service Office has implemented this action and has been reviewing the information monthly.*
- *The Department will work closely with the Attorney General and the State Auditors Office on guidance on pursuing recoupment of the misappropriated public funds.*
- *The Department will send a reminder to all administrations reminding them to promptly notifying the State Auditor's Office of any suspected loss of public funds as directed by RCW43.09.185 and the DSHS Administrative Policy 16.10.*

Auditor's Concluding Remarks

We thank the Department for its response, and the steps it is taking to prevent future occurrences. We look forward to reviewing these improvements during our next audit.

Applicable Laws and Regulations

Section 20.20.20a of the State Administrative and Accounting Manual states, in part:

Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

Section 43.09.185 of the Revised Code of Washington states:

State agencies and local governments shall immediately report to the state auditor's office known or suspected loss of public funds or assets or other illegal activity.

08-03 The Department of Social and Health Services, Economic Services Administration, did not comply with documentation requirements for its Random Moment Time Sample to ensure administrative costs was properly charged to federal and state funds.

Federal Awarding Agency: U.S. Department of Agriculture
U.S. Department of Health and Human Services

Pass-Through Entity: None

CFDA Number and Title: 10.561 Food Stamp Cluster
93.778 Medical Assistance Program
93.558 Temporary Assistance to Needy Families
93.667 Social Services Block Grant
93.596 Child Care Mandatory and Matching Funds
93.566 Refugee and Entrant Assistance – State Programs

Federal Award Number: Multiple

Applicable Compliance Component: Allowable Costs/Cost Principles

Questioned Cost Amount: None

Background

Agencies receiving federal grant money must take reasonable measures to ensure costs charged to federal grants are commensurate with administrative and overhead resources received by those programs.

The Department of Social and Health Services administers many federally funded programs. In order to equitably allocate the costs of administration and overhead to these grants, the Department uses 12 cost allocation methods in its federally approved Public Assistance Cost Allocation Plan. One method it uses is known as the Random Moment Time Sample (RMTS). RMTS is a monthly survey of how a selected sample of how much time administrative and other staff spend working on these programs. The survey results are tabulated and used by the Department to allocate administrative costs.

During the monthly RMTS process, Department “coordinators” are to distribute and gather documents that ask selected staff to provide information describing the services they are performing at the time the survey is done. This data is entered into a computer program that uses the information to allocate administrative costs to federal and state programs for a future month. The federal government must approve the RMTS process before it can be used to compile and allocate charges to the grant programs.

The most recent federally approved RMTS Program Instructions state:

- 1) The actual sample time must be filled in. Samples **must** be completed up to 5 minutes before and up to one hour after the requested sample time to be considered valid.
- 2) In the worker activity section, workers may only complete section A **or** Section B but not both. Section A is to be completed when the work being completed benefits more than one program. Section B is only completed when the work being completed benefits only one program.
- 3) The signature of the worker is required on the bottom of the form, as well as the date completed if in work status. If the employee was on leave or out of the office on an alternate work schedule, the supervisor may sign the form.

These instructions must be followed to make certain the statistical sample is valid and accurate results are entered into the allocation program. If the data is invalid, the accuracy of the allocation cannot be assured.

The Economic Services Administration uses RMTS to allocate administrative costs to the Temporary Assistance to Needy Families, Refugee Cash Medical, Childcare and Development Fund, Social Service Block Grant, Medicaid and Food Stamps programs.

Description of Condition

We visited five field offices, which represented approximately 20 percent of all RMTS samples completed from December 2007 through February 2008. We found many survey documents were not completed as required by the instructions, invalidating the data. We reviewed 863 of 4,458 survey documents completed during the three-month period and found 100 errors, or an 11.59 percent error rate. All of these errors affected the allocation of costs to the federal programs. Further, we noted most of the errors occurred at two field offices. One field office had an error rate of 7 percent and the largest field office in the state had an error rate of 31 percent. The remaining three offices visited had maintained an acceptable error rate of less than 5%.

The errors noted were:

- Forty-seven sample forms did not have a sample time recorded as required, invalidating the samples.
- Twenty-seven sample forms had items marked in both sections A and B. These errors were not corrected prior to entering into the system.
- Twelve sample forms were not dated, or had dates different than sample date because the sample was completed through e-mail on a later date. In all of these cases, the RMTS coordinator recorded the original sample date in the computer, rather than the date the sample was completed.
- Ten samples were completed outside of the allowable window but entered into the system as if they had been completed at the originally requested sample time.
- Three sample forms had no employee signatures.
- One form was signed by the RMTS coordinator when the employee was in work status.

Cause of Condition

Department management did not ensure all RMTS Coordinators responsible for reviewing surveys for compliance with approved instructions understood the RMTS Instructions. Further, not all Coordinators were adequately trained and their work was not monitored to ensure federal requirements were followed.

Effect of Condition

Six federal programs in the Administration rely on the RMTS process for the allocation of administrative charges. If samples are not completed in a manner approved by the federal government, then the amount of administrative costs claimed under each of the federal programs could be reallocated or disallowed.

For the three-month period we audited, the RMTS results were used to allocate the following program expenditures from April through June 2008. The amounts allocated to each program (federal share) for the period were:

CFDA No.	Federal Program Name	Amount Allocated
93.778	Medical Assistance Program	\$ 9,696,921
10.561	Food Stamp Cluster	\$ 8,108,352
93.558	Temporary Assistance to Needy Families	\$ 3,102,873
93.667	Social Services Block Grant	\$ 2,370,188
93.596	Child Care Mandatory & Matching Funds	\$ 2,289,408
93.566	Refugee and Entrant Assistants – State Programs	\$ 58,055
Total		\$ 25,625,797

Because of the complexity of the cost allocation process, we determined it would not be an effective use of audit resources to attempt to establish the portion of these costs which should be questioned.

Recommendation

We recommend the Department ensure all staff responsible for administration and coordination of the RMTS process understand and comply with the survey requirements. This would include training for all RMTS coordinators to ensure they understand the approved process and their responsibilities for reviewing all samples for compliance and correction prior to recording them and using them for allocating costs.

Additionally, we recommend the Department consult with the U.S. Department of Health and Human Services, which is responsible for approving the Department's cost allocation methods, to determine what if any of the costs affected by this compliance issue should be repaid.

Department's Response

The Economic Services Administration (ESA) concurs with the State Auditors Office audit findings for the Random Moment Time Sample (RMTS) and will continue to work with staff on compliance.

Several measures have already been taken to educate staff on RMTS requirements, processes and responsibilities for reviewing samples:

- 1. In October 2008, the RMTS form and the RMTS-Barcode instructions were sent to RMTS Coordinators to ensure that all RMTS Coordinators have a copy to review and refer to.*
- 2. In December 2008, an iESA news article, directed to field staff, was published describing the RMTS process and how to properly complete the forms.*
- 3. The ESA Operations Support Division (OSD) identified members of a workgroup to update the current RMTS instructions and develop training materials for Community Service Office RMTS Coordinators.*

Upon completion of the updated instructions, the ESA OSD Budget Chief will attend a Regional Administrator (RA) meeting to discuss RMTS requirements and brief RAs on next steps, which will include annual training of Community Service Office Administrators and RMTS Coordinators.

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

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 45 Code of Federal Regulations, Subtitle A (10-1-03 Edition)
Section 95.507 - Plan Requirements, sub-section (b.8) states in part:

. . . an adequate accounting and statistical system exists to support claims that will be made under the cost allocation plan.

Section 95.517 - Claims for Federal Financial Participation, sub-section (a) states in part:

A State must claim FFP for costs associated with a program only in accordance with its approved cost allocation plan.

The U.S. Office of Management and Budget's Circular A-87, Attachment B, (11.h) - Support of Salaries and Wages, states:

(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 Aid to Families with Dependent Children (AFDC), 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 (c);

(ii) The entire time period involved must be covered by the sample; and

(iii) The results must be statistically valid and applied to the period being sampled.

The Implementation Guide for Circular A-87, ASMB C-10, (<http://www.hhs.gov/grantsnet/state/asmbc10.pdf>), issued on April 8, 1997 by the U.S. Department of Health and Human Services, subsection 3-21, states in part:

. . . a statistical reporting system (e.g. random moment sampling) should be considered for employees working in dynamic situations (performing many different types of activities on a variety of programs over a short period of time).

08-04 The Department of Social and Health Services is not complying with federal requirements for allocating employee salaries and wages in accordance with its Public Assistance Agency Cost Allocation Plan.

Federal Awarding Agency:	U.S. Department of Agriculture U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	10.561 Food Stamp Cluster 93.563 Child Support Enforcement 93.658 Foster Care Title IV-E 93.667 Social Services Block Grant 93.775 Medical Assistance
Federal Award Number:	Multiple
Applicable Compliance Component:	Allowable Costs/Cost Principles
Questioned Cost Amount:	\$23,394

Background

Federal regulations require the Department of Social and Health Services to prepare and administer a Public Assistance Cost Allocation Plan. The plan must provide a description of procedures the Department uses to identify, measure and allocate all direct and indirect costs to each program its administers. The Plan must be approved by the grantors.

Agency costs charged to federal awards, except those for financial assistance to recipients, medical vendor payments and costs for services and goods provided directly to program recipients must be included in the Plan.

Cost allocation bases are used to accumulate and distribute administrative costs to the benefitting federal programs. These distributions may be based on caseloads, number of employees, employee time and activity reports, or other reasonable criteria.

An administrative cost is eligible for federal reimbursement only if the methodology used to account for and claim the cost is clearly identified as part of an approved Plan.

The Department's Financial Services Administration, Office of Accounting Services is responsible for developing and administering the Plan. In 2007, the agency submitted amendments to its plan that were approved by grantors for use in fiscal year 2008.

Description of Condition

The Department claimed federal reimbursement for employee salaries and benefits that did not comply with the methodologies described in its approved Plan and did not comply with federal Office of Management and Budget (OMB) Circular A-87 requirements regarding documentation for support of wages and benefits charged to federal awards. Circular A-87 requires monthly personnel activity reports such as timesheets when employees work on more than one federal program. This applies whether salary costs are charged directly to a grant, indirectly through a cost allocation process, or through a combination of methods.

For fiscal year 2008, we examined the allocation of \$17.3 million in payroll costs charged during March of that year for compliance with the plan and Circular. We found 12 employees whose salaries were distributed using an unapproved allocation base and whose salaries were charged directly or indirectly to federal grant programs without adequate timesheets or other documentation.

Financial Services Administration

We noted the salaries of two employees were not allocated as required by the plan. The incorrect allocations resulted in \$4,130 being incorrectly charged to the Medical Assistance program.

Social Service Payment System

We noted four employees working on the Social Service Payment System whose costs were allocated using four different methods, however the plan provides that these staff should have been allocated using one specific method. The incorrect allocation resulted in:

- \$10,289 being incorrectly charged to the Medical Assistance program,
- \$1,094 being incorrectly charged to the Social Services Block Grant,
- \$1,718 being incorrectly charged to the Foster Care program, and
- \$1,175 being incorrectly charged to the Food Stamp program.

Economic Services Administration (ESA)

We found six ESA staff members whose salary allocations were inconsistent with the plan. In addition, none of these staff maintain time and effort or alternative documentation to support the allocation of their salaries. The incorrect allocations and lack of adequate support resulted in:

- \$1,280 being incorrectly charged to the Foster Care program.
- \$672 being incorrectly charged to the Social Services Block Grant.
- \$488 being incorrectly charged to the Medical Assistance program.
- \$1,333 being incorrectly charged to the Food Stamp program.
- \$1,215 being incorrectly charged to the Child Support Enforcement Program.

Cause of Condition

Staff responsible for establishing how these positions will be allocated in the Department’s payroll system were not aware of federal regulations regarding allocation under the plan and documentation for employees whose positions are paid through these grants.

Effect of Condition and Questioned Costs

When a public assistance agency charges federal programs outside of the methods approved in the Plan, federal grantors cannot be assured costs allocated to their programs are accurate and valid.

Further, without adequate time and effort documentation, federal grantors cannot be assured salaries and wages charged to their programs are accurate and valid. This could jeopardize future federal funding.

We are questioning the following costs because they were allocated directly to federal programs or they were allocated through cost allocation bases that were not approved in the Plan and were charged without adequate time and effort documentation.

Questioned Costs by Division for March 2008:

	ESA	FSA	SSPS	Totals
Medicaid Cluster				
Federal	\$ 244	\$ 2,065	\$ 5,144	\$ 7,453
State Match	244	2,065	5,145	7,454
Social Services Block Grant				
Federal				
State Match	\$ 672		\$ 1,094	\$ 1,766
Child Support Enforcement				
Federal				
State Match	\$ 802			\$ 802
	413			413
Foster Care Title IV-E				
Federal	\$ 640		\$ 859	\$ 1,499

State Match	640		859	1,499
Food Stamp Cluster				
Federal	\$ 1,137		\$ 588	\$ 1,725
State Match	196		587	783
				\$ 23,394

Our audit examined payroll costs allocated in March 2008. However, we believe if these costs were allocated in the same manner for the entire fiscal year likely questioned costs will approximate \$280,728.

Recommendations

We recommend that DSHS:

- Establish procedures to ensure salary allocation is consistent with the approved Public Assistance Cost Allocation Plan.
- Comply with time and effort standards contained in OMB Circular A-87 for payroll costs.

The Department should consult with its federal grantors to determine if questioned costs should be repaid.

Department's Response

Financial Services Administration

The Financial Services Administration (FSA), Office of Financial Recovery (OFR) and Information Technology Office (ITO) do not concur with the FY08 SAO audit findings that staff are incorrectly charged to the Medical Assistance program. Although the department does concur that it does not have sufficient documentation to support the allocation of costs.

In the Office of Financial Recovery, Base 531 was established for the OFR Estate Recovery Unit. The Enforcement Manager's position was charged to base 531 at a higher percentage due to the greater amount of work effort necessary in estate recovery collections. The manager spends a disproportionate amount of time on estate cases due to: the higher dollar amounts per case, the legal proceedings and the numerous people involved in each case. We will improve the documentation on how the position is charged to the benefiting funding sources as described in Public Assistance Cost Allocation Plan's base (ICP) 531 methodology.

In the Information Technology Office, the staff attributed to the cost allocation finding spends 100% of their time solely for the administration and maintenance of the Purchasing Management Extra (PMX) system. At the end of the year, the ITO staff generates PMX reports to calculate the dollar value of the consumable inventory at each warehouse or institution. This ITO staff time is then allocated to each of the programs operating institutions and/or warehouse based upon its proportion of the inventory. ITO will maintain and provide documentation on how the position is charged to the benefiting funding sources as described in Public Assistance Cost Allocation Plan.

Social Service Payment System

The Social Service Payment System (SSPS) concurs with the FY08 SAO audit finding concerning the allocation of staff time related to four (4) SSPS positions. The coding for the four positions in question will be changed to charge directly to the SSPS Project effective April 1, 2009. The Administrative Services Division will work with the Children's Administration, Developmental Disabilities, Long Term Care Services, and the Economic Services Administration to seek reimbursement of the charges via a Memorandum of Understanding that will detail the cost recovery methodology. The Public Assistance Cost Allocation Plan will be updated to reflect this methodology.

Economic Services Administration (ESA)

The Economic Services Administration (ESA) concurs with the FY08 SAO audit findings for Cost Allocation and will continue to work towards compliance. The ESA Operations Support Division (OSD)

will contact each respective region regarding employees identified in the audit to determine the appropriate course of action. If necessary, account coding and/or the written Public Assistance Cost Allocation Plan will be updated. Cost Allocation will continue to be discussed at the quarterly Regional Business Manager meetings and the ESA OSD will attend a Regional Administrator meeting to discuss Cost Allocation requirements.

Auditor's Concluding Remarks

We thank the Department for its response, and follow up on this issue during our next audit.

Applicable laws and Regulations

Title 45 Code of Federal Regulations, Subtitle A (10-1-03 Edition), Section 95.507 - Plan Requirements, sub-section (b.8) states in part:

... an adequate accounting and statistical system exists to support claims that will be made under the cost allocation plan.

Plan requirements.

(a) The State shall submit a cost allocation plan for the State agency as required below to the Director, Division of Cost Allocation (DCA), in the appropriate HHS Regional Office. The plan shall:

(1) Describe the procedures used to identify, measure, and allocate all costs to each of the programs operated by the State agency...

(4) The procedures used to identify, measure, and allocate all costs to each benefiting program and activity (including activities subject to different rates of FFP).

Section 95.517 - Claims for Federal Financial Participation, sub-section (a) states in part:

A State must claim FFP for costs associated with a program only in accordance with its approved cost allocation plan.

The U.S. Office of Management and Budget's Circular A-87, Cost Principles for State, Local and Indian Tribal governments provides in:

Attachment A, Section C.3 of the Circular requires allocable costs to be chargeable or assignable in accordance with the relative benefits received.

Attachment B, Section 8(h) of the Circular states in part:

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

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

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

(3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications

that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi annually and will be signed by the employee or supervisory official having first hand knowledge of the work performed by the employee.

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

- (a) More than one Federal award,
- (b) A Federal award and a non Federal award,
- (c) An indirect cost activity and a direct cost activity,
- (d) Two or more indirect activities which are allocated using different allocation bases, or
- (e) An unallowable activity and a direct or indirect cost activity.

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

- (a) They must reflect an after the fact distribution of the actual activity of each employee,
- (b) They must account for the total activity for which each employee is compensated,
- (c) They must be prepared at least monthly and must coincide with one or more pay periods, and
- (d) They must be signed by the employee.
- (e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:

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

...(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 award.

08-05 The Department of Social and Health Services did not comply with federal requirements for time and effort documentation for the Medical Assistance and Food Stamps Employment and Training programs.

Federal Awarding Agency: U.S. Department of Agriculture
U.S. Department of Health and Human Services

Pass-Through Entity: None

CFDA Number and Title: 10.561 Food Stamp Cluster
93.775 Medical Assistance Cluster

Federal Award Number: Multiple

Applicable Compliance Component: Allowable Costs/Cost Principles

Questioned Cost Amount: \$141,515

Background

State agencies may claim reimbursement from federal programs in one of two ways. Costs may be directly charged to a specific grant based on the benefits received or may be allocated through the use of an indirect cost base to multiple programs or funding sources.

Cost allocation bases are used to accumulate and distribute administrative costs to multiple benefitting state and/or federal programs. These distributions may be based on caseloads, number of employees, employee time and effort reports, or other reasonable criteria.

Federal requirements specify how employee salaries and wages charged to federal programs are to be documented. Salaries of employees who charge to multiple funding sources are to be supported by monthly personnel activity reports or equivalent documentation, such as time sheets.

The personnel activity reports are to reflect the actual hours employees work on each program and are used as a basis for requesting federal funds. Budget estimates are allowable on an interim basis if adjustments to actual costs are made at least quarterly.

We have reported findings in this area at Department in each of the preceding three years.

Description of Condition

The Department's Economic Services Administration (ESA) claimed federal reimbursement for employee salaries and benefits that did not comply with federal Office of Management and Budget Circular A-87 requirements regarding documentation for support of salaries and wages charged to federal awards.

Specifically, we examined the allocation of 2,130 staff salaries during March 2008. We found 66 employees whose salaries were charged both directly to a federal grant program and indirectly allocated without adequate timesheets or other documentation to support the split between the two different funding sources.

We found:

- Sixty-four ESA social workers or financial services specialists working in Community Services Offices who charged 10 percent to 90 percent of their salaries to the Medical Assistance Program without adequate time and effort documentation. The remainder of their salaries was allocated correctly through an approved method. We are questioning \$137,216 in unsupported salaries charged to the Medical Assistance Program in March of 2008. Since these questioned costs are based on review of one month, it is likely that questioned costs for the entire fiscal year could be in excess of \$1.6 million.

- Two ESA staff in a Community Service Office, who were partially allocated and partially direct charged to the Food Stamps Employment and Training Program without adequate time and effort documentation. We are questioning \$4,299 charged directly to the Food Stamps Employment and Training Program without adequate support. Likely questioned cost for the entire fiscal year were \$51,591.

Cause of Condition

In response to prior findings, the DSHS has updated its Federal Compliance with Time Certification policy, which requires monthly time reporting for employees who work directly on federal programs and who also charge indirectly through a cost allocation. Once a quarter, employees are required to review monthly documentation of hours spent on each program or activity and sign a certification that contains the following wording:

“I certify the account coding was reviewed and determined to be accurate for the work being performed and that this position works on multiple activities, **which are supported by personnel activity reports or equivalent documentation** (emphasis added) and are correctly charged to the applicable federal program. Certification of this form ensures DSHS complies with SAAM 50.20.40 and OMB Circular A-87.”

We found 64 of the 66 employees had completed a quarterly certification of salary charges but did not prepare personnel activity reports upon which to base it. ESA staff maintained the policy is confusing and may be misleading staff into believing they comply with federal regulations by signing the quarterly certification.

Without adequate time and effort documentation, federal grantors cannot be assured that salaries and benefits charged to programs are accurate and valid. This could jeopardize future federal funding to the state. We are questioning unsupported salary costs of \$141,515.

Recommendations

We recommend the Department:

- Consult with the federal grantor to determine whether questioned costs should be repaid.
- Ensure its policy clearly communicates the federal requirements for documentation of salaries and wages for staff who charge more than one federal grant.
- Provide training to regional staff responsible for monitoring compliance with time and effort requirements.

Department's Response

The Economic Services Administration (ESA) concurs with the State Auditors Office audit findings for Time and Effort and will continue to work with staff on compliance. The following measures have already been taken to educate staff on these requirements:

1. *In January 2008, the DSHS Office of Accounting Services presented Time and Effort training to fiscal staff at the Regional Business Manager (RBM) meeting.*
2. *In June and August 2008, the DSHS Administrative Policies regarding Time and Effort (19.50.01.A & 19.50.01.B) were updated and sent to the RBMs giving staff a clearer understanding of applicable state and federal requirements*
3. *The Community Services Division Director has followed-up by requiring the RBMs to train all appropriate staff in the field.*

Time and Effort will continue to be discussed at the quarterly Regional Business Manager meetings to ensure RBMs have the most accurate information, provide an opportunity to discuss questions, and to share best practices. Additionally, the ESA Operations Support Division (OSD) Budget Chief will attend a Regional Administrator meeting to discuss Time and Effort requirements. ESA OSD Fiscal Services Office, in conjunction with a recently formed RMTS Workgroup, will evaluate the Random Moment Time Sample (RMTS) process to determine if additional programs can be included in the sample as a means to automate the reporting functionality and decrease the need for time sheets.

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

Auditor's Concluding Remarks

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

Applicable laws and Regulations

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

Attachment A, Section C.3 of the Circular requires allocable costs to be chargeable or assignable in accordance with the relative benefits received.

Attachment B, Section 8(h) of the Circular states in part:

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

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

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

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

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

- (a) More than one Federal award,
- (b) A Federal award and a non Federal award,
- (c) An indirect cost activity and a direct cost activity,
- (d) Two or more indirect activities which are allocated using different allocation bases, or

(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.

08-06 The Recreation and Conservation Office does not have adequate internal controls over sub-recipient monitoring.

Federal Awarding Agency:	U.S. Department of Commerce
Pass-Through Entity:	Washington State Recreation and Conservation Office
CFDA Number and Title:	11.438 Pacific Coast Salmon Recovery
Federal Award Number:	NA16FP2596, NA03NMF4380227, NA04NMF4380260, NA05NMF4381269, NA06NMF4380091 and NA07NMF4380301
Applicable Compliance Component:	Subrecipient Monitoring
Questioned Cost Amount:	None

Background

The Recreation and Conservation Office received over \$19 million in federal grants from the U.S. Department of Commerce for salmon recovery efforts during fiscal year 2008. Approximately 97 percent of this money is passed on to sub-recipients such as cities, towns, counties, state agencies, special-purpose districts, non-profit organizations, Indian tribes and private landowners. Projects frequently take several years to complete. Federal regulations require the Office to monitor sub-recipients to ensure they are complying with grant requirements.

During our fiscal year 2007 audit, we reported the Office did not adequately monitor sub-recipients.

Description of Condition

We reviewed the Office's corrective action plan and improvements that had been made since our last audit. While we found some issues had been resolved, we found sub-recipient monitoring still is inadequate.

Allowable costs/cost principles

Pass-through entities are to provide reasonable assurance that the costs of goods and services charged to federal awards are allowable and charged in accordance with regulations. While the Office reviews sub-recipients' costs for allowability prior to reimbursement, it does not require supporting documentation such as receipts, invoices or timesheets. Although certain costs are allowable, the Office requires only a check number or a term such as "payroll" as documentation for reimbursement.

We also found compensating controls were not operating as designed. The Office does not regularly inspect project sites or review sub-recipients' financial records. As a result of the prior year finding, the Office stated it would use a risk analysis to help determine the level of monitoring required. The Office has not implemented these compensating controls.

Earmarking

Sub-recipients are allowed to use a percentage of grant funds for administrative costs related to the grant. Pass-through entities are to provide reasonable assurance that only allowable costs that are properly calculated and valued are included in these costs. We could not determine whether these requirements were met due to the inadequacy of supporting documentation.

Cause of Condition

Office management believed the documentation it receives on sub-recipient costs was sufficient evidence of allowability. In addition, Office management did not allocate adequate resources to review sub-recipients' financial records or conduct risk assessments of sub-recipients prior to funding.

Effect of Condition

The Office cannot ensure that costs reimbursed to sub-recipients are accurate or allowable. Because the Office distributes grant money to non-profits, tribes and private landowners who are not required to have an

audit unless their federal expenditures are more than \$500,000, the risk of non-compliance is increased. In calendar year 2007, the Office provided federal funding to at least 45 sub-recipients who were not required to have an audit.

The Office spent more than \$19 million of Pacific Coast Salmon Recovery grant funds in fiscal year 2008. Due to the lack of supporting documentation, it was not possible to determine if these costs were allowable.

Recommendations

We recommend the Office establish and follow policies and procedures to effectively monitor sub-recipients' use of federal funds. The Office should require supporting documentation such as receipts and invoices, or establish adequate compensating controls to ensure all costs are allowable and were made in accordance with federal restrictions.

Office's Response

We thank the auditor for their review of RCO processes and files. RCO takes the stewardship of any funds very seriously. Review of RCO accounting practices by the SAO is just one way we ensure that the agency is appropriately using grant funds.

We have made important progress since the last audit when we indicated that our updated controls would be in place by June, 2009. RCO continues to develop compensating controls. This will include a risk assessment tool, sub-recipient fiscal review (both in person and through the mail), and A-133 audit review. We are still on target to fully implement by June 2009.

We appreciate the State Auditor's guidance as RCO moves to updating our grant reimbursement process to allow electronic billing and performance-based contracting. We need to work together to finding new ways to maintain our financial stewardship obligations while continuing our efforts to implement the state's goals on sustainability. Requiring sub-recipients to copy and mail thousands of individual receipts, invoices and timesheet wastes funds and natural resources. As we implement a risk-based approach to sub-recipient monitoring, RCO does not anticipate requiring all sub-recipients to provide all supporting documents.

Allowable costs/cost principles

RCO is working on compensating controls. Finalizing and implementing the compensating controls has been a work in progress. RCO is working with OFM and agency staff. Major compensating controls will include:

- Risk Assessment*
- Sub-Recipient Monitoring*
- A-133 Audit Review*
- Grant Management and Fiscal Site Visits*

Earmarking

It is unclear why this finding has a heading of "Earmarking". The explanation provided by the SAO does not seem to relate the finding to the category of earmarking. RCO believes the system of reimbursement is adequate for capturing administrative and direct project charges. However, we will use our reviews and risk management tool to ensure sub-recipients are capturing this information correctly.

Auditor's Concluding Remarks

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

Applicable Laws & Regulations

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

The auditee shall:

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

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, outlines responsibilities for pass-through entities receiving federal funds and states in part:

Subsection D – Federal Agencies and Pass-Through Entities

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 those performance goals are achieved.
- (4) Ensure that subrecipients expending \$300,000 (\$500,000 for fiscal years ending after December 31, 2003) or more in Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.
- (5) Issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.
- (6) Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.
- (7) Require each subrecipient to permit the pass-through entity and auditors to have access to the records and financial statements as necessary for the pass-through entity to comply with this part.

Subsection B – Audits

210(a) General:

An auditee may be a recipient, a subrecipient, and a vendor. Federal awards expended as a recipient or a subrecipient would be subject to audit under this part. The payments received for goods or services provided as a vendor would not be considered Federal awards.

08-07 The Department of Community, Trade, and Economic Development did not comply with federal performance reporting requirements.

Federal Awarding Agency: U.S. Department of Housing and Urban Development
Pass-Through Entity: None
CFDA Number and Title: 14.239 Home Investment Partnerships Program
Federal Award Number: M03-SG-53-0100, M04-SG-53-0100, M05-SG-53-0100, M06-SG-53-0100, M07-SG-53-0100
Applicable Compliance Component: Reporting
Questioned Cost Amount: None

Background

The federal Home Investment Partnership Program (HOME) is administered in this state by the Housing Division at the Department of Community, Trade, and Economic Development. Grant funds may be used for housing rehabilitation, tenant-based rental assistance, assistance to homebuyers, acquisition of housing, and construction of housing. Funding also may be used for other necessary and reasonable activities related to the development of non-luxury housing, such as site acquisition, site improvements, demolition and relocation.

The grant program is designed to expand the supply of affordable housing, particularly rental housing, for low- and very low income Americans; to strengthen the abilities of state and local governments to design strategies to develop and achieve adequate supplies of decent, affordable housing; to provide financial and technical assistance to participating jurisdictions, including the development of affordable low-income housing programs; and to extend and strengthen partnerships among governments and the private sector, including for-profit and nonprofit organizations, in the production and operation of affordable housing.

The Department spent \$8,684,190 in grant money during fiscal year 2008. Nearly 95 percent was paid to grant subrecipients.

Federal regulations require the Department to submit an annual performance report on the program. The format and content of this report is specified by the grantor.

Description of Condition

We determined the Department did not submit the required performance report during state fiscal year 2008. The Department further stated it has never submitted this report.

Cause of Condition

Program management was aware of the reporting requirement but stated that the grantor had never directed it to submit the report.

Effect of Condition

The required performance report summarizes economic opportunities for low- and very low-income individuals. Non-compliance with this requirement prevents the grantor from monitoring local economic development, neighborhood economic improvement and economic self-sufficiency.

Recommendations

We recommend the Department work with the grantor to define performance reporting requirements. The Department should build these performance reporting requirements into subrecipient contract, update policies and procedures to include these requirements, and submit the report annually.

Department's Response

We concur with the finding. As stated in the finding, the U.S. Department of Housing and Urban Development (HUD) has not provided clear direction on the scope of the report or made an issue of the fact that the report has not been submitted. The Section 3 reporting issue was not raised during several program reviews conducted by HUD personnel at CTED. HUD programs in many other states are also currently affected by this issue.

CTED's Housing Division has determined what it believes are the performance reporting requirements and will file the required report by the due date of March 31, 2009.

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

March 2008 OMB Circular A-133 Compliance Supplement, chapter 4-14.239-6 states in part:

2. Performance Reporting

HUD 60002, Section 3 Summary Report, Economic Opportunities for Low- and Very Low-Income Persons (OMB No. 2529-0043) – For each grant over \$200,000 that involves housing rehabilitation, housing construction, or other public construction, the prime recipient must submit Form HUD 60002 (24 CFR sections 135.3(a) and 135.90).

Key Line Items –

- a. 3. Dollar Amount of Award
- b. 8. Program Code
- c. Part I, Column C – Total Number of New Hires that are Sec. 3 Residents
- d. Part II, Contracts Awarded, 1. Construction Contracts
 - (1) A. Total dollar amount of construction contracts awarded on the project
 - (2) B. Total dollar amount of construction contracts awarded to Section 3 businesses
 - (3) D. Total number of Section 3 businesses receiving construction contracts
- e. Part II, Contracts Awarded, 2. Non-Construction Contracts
 - (1) A. Total dollar amount of all non-construction contracts awarded on the project/activity
 - (2) B. Total dollar amount of non-construction contracts awarded to Section 3 businesses
 - (3) D. Total number of Section 3 businesses receiving non-construction contracts

08-08 The Department of Community, Trade, and Economic Development did not comply with federal suspension and debarment requirements for subrecipients.

Federal Awarding Agency:	U.S. Department of Justice
Pass-Through Entity:	None
CFDA Number and Title:	16.575 Crime Victim Assistance
Federal Award Number:	2008-VA-GX-0012
Applicable Compliance Component:	Suspension and Debarment
Questioned Cost Amount:	None

Background

The Victims of Crime Act (VOCA) is the primary source of federal financial support for direct services to crime victims. The Department of Community, Trade, and Economic Development is the designated VOCA assistance agency for the state. This money is used to administer programs for victims of sexual assault; crime victim service centers; and domestic violence. In fiscal year 2007, the Department received \$7.6 million in VOCA money.

The state uses 5 percent of the award to administer the programs. The remainder, approximately \$7.2 million, is allocated to the three programs. The Department subcontracts for services to domestic violence victims with the Department of Social and Health Services and with private organizations to provide the other services.

The Department is responsible for ensuring subrecipients are not suspended or debarred from participating in federally funded programs by doing one of the following: obtaining a signed certification from each subrecipient; adding a clause or condition in each contract that contains appropriate suspension and debarment language; or checking the Excluded Parties List System on the Internet.

Description of Condition

The Department includes all of the appropriate language pertaining to suspension and debarment in the General Terms and Conditions agreements with the subrecipients. However, a disclaimer at the beginning of the suspension and debarment statement states: "This section applies to contractors receiving an award of \$100,000 or more". No suspension and debarment dollar threshold for subrecipient agreements is included in federal regulations.

Cause of Condition

The Department was following inaccurate guidance provided on the grantor's Web site. The Web site stated the suspension and debarment threshold for all agreements was \$100,000.

Effect of Condition and Questioned Costs

Without adequate suspension and debarment contract language, the Department may be held liable for any amounts paid to subrecipients that have been suspended or debarred from receiving federal funds.

We found the Department awarded four VOCA subrecipients for amounts that were less than \$100,000 in state fiscal year 2008.

Recommendation

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

Department Response

We concur with the finding. The Office of Crime Victims Advocacy section of the agency followed contract language recommended by the Office of Justice Programs Financial Guide located on their website. We now understand that the guidance was inaccurate. This contract language issue was not raised during a program review by the Department of Justice, Office of Justice Programs, Office for Victims of Crime conducted within the past year.

All new contracts effective July 1, 2009 will have the required suspension and debarment language as found in the agency's standard contract template.

Auditor's Concluding Response

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

28 Code of Federal Regulations

PART 66_UNIFORM ADMINISTRATIVE REQUIREMENTS FOR GRANTS AND COOPERATIVE

Subpart C_Post-Award Requirements

Sec. 66.35 Subawards to debarred and suspended parties.

Grantees and subgrantees must not make any award or permit any award (subgrant or contract) at any tier to any party which is debarred or suspended or is otherwise excluded from or ineligible for participation in Federal assistance programs under Executive Order 12549, "Debarment and Suspension."

08-09 The Washington State Patrol did not comply with federal requirements for suspension and debarment for the National Motor Carrier Safety program.

Federal Awarding Agency: U.S. Department of Transportation
Pass-Through Entity: None
CFDA Number and Title: 20.218 National Motor Carrier Safety
Federal Award Number:
Applicable Compliance Component: Suspension and Debarment
Questioned Cost Amount: None

Background

The Federal National Motor Carrier Safety Program is administered in the state by the Washington State Patrol.

The program's objective is to reduce the number and severity of accidents and hazardous material incidents involving commercial motor vehicles by substantially increasing the level and effectiveness of enforcement activity and the likelihood that safety defects, driver deficiencies, and unsafe carrier practices will be detected and corrected. Total expenditures in fiscal year 2008 were approximately \$4.6 million.

Federal regulations prohibit recipients of federal awards from contracting with vendors suspended or debarred from doing business with the federal government. The federal government may debar a party for fraud convictions, anti-trust violations, forgery or other offenses indicating a lack of business integrity or honesty, a history of failure to perform agreements or a failure to pay a substantial debt.

For any purchase contract that exceeds or is expected to exceed \$25,000, grantees must verify the contractor has not been suspended or debarred by doing one of three things: checking the federal Excluded Parties List; collecting a certification from the vendor; or adding a clause or condition to the contract.

Description of Condition

We noted the Patrol makes most of its large purchases for this program, such as vehicles and computer equipment, through use of state master contracts, which are negotiated and established by the state Department of General Administration. The master contract process allows multiple agencies to participate in the contract, and receive the generally favorable terms which had been negotiated for the state as a whole. Since General Administration does not know the funding sources various agencies may use to purchase goods or services through a master contract, it does not include compliance with federal suspension and debarment requirements as part of its process unless specifically requested by an agency. We reviewed six master contracts, with related purchases totaling over \$283,000. For the contracts we reviewed, no suspension and debarment certifications or clauses were included, and neither General Administration nor the State Patrol checked the Excluded Parties List.

Cause of Condition

The State Patrol relied on the master contract procurement process. The Patrol was unaware that it was responsible for ensuring compliance with suspension and debarment requirements when participating in state master contracts.

Effect of Condition

The State Patrol cannot ensure federal funds are paid to vendors that are eligible to participate in federal programs. Any payments made to an ineligible party are unallowable and would be subject to recovery by the funding agency. However, we were able to verify that the vendors had not been suspended nor debarred and we are not questioning these costs.

Recommendation

We recommend the State Patrol establish and follow internal controls over suspension and debarment requirements to ensure vendors receiving \$25,000 or more are eligible to participate in federal programs.

Agency's Response

We concur with the finding and recommendation of the State Auditor's Office that the State Patrol did not insure compliance with federal suspension and disbarment certifications for purchases made off of master state contracts awarded by the state Department of General Administration. We have implemented procedures to insure that the federal suspension and disbarment certifications are completed for all future purchases.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 49 of the Code of Federal Regulations, Section 18.35 states:

Grantees and subgrantees must not make any award or permit any award (subgrant or contract) at any tier to any party which is debarred or suspended or is otherwise excluded from or ineligible for Participation in Federal assistance programs under Executive Order 12549, "Debarment and Suspension."

08-10 Federal funds were misappropriated at the Department of Social and Health Services’ Division of Children and Family Services.

Federal Awarding Agency: U.S Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: 93.658 Foster Care – Title IV-E
93.667 Social Services Block Grant
93.558 Temporary Assistance for Needy Families
93.777 Medicaid
93.659 Adoption Assistance
Federal Award Number: Foster Care Title IV; G-0801WA1401, G0701WA1401
Social Services Block Grant; G-0701WASOSR, G-0801WASOSR
Temporary Assistance for Needy Families; G-0702WATANF, G-0802WATANF
Medicaid; 5-0805WA5028, 5-0805W5048, 5-0705WA5028, 5-0705W5048
Adoption Assistance; G-0801WA1407, G-0701WA1407
Applicable Compliance Component: Allowable Cost; Activities Allowed
Questioned Cost Amount: \$1,278.78 Foster Care Title IV
\$1,072.94 Social Services Block Grant
\$ 910.01 Temporary Assistance for Needy Families
\$ 355.30 Medicaid
\$ 166.04 Adoption Assistance

Background:

The Department of Social and Health Services’ Children's Administration Division of Children and Family Services (DCFS) is located in regional field offices. It works to provide services to children and families experiencing family conflict or who have abuse and/or neglect issues.

In May 2008, questionable overtime by a social worker prompted Division management to review the employee’s time and travel.

Management contacted Department clients to confirm the social worker had made the visits he reported. The clients informed management the employee did not make on-site visits on days for which he requested and received travel reimbursements. Management contacted the Washington State Patrol on May 13, 2008 and requested an administrative investigation.

The State Auditor’s Office received a loss report from the Department on July 29, 2008 stating the employee submitted mileage reimbursements for home visits with foster children that did not occur.

The Washington State Patrol (WSP) conducted an administrative investigation of this matter (Case No. D08-211). The Department promptly notified the State Auditor Office about a suspected loss of public funds as required by RCW 43.09.185.

Description of Condition:

Social workers document their interactions with their clients in a database. Social workers submit travel reimbursement requests to their immediate supervisor for review and approval. To ensure each request is accurate, the supervisor will often compare the request to documentation in the database.

To create the appearance each falsified travel voucher request was legitimate, the employee documented in the database that he visited clients and interviewed children and families. When the employee’s supervisor compared the travel reimbursement requests to the database, the supervisor observed documentation of site

visits performed. During the WSP investigation, the employee stated documentation was falsified and visits were never performed.

The Department uses a federally approved method for allocating administrative costs, including payroll and travel, amongst various federal funding sources, including Foster Care Title IV, Social Services Block Grant, Temporary Assistance for Needy Families and Medicaid. The Department does not have documentation to show the employee did not actually work his required hours, and so does not question his wages earned. However, the travel cost reimbursements received by the employee for the trips that did not occur are considered a misappropriation of funds. The total amount of suspected loss was \$6,152.84. Of this amount, the State Auditor's Office estimates \$3,783.08 was paid with federal dollars from the following programs:

- \$1,278.78 for Foster Care Title IV; CFDA 93.658
- \$1,072.94 for the Social Services Block Grant (SSBG); CFDA 93.667
- \$910.01 for Temporary Assistance for Needy Families (TANF); CFDA 93.558
- \$355.30 for Medicaid; CFDA 93.777
- \$166.04 for Adoption Assistance; CFDA 93.659

Cause of condition:

A social worker falsified documentation and submitted reimbursement requests based on that documentation.

Effect of condition:

The misappropriation of \$6,152.84 by the social worker deprived the Department of the use of these funds. Because \$3,783.08 of the misappropriation was federal money, the state may be required to reimburse the federal government its share of the loss.

Recommendation:

We recommend the Department consult with its grantor to determine what costs need to be repaid.

In addition, we recommend the Department seek recovery of \$6,152.84 in misappropriated mileage reimbursements plus an additional \$1,530 in audit cost from the former social worker. Any compromise or settlement of this claim must be approved in writing by the Attorney General and State Auditor as directed by state law (RCW 43.09.330). Assistant Attorney General Marta DeLeon is the contact person for the Attorney General's Office and she can be reached at 360-753-3168 or martad@atg.wa.gov. The contact for the State Auditor's Office is Jan Jutte, Director of Legal Affairs and she can be reached at 360-902-0363 or juttej@sao.wa.gov.

Department Response:

The Department concurs with the findings of this investigation and appreciates the help of the Washington State Patrol and the State Auditors Office. The \$7,682.84 loss, which includes the \$1530, is being referred to the department's Office of Financial Recovery, (OFR) for collection. The federal share of the loss will be appropriately refunded to the federal government. Disciplinary action, initiated as a result of the investigation, resulted in the employee's termination.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

The auditee shall:

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

Section 43.09.185 of the Revised Code of Washington states:

State agencies and local governments shall immediately report to the state auditor's office known or suspected loss of public funds or assets or other illegal activity.

08-11 The Department of Social and Health Services does not ensure that Temporary Assistance to Needy Families payments are reduced for clients who do not participate in WorkFirst activities as required by state and federal law.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: 93.558 Temporary Assistance for Needy Families
Federal Award Number:
Applicable Compliance Component: Special Test and Provision N3- Penalty for Refusal to Work
Questioned Cost Amount: \$4,119.20

Background

The Department of Social and Health Services Economic Services Administration administers the Temporary Assistance to Needy Families (TANF) program for the state to provide time-limited assistance to needy families with children so that the children can be cared for in their own homes or in the homes of relatives. The program served approximately 52,000 households each month and spent more than \$540 million in fiscal year 2008.

Federal law requires the Department to submit a state plan, which outlines the rules, policies and procedures the Department states it will follow in its administration of the program. The state plan in place during the audit period requires TANF clients, beginning at age 16, to participate in WorkFirst, a program designed to help low-income families prepare for and find work. In Washington, WorkFirst participation by clients between 16 and 19 is defined as being enrolled in and attending school or actively pursuing a high school diploma equivalent. Clients who are 18 or 19 must participate in job search activities if they have a high school diploma or equivalent. There are approximately 10,000 clients in Washington between 16 and 19 whose families or custodians receive TANF benefits each month. Progress and participation in WorkFirst activities is recorded in the electronic Jobs Automated System.

Department case workers are required to ensure WorkFirst participation by clients. An Individual Responsibility Plan is developed with each child and his or her parent or guardian. Non-compliance with the plan would result in a reduction of benefits up to 40 percent.

Description of Condition

We initially selected a random sample of 30 TANF clients for review, including seven clients between 16 and 19. We found the Department had no documentation to show the 16-19 year olds were participating in the WorkFirst program. Benefits had not been reduced for these clients.

Based on these results, we expanded our review to focus on clients between 16 and 19 years old. We used a statistically valid sampling plan to select 45 case files for review. Of those, we found 23 did not have a current Individual Responsibility Plan or evidence of school attendance. None of these clients' benefits were reduced.

Cause of Condition

Department staff responsible for monitoring the cases for these particular clients has not been properly trained in the use of Department tracking systems or the WorkFirst requirements.

Effect of Condition and Questioned Costs

The lack of oversight of WorkFirst participation results in client benefits not being reduced for non-participation as required. Benefit payments related to the exceptions we noted equaled \$10,297 for the month we examined. Based on a benefit reduction rate of 40 percent, we are questioning \$4,119 of that amount.

Use of the sampling plan allows us to project the questioned costs associated with known instances of non-compliance across all clients ages 16-19. By extrapolating the results of our testing to the entire population of 10,520 clients ages 16-19, the likely questioned costs associated with the Department's non-compliance approaches \$1 million per month.

Our audit work was designed to determine if the Department could demonstrate it complied with federal requirements for ensuring client participation in the WorkFirst program, and for reducing benefits for non-participation. It was not designed to determine if those clients were in school or otherwise meeting participation requirements.

Recommendation

We recommend the Department ensure staff responsible for monitoring of TANF clients are adequately trained in federal and state requirements. Particular attention should be paid to client populations with higher risks of potential non-compliance.

We further recommend the Department consult with its federal grantor to determine what questioned costs should be repaid.

Department's Response

The Department agrees it is out of compliance with the current documentation standards for dependent teen school attendance as defined in the WorkFirst Handbook.

The Department agrees that training regarding this requirement may be an issue but believes the problem is more likely the result of excessive caseloads where competing demands for eligibility related to federal work participation, payment accuracy, and timely benefit issuance may take precedence in the field. Dependent teen Individual Responsibility Plan requirements are not a federal requirement and as such, may be viewed as a lesser priority.

The Department disagrees with the audit finding that these families have been incorrectly paid. The state WorkFirst policies are state options and failure to attend high school or to complete an Individual Responsibility Plan (IRP) by a dependent teen is not a violation of federal TANF regulations. As such, these families have not been incorrectly paid federal TANF funds. WorkFirst policy requires that families must be contacted and given an opportunity to comply with the school attendance policy. If they fail to do so, the family must be given adequate and advance notice of the grant reduction. Until these actions are taken, we are required to continue including the dependent teen in the calculation of the TANF benefit.

1. *There is no federal law which mandates participation by TANF recipients beginning at age 16.*
 - a. *Work participation requirements apply to families that contain an adult or minor child head of household. [Ref: 42 USC 607(b)(1)(B)(i)]*
 - b. *Activities such as school attendance and maintenance of grade levels and attendance are optional activities which states may impose as part of the development of an individual responsibility plan. [Ref: 42 USC 608(b)(2)(A)(ii)]*
2. *There is no federal law which mandates the development of an Individual Responsibility Plan.*
 - a. *Development of an IRP is a state option under the TANF regulations. [Ref: 42 USC 608(b)(2)]*

The Department will review the cases cited in this audit to determine if the children are in school. For cases where they are not in school, appropriate actions will be taken to follow state policy and pursue the sanction process.

As a result of this finding, the department's further review of applicable state statutes has clarified that the state statutes governing teen education requirements apply to teens who are themselves parents and not teens in general. The Department will amend the TANF State Plan to eliminate the requirement to sanction dependent children (16 and 17 years of age) who are not in school. In addition, the Department will revise the WAC and WorkFirst Handbook to eliminate documentation of dependent teen school attendance as a program 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, *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.

Washington Administrative Code 388-310-0200 states:

“(a) You are required to participate in WorkFirst activities, and become what is called a "mandatory participant," if you:

- (i) Receive TANF or SFA cash assistance; and
- (ii) Are a custodial parent or age sixteen or older; and
- (iii) Are not exempt.”

Washington Administrative Code 388-310-0900 states:

“(c) You will be required to be in high school or a GED certification program if you are a mandatory participant, sixteen or seventeen years old and you do not have a high school diploma or GED certificate.”

Washington Administrative Code 388-310-1600 states:

“When you are a mandatory WorkFirst participant, you must follow WorkFirst requirements to qualify for your full grant. If you or someone else on your grant doesn't comply and you can't prove that you had a good reason, you do not qualify for your full grant. This is called being in WorkFirst sanction status.

(a) When someone in your household is in sanction status, we impose penalties. The penalties last until you or the household member meet WorkFirst requirements.

(b) Your grant is reduced by the person(s) share or forty percent, whichever is more.”

08-12 The Department of Social and Health Services is not reimbursing the federal government its proper share of child support collections.

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:	N/A
Applicable Compliance Component:	Matching
Questioned Cost Amount:	\$1,006,459

Background

The Department of Social and Health Services (DSHS) Division of Child Support administers the Child Support Enforcement program in the state. The objective of the program is to collect child support for children receiving public assistance and children who have a parent or parents who do not live with the child. The program has approximately 382,000 open cases and spent more than \$167 million in federal and state funds in fiscal year 2008.

The program collects child support primarily from non-custodial parents; these collections generally are passed on to the custodial parent or guardian. However, if the child has received assistance from the Temporary Assistance for Needy Families (TANF) program, Medicaid or Foster Care Assistance, federal law requires the Department to retain part of the support payment collected to reimburse those programs. Since those programs are partially funded by federal dollars, the state is required to reimburse the federal government its share of program costs. The federal share of these programs is set by the grantor, and may change each year. Therefore, the percentage of support collections to be refunded must also change to correspond to the new rate.

The amount of child support collections retained as reimbursement for payments made under TANF, Medicaid, or foster care for State Fiscal Year 2008 was approximately \$79.9 million.

Description of Condition

The federal reimbursement percentages in effect during fiscal year 2008 were 50.12 percent for the first quarter, and 51.52 percent for the remaining three quarters. The Department incorrectly calculated the Federal share of support collections at 50 percent throughout fiscal year 2008.

Cause of Condition

Department staff members responsible for ensuring compliance with the federal reimbursement rate for child support collections were not aware the federal participation rate changed. The Department did not have adequate controls to ensure changes in these rates were identified and used.

Effect of Condition and Questioned Costs

The Department failed to calculate and remit the correct amount of support collections to the federal government. By applying the incorrect percentages during the fiscal year, the amount remitted by the Department was \$1,006,459 less than it should have been. We are questioning that amount.

Recommendation

We recommend the Department establish controls to ensure the correct amount of support collections are remitted to the federal government. Additionally, we recommend the Department consult with its grantor to determine what costs need to be repaid.

Department Response

The Department partially concurs with the finding. The DSHS Office of Accounting Services (OAS) requests Title IV-D grant draws from the federal government twice a month on behalf of the Division of Child Support (DCS) based on expenditures exported from the Agency Financial Reporting System (AFRS) for that period of time. The department confirmed that AFRS was not updated to reflect the correct Federal Medical Assistance Percentage (FMAP) rate for State Fiscal Year 2008 (SFY08).

DCS submits a quarterly expenditure report (Federal Form 396-A) to the federal government, and the federal government automatically adjusts DCS's grant award amount to match DCS's quarterly report. The expenditure report generated using data from the DCS Support Enforcement Management System (SEMS), accurately reflects the FMAP rate for the respective time period. Since DCS's quarterly report is based on SEMS, which contained the correct FMAP rate, the federal quarterly expenditure report did not need to be revised.

AFRS contained incorrect expenditure data for SFY08. The DCS Accounting Unit completed a correction journal voucher in October, 2008 moving \$1,006,459.14 from federal expenditures to state expenditures, thereby, reducing the subsequent federal draw. When the department creates a JV that increases state expenditures, and reduces federal expenditures, the federal funds are reduced on the next federal draw because it reduces the amount of federal funds we would normally have drawn.

Only OAS has the ability to change the FMAP rate in AFRS. To ensure the correct FMAP rate is reflected in AFRS in the future, the DCS Accounting Unit will incorporate a review of the FMAP rate associated with the AFRS edits in the administration's annual cost allocation review process to ensure AFRS was updated with the correct rate. Based upon the results of that review, ESA will notify the OAS of any changes needed.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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.

Code of Federal Regulations Title 45, Section 304.26 states in part:

(a) From the amounts of support collected by the State and retained as reimbursement for title IV-A payments and foster care maintenance payments under title IV-E, the State shall reimburse the Federal government the Federal share of the support collections. In computing the Federal share of support collections for assistance payments made under titles IV-A and IV-E, the State shall use the **Federal medical assistance percentage** in effect for the fiscal year in which the amount is distributed.

08-13 The Department of Early Learning and the Department of Social and Health Services do not have adequate internal controls over direct payments to child care providers.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Child Care and Development Cluster 93.575 Child Care and Development Block Grant 93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund
Federal Award Number:	G-0801WACCDF
Applicable Compliance Component:	Activities Allowed or Unallowed
Questioned Cost Amount:	None

Background

The Washington Department of Early Learning (DEL) administers the federal Child Care and Development program. The program is designed to assist eligible working families in paying for child care. In fiscal year 2008 approximately \$260 million was paid to child care centers and providers through the Working Connections Child Care Program.

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

Our audits of fiscal years 2005-2007 reported the Departments did not adequately monitor direct payments made to child care providers. Payments are made through the Social Services Payment System (SSPS) maintained by DSHS. Monitoring is critical to ensure payments are allowable.

Description of Condition

In response to the prior year audit finding, the Departments stated they would develop and follow a process to audit the reconciliation of child care payments with attendance record documentation in addition to providing training to care providers on proper billing procedures. The Departments agreed that program integrity could be improved and that they would formalize each Department's roles and responsibilities in a signed agreement.

During our audit, we found the Departments had made a number of improvements, including the performing federally-mandated audits of child care authorizations. However, they still do not have a process to reconcile child care payments to attendance records in order to determine if the payments were fully supported.

The inadequate monitoring of direct payments, specifically the lack of reconciliation between child attendance records and payment requests submitted by providers, has not been resolved.

Cause of Condition

The Departments did not reach an agreement regarding the roles and responsibilities of each as they relate to child care payment reconciliations.

Effect of Condition

The lack of controls over payments to providers results in a high risk that overpayments to providers will be made and not identified or recovered. The Departments are aware of overpayments made to licensees, and are aware that the licensees are claiming more than authorized amounts.

While we recognize the improvements both Departments have made over the monitoring of child care payments, having no system in place for reconciling payments to source documentation is a significant control weakness that leaves the program vulnerable to abuse. We performed a detailed review of a small sample of payments and attendance records during our fiscal year 2006 audit and found more than \$55,000 in overpayments. Since the Departments had not implemented a reconciliation process, and because of the time and effort involved in detailed testing of Child Care attendance records, we determined that re-performing this testing would not be an effective use of our resources.

Recommendation

We recommend the Departments establish and follow adequate monitoring procedures for provider payments to include reconciliation of provider attendance records to payments made to ensure expenditures are allowable.

Departments' Response

The departments concur with the auditor's assessment that the corrective action plan identified in response to the 2007 audit finding was not implemented at the time of auditor's 2008 review. The departments did come to agreement on the specific areas of responsibility in implementing that plan and reflected their respective responsibilities in the Service Level Agreement (SLA).

In July, 2008, the Department of Early Learning and the Department of Social and Health Services (DSHS) implemented the process to reconcile child care payment to child care provider attendance records to determine if the payments were supported by appropriate documentation. As stated above, the respective responsibilities for each agency were documented in the SLA signed on October 8, 2008.

On a monthly basis, licensed child care center and child care licensed family home payment files are randomly selected from the Social Service Payment System (SSPS) and by DSHS. DEL sends a written request to the providers to obtain attendance records from providers and provides them to DSHS to reconcile with the SSPS payment files. If a discrepancy is found, DSHS follows DEL policy to write the overpayment. If a provider fails to provide DEL with the requested attendance records, DSHS finds the case in error and establishes an Overpayment.

Auditor's Concluding Remarks

We thank the Departments for their responses and will review the status of the corrective action during our next audit.

Applicable Laws and Regulations

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

The auditee shall:

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

OMB Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment A, Section C, Basic Guidelines, states in part:

Factors affecting allowability of costs.

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

Washington Administrative Code 170-295-7030 states:

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

Washington Administrative Code 170-296-0520 states:

(3) Daily attendance records, listing the dates and hours of attendance of each child must be kept up-to date and maintained in the licensed space of the family home child care for five years.

(4) When a child is no longer enrolled, the date of the child's withdrawal must be recorded in the child's file. You must maintain the child's file for at least five years from the child's last date of attendance. After five years the file may be destroyed or returned to the parent. The child's file must be made available for review by the child's parents and us during this period.

Washington Administrative Code 388-290-0138 states in part:

What responsibilities does my eligible in-home/relative provider have?

Your in-home/relative provider must:

- (6) Keep correct attendance records. Records must:
 - (a) Show both days and times the care was provided;
 - (b) Be kept for five years; and
 - (c) Be given to us, within fourteen consecutive calendar days, if we ask for them.

08-14 Child Care public funds were misappropriated at the Department of Social and Health Service's Economic Services Administration.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: Department of Early Learning
CFDA Number and Title: Child Care and Development Cluster
93.575 Child Care and Development Block Grant
93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund
Federal Award Number: G-0801WACCDF
Applicable Compliance Component: N/A
Questioned Cost Amount: \$66,304.57

Background

The Department of Early Learning administers the child care program in the state. The Department contracts with the Department of Social and Health Services (DSHS) to determine program eligibility and approve child care provider payments for families applying for and receiving Working Connections Child Care assistance. In fiscal year 2008, DSHS paid \$276 million to child care providers.

On January 2, 2008, a DSHS manager on special assignment at the North King County Community Service Office received an anonymous written complaint that stated an employee of that office was involved in a misappropriation of child care money. The following day, a second concern was raised by a lead worker about a suspected misappropriation on a separate child care case, involving the same employee. An internal investigation led to the discovery of 22 suspect payments to in-home child care providers starting in May 2007 involving three employees.

On January 15, 2008, after the internal investigation was complete, DSHS referred the incident to Washington State Patrol. The Patrol forwarded the criminal investigations for one permanent employee and two non-permanent employees to the Seattle Police Department on February 4, 2008. On October 8, 2008, Seattle Police Department closed the investigation for the permanent employee because they were unable to find sufficient evidence to charge the employee with a crime. On October 30, 2008, the United States Attorney filed charges against the two non-permanent employees. The State Patrol closed the investigations for the non-permanent employees on October 31, 2008 and the permanent employee on January 9, 2009.

Description of Condition

We reviewed DSHS' internal investigation and agreed with its conclusion that \$130,376.76 in public funds was misappropriated by the employees who issued child care payments to individuals for child care services not rendered.

Of the \$130,376.76, approximately half, or \$66,304.57, was federal dollars.

Cause of Condition

The Department did not have adequate internal controls to prevent the employees from misappropriating child care payments. Payments to providers were inadequately monitored by the Department.

Effect of Condition and Questioned Costs

Inadequate internal controls led to the misappropriation of funds at the Administration and deprived the Department, as well as eligible clients and providers, of the use of these funds. Because this involved federal funds, the state may be required to reimburse the federal government its share of the loss.

Recommendation

We recommend the Department seek recovery of the \$130,376.76 in misappropriated public funds and \$3,825 of related audit/investigation costs from the former employees and/or its insurance bonding company, as appropriate. Any compromise or settlement of this claim must be approved in writing by the Attorney General and State Auditor as directed by RCW 43.09.330. Assistant Attorney General Marta DeLeon is the contact person for the Attorney General's Office and she can be reached at 360-753-3168 or martad@atg.wa.gov. The contact for the State Auditor's Office is Jan Jutte, Director of Legal Affairs and she can be reached at 360-902-0363 or juttej@sao.wa.gov.

Insurance coverage for employees is as follows:

Insurance Company: Traveler's

Policy Number: 104238506

Policy Type: Commercial Crime Policy

Amount of Coverage: \$10,000,000/ \$ 500,000 deductible

Coverage Period: August 1, 2004 until cancelled

We also recommend the Department continue to establish, follow and monitor an effective system of internal controls designed to ensure the protection of public assets from loss.

Department's Response

The departments concur with the findings of misappropriated public funds. The Department of Social and Health Services (DSHS) will work closely with the Attorney General and the State Auditor's Office in pursuing recoupment of the misappropriated public funds.

The two non-permanent employees are no longer employed by DSHS. The two non-permanent employees were referred by the Seattle Police Department to the Social Security Fraud Division for identity theft and as a result were arrested and charged with a felony. DSHS does not know if a court date has been set for the trial.

DSHS received the final report on the investigation of the permanent employee from the Washington State Patrol on January 9, 2009. The report stated they could not find a direct connection between the misappropriated funds and the permanent employee. The investigation did not turn up any evidence that directly tied the permanent employee to the authorization of the misappropriated funds. No charges were brought against the permanent employee. The employee, on home assignment since the investigation began approximately a year ago, will return to work on February 2, 2009.

DSHS has various internal controls in place that minimize the risk of being able to misappropriate child care payments. Even with precautions in place, there is always a possibility that a worker, intent on engaging in illegal behavior, will work outside the rules to carry out fraudulent activities. In this case, the employees intentionally authorized benefits without going through the proper procedures or following eligibility requirements. The leadworker, in performing oversight, appropriately noticed the apparent improper authorization which resulted in the associated investigations. DSHS will review the internal controls in place and determine additional controls to monitor childcare authorizations.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

RCW 43.09.185 states:

State agencies and local governments shall immediately report to the state auditor's office known or suspected loss of public funds or assets or other illegal activity.

Section 20.20.20a of the State Administrative and Accounting Manual states, in part:

Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

08-15 The Department of Early Learning does not have adequate controls to ensure that contractors have not been suspended or debarred from working on federally funded programs.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.575 Child Care Cluster
Federal Award Number:	G-0801WACCDF
Applicable Compliance Component:	Suspension and Debarment
Questioned Cost Amount:	None

Background

The Department of Early Learning administers the Child Care and Development Fund, which provides federal funds to states to increase the availability, affordability, and quality of child care services for low-income families in which the parents are working or attending training or educational programs.

Federal regulations prohibit states from awarding contracts to parties that have been suspended or debarred from participating in federally funded programs. For any purchase contract that exceeds or is expected to exceed \$25,000, grantees must verify the contractor has not been suspended or debarred by doing one of three things: checking the federal Excluded Parties List; collecting a certification from the vendor; or adding a clause or condition to the contract.

Description of Condition

We reviewed 14 contract files valued at \$3.5 million to determine if controls were in place to ensure compliance with federal requirements. We found none of these contracts met the federal requirements for suspension and debarment.

Cause of Condition

The Department relied on its general contract terms to comply with federal requirements. However, the boilerplate contract language used did not include suspension and debarment certifications or clauses.

Effect of Condition

The Department may be held liable for any amounts paid to contractors who have been suspended or debarred from receiving federal funds. We were able to subsequently verify that the vendors associated with the contracts we reviewed were not suspended or debarred from working on federal programs, and therefore are not questioning the costs associated with these contracts.

Recommendation

We recommend the Department ensure all staff responsible for contracting have adequate knowledge and training in federal requirements, and that general contract terms be updated to include appropriate suspension and debarment language.

Department's Response

The Department of Early Learning (DEL) began preparing and executing contracts July 1, 2007. Until that time, all federally funded contracts were prepared and executed by the Department of Social and Health Services on behalf of DEL. Since we were a new agency, DEL used the Office of Financial Management (OFM) generic contract template. The OFM generic template for personal service contracts did not

contain a suspension and debarment clause and DEL did not check the federal debarment web site for federally funded contracts.

Once the auditors informed DEL staff of the requirement to include the suspension and debarment contract language or check the federal debarment web site, all federally funded contracts were checked on the federal debarment web site. None of the DEL contractors were on the federal suspension or debarment list.

All new federally funded contracts are being checked on the federal suspension and debarment web site and the information is placed in the contract file. Additionally, DEL is working with the Attorney General's Office to develop contract templates that will provide DEL with essential contract language.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

45 CFR 1185.300

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 if allowed by this rule; or
- (c) Adding a clause or condition to the covered transaction with that person.

08-16 The Department of Social and Health Services does not have internal controls to ensure Child Welfare Services complies with earmarking compliance requirements.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: 93.645 Child Welfare Services
Federal Award Number:
Applicable Compliance Component: Earmarking
Questioned Cost Amount: \$847,751.58

Background

The Department of Social and Health Services (DSHS), Children’s Administration, administers the Child Welfare Services program in the state. The objective is designed to promote state flexibility in the development and expansion of a coordinated child and family services program. The program is designed to aid in long-term solutions for children and families beyond services available through Child Protective Services or Family Reconciliation Services. The Department spent more than \$6.2 million in federal money during fiscal year 2008.

Effective October 1, 2007, federal regulations require at least 90 percent of all grant funds to be used in direct support of program objectives, including promoting and protecting the safety and welfare of children; preventing or remedying abuse, exploitation and delinquency of children; and working with families to ensure children are in a safe environment. Not more than 10 percent may be spent on administrative and overhead costs. These costs are defined by the grantor, and include but are not limited to accounting, budgeting, and auditing services; maintenance and operation of space and facilities; and program management other than case worker supervision.

Description of Condition

We identified all expenditures charged to the grant between October 1, 2007 and June 30, 2008 in order to determine the total classified as administrative costs under federal rules. Based on total federal grant expenditures of \$5,261,185 during that period, the maximum allowable administrative costs were \$526,185. However, the Department charged the grant \$1,373,937 in administrative costs, or approximately 26 percent.

Cause of Condition

The Department acknowledged awareness of and agreement to the limit on administrative costs with its grantor. However, the Department failed to properly identify what constituted administrative costs, the effective date of the requirement, and that the requirement applied to all grant awards active as of the effective date. Children’s Administration management indicated it did not closely monitor this program requirement because of what the Department considers the small dollar amount of the grant.

Effect of Condition and Questioned Costs

Program costs intended for the direct support of program objectives were not available for that use. We are questioning \$847,752, the amount the Department charged for administrative costs in excess of the 10 percent allowed.

Recommendation

We recommend that Department staff and management responsible for monitoring grant activities ensure that grants funds are used in accordance with federal requirements.

We further recommend the Department consult with its federal grantor to determine whether questioned costs should be repaid.

Department's Response

The Department concurs with this finding and understands the "Assurance" required by the change to Title IV-E of the Social Security Act; P.L. 109-288, (The Child and Family Services Improvement Act of 2006) as signed into law September 28, 2006. This "Assurance" was a change in the law that took effect October 1, 2007 and applied to any expenditures of Title IV-B, subpart 1 funds expended after this date. It requires a signature from an Administration head on a "Certificate of Assurance" form included as an attachment to our Annual Progress and Services Report. The Federal Fiscal Year (FFY) 2007 grant period was October 1, 2006 through September 30, 2008, which meant this change in law became effective half way through the period of the grant. Because the effective date of this change corresponded with the beginning of FFY 2008 the Department mistakenly assumed it did not apply to FFY 2007. This error will not be an issue in future grant periods. We will work with our federal grantor on the appropriateness of adjustments to this grant and return any federal funds that are not eligible under this law due to the changes. Our current practice is to limit the administrative expenditures charged to the grant to a maximum of 10% as outlined in the new law.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

The auditee shall:

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

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Part 4 states in part:

"The term "administrative costs" means costs for the following but only to the extent incurred in administering the State plan for this program: procurement; payroll management; personnel functions (other than the portion of the salaries of supervisors attributable to time spent directly supervising the provision of services by caseworkers); management; maintenance and operation of space and property; data processing and computer services; accounting; budgeting; auditing; and travel expenses (except those related to the provision of services by caseworkers or oversight of the program). (Pub. L. No. 109-288, Sections 422(b)(14) and (c) and 424(e) (42 USC 622(b)(14) and (c) and 623(e))."

Child and Family Services Improvement Act of 2006 Pub. L. No. 109-288, Sections 422(b) states:

(14) not later than October 1, 2007, include assurances that not more than 10 percent of the expenditures of the State with respect to activities funded from amounts provided under this subpart will be for administrative costs.

08-17 The Department of Social and Health Services, Children's Administration, is not following established internal controls over 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:	N/A
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	\$163,832

Background

The federal Adoption Assistance program provides funds to states for parents who adopt eligible children with special needs. The Children's Administration of the Department of Social and Health Services (DSHS) administers the program for the state from six regional offices with staffing from an adoption support program specialist. Approximately 12,000 children are in the Adoption Assistance program in the state.

The Department paid approximately \$62.7 million in adoption assistance payments in fiscal year 2008. We examined \$542,927 in payments.

Description of Condition

We reviewed case files for 30 adopted children to determine if the children met eligibility requirements and that payments were properly supported. Our selection of the files was based on the type of payment made, the amount, and the age of the child.

We identified seven case files that did not include sufficient documentation to support eligibility or show why a payment was made. Exceptions noted included (some case files had multiple exceptions, and so may be listed more than once):

- A one-time payment plus 12 months of maintenance payments were made for an adopted child who, according to the adoption support agreement, was not eligible for federal assistance.
- No documentation for nine lump sum payments to show why they were made or that they were properly authorized.
- One case file showed no evidence of having been reviewed at least every five years as required by state law.
- Five case files did not include support showing adopted children over age 18 were still in school and were entitled to receive adoption support assistance.

Payments associated with these case files totaled \$33,393.

We noted these exceptions were related to program activity at one particular regional office. Based on this, we expanded our work at that office to an additional 24 case files.

We found one or more exceptions related to 17 of the 24 additional case files selected:

- No documentation for eight lump sum payments in the case files to show why they were made or that they were properly authorized.
- 15 case files showed no evidence of having been reviewed at least every five years as required by state law.
- Five case files did not include support showing that adopted children over age 18 were still in school and were entitled to receive adoption support assistance.
- Two case files did not contain the Decree of Adoption from the courts.

Payments associated with these case files totaled \$130,439.

Cause of Condition

The Department does not have adequate controls to ensure payments for adoption assistance are allowable and that adoption case files are complete and accurate. Department management did not perform sufficient monitoring to ensure payments were properly supported and made only for eligible clients, and did not ensure its staff was adequately trained to perform the functions required. The Department stated the region with the high exception rate experienced significant employee turnover in July of 2006. Since that time, monitoring of payments and updating of case files have not been performed.

Effect of Condition and Questioned Costs

The Department made assistance payments that were unsupported or unallowable. We are questioning \$163,832.94 in payments related to these exceptions. The weaknesses identified increase the risk of additional inappropriate payments without detection.

Recommendation

We recommend the Department:

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

Department's Response

We concur with the findings of this audit and agree that established controls for adoption support payments were not adhered to at the one particular regional office reviewed by the State Auditor's Office. We appreciate the Auditor's recommendations and will incorporate them into our corrective action; we will implement established internal controls in the region where they have not been followed and reaffirm them statewide. This will be done through increased training in the areas of monitoring, client eligibility determination, and 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

RCW 74.13.118: Review of support payments.

At least once every five years, the secretary shall review the need of any adoptive parent or parents receiving continuing support pursuant to RCW 26.33.320 and 74.13.100 through 74.13.145, or the need of any parent who is to receive more than one lump sum payment where such payments are to be spaced more than one year apart.

At the time of such review and at other times when changed conditions, including variations in medical opinions, prognosis and costs, are deemed by the secretary to warrant such action, appropriate adjustments in payments shall be made based upon changes in the needs of the child, in the adoptive parents' income, resources, and expenses for the care of such child or other

members of the family, including medical and/or hospitalization expense not otherwise covered by or subject to reimbursement from insurance or other sources of financial assistance.

Any parent who is a party to such an agreement may at any time in writing request, for reasons set forth in such request, a review of the amount of any payment or the level of continuing payments. Such review shall be begun not later than thirty days from the receipt of such request. Any adjustment may be made retroactive to the date such request was received by the secretary. If such request is not acted on within thirty days after it has been received by the secretary, such parent may invoke his rights under the hearing provisions set forth in RCW 74.13.127.

RCW 13.50.010: Definitions — Conditions when filing petition or information — Duties to maintain accurate records and access.

(1) For purposes of this chapter:

(a) "Juvenile justice or care agency" means any of the following: Police, diversion units, court, prosecuting attorney, defense attorney, detention center, attorney general, the legislative children's oversight committee, the office of [the] family and children's ombudsman, the department of social and health services and its contracting agencies, schools; persons or public or private agencies having children committed to their custody; and any placement oversight committee created under RCW 72.05.415;

(b) "Official juvenile court file" means the legal file of the juvenile court containing the petition or information, motions, memorandums, briefs, findings of the court, and court orders;

(c) "Records" means the official juvenile court file, the social file, and records of any other juvenile justice or care agency in the case;

(d) "Social file" means the juvenile court file containing the records and reports of the probation counselor.

(2) Each petition or information filed with the court may include only one juvenile and each petition or information shall be filed under a separate docket number. The social file shall be filed separately from the official juvenile court file.

(3) It is the duty of any juvenile justice or care agency to maintain accurate records. To this end:

(a) The agency may never knowingly record inaccurate information. Any information in records maintained by the department of social and health services relating to a petition filed pursuant to chapter 13.34 RCW that is found by the court to be false or inaccurate shall be corrected or expunged from such records by the agency;

(b) An agency shall take reasonable steps to assure the security of its records and prevent tampering with them; and

(c) An agency shall make reasonable efforts to insure the completeness of its records, including action taken by other agencies with respect to matters in its files.

(4) Each juvenile justice or care agency shall implement procedures consistent with the provisions of this chapter to facilitate inquiries concerning records.

(5) Any person who has reasonable cause to believe information concerning that person is included in the records of a juvenile justice or care agency and who has been denied access to those records by the agency may make a motion to the court for an order authorizing that person to inspect the juvenile justice or care agency record concerning that person. The court shall grant the

motion to examine records unless it finds that in the interests of justice or in the best interests of the juvenile the records or parts of them should remain confidential.

(6) A juvenile, or his or her parents, or any person who has reasonable cause to believe information concerning that person is included in the records of a juvenile justice or care agency may make a motion to the court challenging the accuracy of any information concerning the moving party in the record or challenging the continued possession of the record by the agency. If the court grants the motion, it shall order the record or information to be corrected or destroyed.

(7) The person making a motion under subsection (5) or (6) of this section shall give reasonable notice of the motion to all parties to the original action and to any agency whose records will be affected by the motion.

(8) The court may permit inspection of records by, or release of information to, any clinic, hospital, or agency which has the subject person under care or treatment. The court may also permit inspection by or release to individuals or agencies, including juvenile justice advisory committees of county law and justice councils, engaged in legitimate research for educational, scientific, or public purposes. The court may also permit inspection of, or release of information from, records which have been sealed pursuant to *RCW 13.50.050(11). The court shall release to the sentencing guidelines commission records needed for its research and data-gathering functions under RCW 9.94A.850 and other statutes. Access to records or information for research purposes shall be permitted only if the anonymity of all persons mentioned in the records or information will be preserved. Each person granted permission to inspect juvenile justice or care agency records for research purposes shall present a notarized statement to the court stating that the names of juveniles and parents will remain confidential.

(9) Juvenile detention facilities shall release records to the sentencing guidelines commission under RCW 9.94A.850 upon request. The commission shall not disclose the names of any juveniles or parents mentioned in the records without the named individual's written permission.

(10) Requirements in this chapter relating to the court's authority to compel disclosure shall not apply to the legislative children's oversight committee or the office of the family and children's ombudsman.

WAC 388-27-0275: When does the department review an adoption support agreement?

(1) The adoption support program must review an agreement:

- (a) At least once every five years; or
- (b) When the adoptive parents request a change in the terms of the agreement.

(2) The department may review an adoption support agreement:

- (a) Whenever variations in medical opinions, prognosis, or costs warrant a review; or
- (b) At the department's request.

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.

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

13230. Records Management

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

The CA office, in accordance with local procedures, assigns a case number for each family, child, or licensing file as appropriate. The case number will begin with the two-digit office/county code, followed by a letter designating the type of case, and the case-unique number assigned by the local office. The letter prefixes are:

"L" or "D" - Family/Parent File at regional discretion.
"D" -- Child with any dependency, voluntary, or CHINS legal actions.
"H" - Licensed Home or Facility

The Regional Administrator, the Area Manager, and the DLR Regional Manager establish procedures for their respective areas of responsibility for support staff to build, assign a unique number, file, store, add volumes, secure, transfer, and retrieve social service records, with all inactive service records maintained in a central file location until transfer to the central Records Retention Center (RRC).

All closed social service records (other than those files for children whose parental rights were terminated) with closed services will be transferred to the RCC periodically.

Licensing files that were closed due to a revocation or denial of a license will be retained permanently in the local office.

Closed records of children whose parental rights were terminated will be sent from the local office to state office adoptions staff for forwarding to State Archives. This includes records for children who were not subsequently adopted.

The local or regional DCFS or DLR office, as appropriate, maintains case records on all persons or providers licensed or certified by the department.

13710. Expectations for Accuracy

Information in social service records must be complete and accurate, to the best ability of assigned social work or other staff, and can be shared only with authorized representatives of public or private agencies having a legitimate need to be informed concerning clients whom they are actively serving.

The Regional Administrator and the Regional Manager are responsible, in their respective areas, for the integrity of data in electronic and paper files.

Title IV-E Desk Guide: Documentation

File Construction

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

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

08-18 The Department of Social and Health Services, Office of Financial Recovery and Health and Recovery Services Administration, does not have internal controls to ensure that interest penalty collections are refunded to the federal government.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number: 5-0805WA5028, 5-0805WA5048
Applicable Compliance Component: Allowable Costs/Cost Principles
Questioned Cost Amount: None

Background

The state Medicaid program spent approximately \$6.4 billion during fiscal year 2008, approximately half of which was paid with federal funds. Most Medicaid expenditures are payments to providers of medical treatment, prescriptions, medical equipment, home health care and other services to Medicaid clients. Providers submit payment claims to the Department of Social and Health Services for these services. Not all claims submitted are allowable or accurate. The Department has internal post-payment audits designed to identify and recover overpayments to providers. When an overpayment is identified and notification sent to the provider, the Department may assess a 1 percent monthly interest penalty on the amount owed until the overpayment is recovered. Federal law requires the Department to pay back the federal portion of overpayments.

In our audit of fiscal year 2007, we reported a finding regarding the Department’s lack of controls to ensure the federal share of interest penalty collected from providers is refunded to the federal government in an accurate and timely manner.

In response to our 2007 finding the Department stated it would establish and follow policies and procedures to address the issue.

Description of condition

During our current audit, we found the Department did not have polices and procedures in place to ensure the federal share of interest penalty collected from providers is refunded to the federal government in an accurate and timely manner.

Cause of Condition

The Department’s policy on identification and remittance of interest collected on Medicaid provider overpayments was not finalized until July 1, 2008, which was after the end of the fiscal period under audit.

Effect of Condition

The Department collected \$286,326.93 in interest penalties on overpayments from Medicaid providers from July 1, 2007 through June 30, 2008. Of this, \$145,486.354 is the federal share of interest penalty collections. The Department did not remit this amount to the federal government in a timely manner. These interest penalty collections were not refunded to the federal government until October of 2008.

Recommendations

We recommend the Department follow its newly established policies and procedures to ensure the federal share of interest penalty collected from providers is refunded in an accurate and timely manner.

Department's Response

We concur with the audit finding. On the November 17, 2008 federal draw, the Department returned \$145,486.35 of the interest penalties on overpayments to the federal government pertaining to Statewide Fiscal year 2008.

To comply with the newly established policy and procedures outlined in the Financial Services Administration's Financial Policy 001, the Office of Accounting Services is creating an automated process to generate the interest report on a monthly basis. This report will enable the Department to remit the interest on a monthly basis through the federal claiming process. The new automated process and interest report are in the final stages of being tested; the department expects the automated interest report to be in place January 2009. After the interest report is run each month, the federal share will be verified and a journal voucher will be processed monthly by the Grants Management Section in the Office of Accounting Services. Processing the journal voucher monthly will return the federal portion of the interest collected within the 60 day period.

Auditor's Concluding Remarks

We thank the department for the cooperation and assistance provided during this review. We appreciate the steps the Department is taking to address this issue, and will review this area during our next audit.

Applicable Laws and Regulations

State Medicaid Manual states in part:

2500.1 Preparation of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Summary Sheet and Certification, Form HCFA-64. - Section A - Quarterly Status Of Funding

Line 3 - Interest

Line 3.A - Received On Medicaid Recoveries. -Enter the Federal share of any interest received or earned on Medicaid recoveries during the quarter.

Title 42, code of Federal Regulations, Section 433 states in part:

42 CFR 433.312 Basic requirements for refunds.

(a) Basic rules.

(1) Except as provided in paragraph (b) of this section, the Medicaid agency has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.

(2) The agency must refund the Federal share of overpayments at the end of the 60-day period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider.

(b) Exception.

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

(c) Applicability.

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

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

42 CFR 433.318 Overpayments involving providers who are bankrupt or out of business.

(a) Basic rules. (1) The agency is not required to refund the Federal share of an overpayment made to a provider as required by Sec. 433.312(a) to the extent that the State is unable to recover the overpayment because the provider has been determined bankrupt or out of business in accordance with the provisions of this section...

(b) Overpayment debts that the State need not refund. Overpayments are considered debts that the State is unable to recover within the 60-day period following discovery if the following criteria are met:

- (1) The provider has filed for bankruptcy, as specified in paragraph (c) of this section; or
- (2) The provider has gone out of business and the State is unable to locate the provider and its assets, as specified in paragraph (d) of this section...

(e) Circumstances requiring refunds. If the 60-day recovery period has expired before an overpayment is found to be uncollectible under the provisions of this section, if the State recovers an overpayment amount under a court-approved discharge of bankruptcy, or if a bankruptcy petition is denied, the agency must refund the Federal share of the overpayment in accordance with the procedures specified in Sec. 433.320.

42 CFR 433.320 Procedures for refunds to CMS.

(a) Basic requirements.

- (1) The agency must refund the Federal share of overpayments that are subject to recovery to CMS through a credit on its Quarterly Statement of Expenditures (Form CMS-64).
- (2) The Federal share of overpayments subject to recovery must be credited on the Form CMS-64 report submitted for the quarter in which the 60-day period following discovery, established in accordance with Sec. 433.316, ends.
- (3) A credit on the Form CMS-64 must be made whether or not the overpayment has been recovered by the State from the provider.

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

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

(d) Expiration of 60-day recovery period. If an overpayment has not been determined uncollectible in accordance with the requirements of Sec. 433.318 at the end of the 60-day period following discovery of the overpayment, the agency must refund the Federal share of the overpayment to CMS in accordance with the procedures specified in paragraph (a) of this section.

08-19 Public funds were misappropriated at the Department of Social and Health Services' Division of Developmental Disabilities.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number:	5-0805WA5028, 5-0805WA5048
Applicable Compliance Component:	N/A
Questioned Cost Amount:	Unknown

Background

The Department of Social and Health Services' Division of Developmental Disabilities (DDD) contracts with licensed agencies and individual providers to care for clients with disabilities. In fiscal year 2008, the Division paid approximately \$650 million to care providers.

On August 4, 2006, a supervisor at a DDD Field Services Office notified certain DDD clients that the contract for the home health agency providing their services was to be terminated and that they would need to find an alternative service provider. The supervisor contacted the clients on behalf of the Case Resource Manager, who was out on leave. While reviewing the clients to be notified, the supervisor noticed the Case Resource Manager's spouse was listed as a provider for several of the clients. During the phone conversations, clients stated they had not received services from this individual or the home health agency.

The supervisor initiated an internal investigation into the issue and referred the incident to local police. DDD management also referred the incident to the Medicaid Fraud Unit of the Attorney General's Office and Washington State Patrol. The local police department investigated only the payments made to the case resource manager's spouse as possible employee fraud. The payments made to the home health agency were referred to the Medicaid Fraud Unit, which is responsible for the investigation and prosecution of health care provider fraud involving the Medicaid program.

Description of Condition

We reviewed the local police department's report and agreed with its conclusion that \$8,289.92 in public funds was misappropriated by the employee by issuing payments to her spouse for services to disabled clients that were not rendered.

We reviewed the Department's incident report to the Office of the Governor and the Interagency Referral Report to the Washington State Patrol and determined the Department initially identified approximately \$91,000 in additional payments that were issued to the home health agency for services to disabled clients not rendered. Neither report disclosed the nature of the relationship, if any, between the Case Resource Manager and the home health agency. The final amount of the misappropriation will not be determined until the Fraud Unit completes whatever work it deems necessary.

Approximately half of DDD payments to providers are federal dollars.

Cause of Condition

The Department does not have adequate internal controls to prevent employees from misappropriating client service payments. In addition, payments to providers were inadequately monitored by the Department.

Effect of Condition and Questioned Costs

Inadequate internal controls led to the misappropriation of funds at the Division and deprived the Department, as well as eligible clients and providers, of the use of these funds. Because this involved federal money, the state may be required to reimburse the federal government its share of the loss.

Recommendation

We recommend the Department seek recovery of the \$8,289.92 in misappropriated public funds from the former employees and/or its insurance bonding company, as appropriate. In addition, we recommend the Department seek recovery of any additional losses and associated investigation costs identified at a later date. Any compromise or settlement of this claim must be approved in writing by the Attorney General and State Auditor as directed by RCW 43.09.330. Assistant Attorney General Marta DeLeon is the contact person for the Attorney General's Office and she can be reached at 360-753-3168 or martad@atg.wa.gov. The contact for the State Auditor's Office is Jan Jutte, Director of Legal Affairs and she can be reached at 360-902-0363 or juttej@sao.wa.gov.

Insurance coverage for employees is as follows:

Insurance Company: Traveler's

Policy Number: 104238506

Policy Type: Commercial Crime Policy

Amount of Coverage: \$10,000,000/ \$ 500,000 deductible

Coverage Period: August 1, 2004 until cancelled

We also recommend the Department continue to establish, follow and monitor an effective system of internal controls designed to ensure the protection of public assets from loss.

Department's Response

The department concurs with this finding.

The department will seek recovery of all misappropriated funds, and investigative costs, that have been or will be identified. Referrals to the division of fraud investigation and the office of financial recovery have been made on the funds currently identified as misappropriated. DDD also implemented changes to its Policy 6.01 regarding SSPS monitoring. The policy requires more thorough monitoring, and specifies monitoring roles and what documents need to be reviewed. The policy also requires client contact by a supervisor for service verification.

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

RCW 43.09.185 states:

State agencies and local governments shall immediately report to the state auditor's office known or suspected loss of public funds or assets or other illegal activity.

Section 20.20.20a of the State Administrative and Accounting Manual states, in part:

Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

08-20 The Department of Social and Health Services did not have adequate internal controls to ensure the federal share of overpayments made to Medicaid providers are refunded to the federal government.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number: 5-0805WA5028, 5-0805WA5048
Applicable Compliance Component: Allowable Costs/Cost Principles
Questioned Cost Amount: N/A

Background

Most Medicaid expenditures are payments to providers of medical treatment, prescriptions, medical equipment, home health care, and other services. Providers submit payment claims to the Department of Social and Health Services. In most cases, these payments are composed of approximately 50 percent federal and 50 percent state funds. The Department has a number of post-payment audits designed to identify and recover inappropriate payments to providers, referred to as overpayments.

The Department is required to pay back to the federal government its share of overpayments within 60 days of the date of discovery, even if the state has not recovered the overpayment from the provider. The state does not have to refund the overpayment if the provider has filed for bankruptcy or has gone out of business.

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

The state Medicaid program spent approximately \$6.4 billion during fiscal year 2008, approximately half of which was paid with federal funds.

Description of condition

In fiscal year 2008, the Medicaid program identified 107 overpayments. We selected 28 of those for review.

On October 2, 2008 we requested detailed information that would show whether the federal share of the overpayments selected had been refunded and the date of that refund. We provided the Department six weeks to gather and provide us the information. The Department communicated it would need an extension due to a large workload and the difficulty in obtaining the requested data.

On December 9, 2008, the revised due date, the Department notified us it would not be able to provide all of the requested documentation. The Department requested additional time, and we extended the deadline to January 16, to allow it to provide documentation to show the federal share of the overpayments had been refunded. The Department still was unable to provide the documentation.

Throughout the audit we encountered difficulties in obtaining the necessary documentation. In the prior year audits, the Department was able to provide sufficient documents to show overpayments had been refunded.

Cause of Condition

In 2007 the employee who was primarily responsible for performing this function left the Department, duties were shifted and new staff added. When this transition occurred, employees did not receive adequate training related to overpayment refunding.

The Department did not have clearly defined procedures that allow it to be consistent in processing overpayments nor did the Department have management responsible for overseeing the entire overpayment processes.

Effect of Condition

The Department was unable to clearly evidence that the federal share of eight overpayments totaling \$442,907.29 was refunded to the grantor. The Department's inability to track a specific overpayment from initiation through completion of refunding prevents the Department from being able to adequately monitor those refunds, and from obtaining assurance that the process is working correctly. While we were unable to determine with assurance that the overpayments were refunded, we were also unable to determine that they were not refunded. Because of this, we are not questioning the \$221,453 that we estimate to be the federal share of those overpayments.

Recommendations

We recommend the Department:

- Train staff members to ensure they adequately perform duties related to overpayment refunding.
- Clearly identify those divisions, managers and supervisors with responsibility and authority for each aspect of the overpayment refunding process, including obtaining assurance that the Department can evidence the refunding of each overpayment.
- Work with the U.S. Department of Health and Human Services to provide assurances, to the grantor's satisfaction, that the federal share of overpayments has been properly refunded.

Department's Response:

The Office of Accounting Services (OAS) concurs that due to unexpected staff turnover, staff were not adequately trained to perform the duties related to overpayment refunding. The OAS will ensure that grants management staff is trained by March 2009 on the process of repayment of prior-prior biennium recoveries. OAS will also ensure that the one remaining prior-prior biennium recovery related to this finding that has not already been repaid to the federal government will be repaid by March 2009.

The Department also concurs with the recommendation to clearly identify the OAS and OFR managers, supervisors, and staff that are responsible for their part of the overpayment refunding process.

The Department would like to add clarity to the information presented in the Description of Condition section above. In the initial stages of the audit, the Department communicated that due to federal requirements regarding preparation of the CMS-64 Medicaid Claim during October, and staff resources required to meet this federal mandate, the State Auditor's Office (SAO) requests for data would need to be made prior to October. SAO made the request for detailed information in October when staff were unavailable due to meeting federally mandated requirements. The Department again communicated that resources would not be available until the CMS-64 Medicaid Claim was completed.

Throughout December 2008 and January 2009, FSA staff worked to research the selected overpayments and provide the detailed information to the SAO. There were initial challenges in providing the data due to the loss of a key staff member; however, staff from OAS and OFR provided the requested information to the SAO.

The Department believes that we have provided detailed information to the SAO on all items requested. We have shared this information with the SAO. In a final meeting with the SAO on January 16, 2009, scheduled to review and resolve any remaining outstanding issues or questions, the SAO staff indicated that we had answered all their questions and provided all the needed information.

The Department will work with the appropriate staff of the U.S. Department of Health and Human Services, CMS Region X, to ensure that they are satisfied that the state has refunded the \$221,453.00 federal share of overpayments.

Auditor's Concluding Remarks

We appreciate the Department's commitment to improving its internal controls over federal overpayment refunding. We look forward to reviewing these improvements during our next audit.

Applicable Laws and Regulations

Circular No. A-133, Subpart C, §.300 Auditee responsibilities. states in part:

The auditee shall:

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

42 CFR 433.312 Basic requirements for refunds.

(a) Basic rules.

(1) Except as provided in paragraph (b) of this section, the Medicaid agency has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.

(2) The agency must refund the Federal share of overpayments at the end of the 60-day period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider.

(b) Exception.

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

(c) Applicability.

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

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

42 CFR 433.318 Overpayments involving providers who are bankrupt or out of business.

(a) Basic rules. (1) The agency is not required to refund the Federal share of an overpayment made to a provider as required by Sec. 433.312(a) to the extent that the State is unable to recover the overpayment because the provider has been determined bankrupt or out of business in accordance with the provisions of this section...

(b) Overpayment debts that the State need not refund. Overpayments are considered debts that the State is unable to recover within the 60-day period following discovery if the following criteria are met:

(1) The provider has filed for bankruptcy, as specified in paragraph (c) of this section; or

(2) The provider has gone out of business and the State is unable to locate the provider and its assets, as specified in paragraph (d) of this section...

(e) Circumstances requiring refunds. If the 60-day recovery period has expired before an overpayment is found to be uncollectible under the provisions of this section, if the State recovers an overpayment amount under a court-approved discharge of bankruptcy, or if a bankruptcy petition is denied, the agency must refund the Federal share of the overpayment in accordance with the procedures specified in Sec. 433.320.

42 CFR 433.320 Procedures for refunds to CMS.

(a) Basic requirements.

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

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

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

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

(1) The State is not required to refund the Federal share of an overpayment when the State reports a collection or submits an expenditure claim reduced by a discrete amount to recover an overpayment prior to the end of the 60-day period following discovery.

(2) The State is not required to report on the Form CMS-64 any collections made on overpayment amounts for which the Federal share has been refunded previously.

(3) If a State has refunded the Federal share of an overpayment as required under this subpart and the State subsequently makes recovery by reducing future provider payments by a discrete amount, the State need not reflect that reduction in its claim for Federal financial participation...

(d) Expiration of 60-day recovery period. If an overpayment has not been determined uncollectible in accordance with the requirements of Sec. 433.318 at the end of the 60-day period following discovery of the overpayment, the agency must refund the Federal share of the overpayment to CMS in accordance with the procedures specified in paragraph (a) of this section.

08-21 The Department of Social and Health Services, Health and Recovery Services Administration's internal controls are inadequate to identify and recover Medicaid overpayments to pharmaceutical providers made when billing codes are used inappropriately.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number: 5-0805WA5028, 5-0805WA5048
Applicable Compliance Component: Activities Allowed or Unallowed
Questioned Cost Amount: None

Background

Medicaid is the “payer of last resort”, meaning that other payment sources should be identified and used 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. Federal regulations require states to have processes to identify third parties before Medicaid dollars are used.

Pharmacies submit claims for Medicaid client prescriptions through an electronic Point of Sale system. This system interfaces with the Medicaid Management Information System (MMIS), which processes requests for payment through a series of criteria within the system, or edits. Claims are paid if they successfully pass all edits.

When pharmacies submit claims for payment to Medicaid, they must enter any third-party payers that may be liable for paying. If a provider submits a claim on behalf of a client who has other insurance without accurately entering the third-party resource, the Point of Sale system will deny the claim. However, the system edits intended to identify and deny these claims can be rendered inoperative by use of manual override codes. The override codes, part of the National Council for Prescription Drugs Programs electronic claims submission standard, are recognized nationally as electronic claims processing standards used throughout the pharmacy community. The override codes were established for uses such as processing payment for a drug the client's insurance does not cover, but which is covered by Medicaid.

In our audits of state fiscal years 2006 and 2007, we reported a lack of adequate controls over use of override codes. The accuracy of information entered into the system depends on the pharmacy. The pharmacy can enter either the accurate third-party payer information or override codes to bypass the system that would deny payment on the claim should the information be inaccurate. Due to this significant, inherent control weakness, claims for pharmaceutical payments are susceptible to error or abuse. Claims that should have been paid in whole or in part by third parties could be paid by the Medicaid program. To compensate for this, the Department established a post-payment audit program to identify and recover payments made to providers who inappropriately billed Medicaid.

The Department paid more than \$429 million to pharmacies for services to Medicaid clients in fiscal year 2008. This does not include payments for clients who are eligible for Medicare in addition to Medicaid. For those individuals, Medicaid will cover any costs not covered by Medicare, and so use of the override code would not be uncommon. We eliminated those payments from the scope of this review.

Description of Condition

We reviewed the Department’s post-payment audit program to determine if it is effective in identifying overpayments and recovering overpayments. We reviewed the Department’s third-party liability audit selection procedures, risk assessment and post-payment audit coverage.

We found the Department has a good understanding of where overpayment risks occur and what they are. Quarterly, the Department pulls data from MMIS and the point-of-sale system and analyzes claims in which override codes were used. In fiscal year 2008, the Department narrowed the scope of the audits to riskier claims by selecting providers based on the amount claims in the “Insurance on MMIS-Override Coverage Codes (OCC) 3, 7 and 8 used”. The table below shows total OCC 3,7,8 claims paid and audited.

	Fiscal year 2008 Claims Paid	Fiscal year 2008 Audited	Coverage percentage
Providers	1,216	11	0.90%
Claims w/ OCC 3,7,8 Used - Claim Count	100,796	6,318	6.27%
Claims w/ OCC 3,7,8 Used - Claim Amount	\$7,199,540.17	\$1,162,866.24	16.15%
Claims w/ OCC 3,7,8 and Insurance on MMIS - Claim Count	43,042	6,318	14.68%
Claims w/ OCC(3,7,8) and Insurance on MMIS - Claim Amount	\$4,023,680.50	\$1,162,866.24	28.90%

Other Coverage Code 3: Other coverage exists, claim not covered
 Other Coverage Code 7: Other coverage exists, not in effect at time of service
 Other Coverage Code 8: Contracted copayments

While we found the process to be effective, the Department could not demonstrate the amount of coverage is adequate to address the risk of overpayments. We found that the Department has not analyzed the level of audit coverage needed to determine if it is identifying and recovering all overpayments. The Department could not demonstrate a correlation between the amount of potential overpayments and the resources it devotes to identifying and recovering them.

As shown in the table below, a significant portion of the payments audited by the Department are found to be inappropriate, and are subsequently recovered. These recoveries include state and federal money.

Fiscal Year	Audits Completed	Claim Amount Audited	Recouped	Recovery Percentage
2005	11	\$1,681,420.36	\$684,057.69	40.68%
2006	25	\$2,248,337.34	\$1,244,288.30	55.34%
2007	19	\$2,677,689.96	\$1,141,368.87	42.63%
2008	11	\$1,162,866.24	\$577,507.97	49.66%

Cause of Condition

The Department stated reasonable controls are in place for the Point of Sale system and any further controls would make the system too cumbersome to use. The Department stated it will not place additional restrictions on the use of override codes because that would prevent timely service to Medicaid clients. The Department stated it has compensating controls in place to provide reasonable assurance that improper payments will be recovered through its post-payment audit process.

In response to the prior year’s finding and recommendation, the Department did prepare a type of analysis indicating the potential increase in payment recovery if it added staff. However, this analysis does not

provide information on what would be an appropriate amount of post-payment audit coverage to maximize recovery of overpayment.

Effect of Condition

Inaccurate third-party liability coverage information can be entered into the point-of-sale system causing Medicaid dollars to be spent on pharmacy services that should have been paid by third parties. Due to the lack of risk analysis and adequate post-payment audits, the Department cannot reasonably assure improper payments will be identified and recovered.

The Department's own audit work shows that of the claims audited a significant portion were improperly billed to Medicaid. Approximately half of the funds recovered are federal, and half are state.

Recommendation

We recommend the Department:

- Strengthen controls over entry of claims into the payment system to ensure third-party payers are properly billed before Medicaid is billed, as required by federal regulations.
- Perform on-going risk analysis and assessment to determine the appropriate level of post-payment audit coverage for third-party liability claims to ensure improper payments will be identified and recovered.

Department's Response

The Department does not concur with this finding.

During SFY08 the Health and Recovery Services Administration (HRSA) continued to collaborate with the Washington State Pharmacy Association (WSPA). The collaborative efforts between WSPA and HRSA continue to be targeted at prevention of inappropriate payments for pharmacy claims that are not allowable under the Medicaid program. In addition, HRSA will be evaluating other coverage code usage in the ProviderOne Point of Sale System (POS) which was implemented on October 20, 2008. These activities will result in the decline of inappropriate use of other coverage codes.

HRSA is performing on-going risk analysis and assessment to determine the appropriate level of post-payment audit coverage for third-party liability (TPL) claims against the current staffing resources. In March 2008, a risk assessment and analysis was performed. From this, a plan was implemented to ensure that audits are focused on the most aberrant providers. On a quarterly basis, paid claims data is run to identify providers with the highest usage of other coverage codes. The providers are ranked by paid amount and those with the highest dollars are prioritized and are reviewed by OPRA. The Department believes it is focusing on the highest rate of return through this quarterly review because the pharmacies selected for audit are those with claims where the Department knows the Medicaid client has primary insurance.

HRSA will always strive to enhance its strategies for ensuring adequate post payment audit coverage. The process will continue to focus on identifying and prioritizing audits by risk exposure (i.e. dollars by other coverage code), but may include additional steps or resources to strengthen the over-all post payment review process and provide reasonable assurance that improper payments are recovered.

Auditor's Concluding Remarks

We thank the Department for its response, and will review this area during our next audit.

Applicable Laws and Regulations

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

The auditee shall:

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

When probable liability is established at the time a claim is filed 42CFR433.139 (b) (1) requires:

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.

42CFR 433.140 (a) stipulates the following regarding a state's claim for federal financial participation:

(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.

WAC 388-501-0200 states:

(1) MAA requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(2) MAA pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:

- (a) Prenatal care;
- (b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or
- (c) Preventive pediatric services as covered under the EPSDT program.

(3) MAA pays for medical services and seeks reimbursement from any liable third party when both of the following apply:

- (a) The provider submits to MAA documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and
- (b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:
 - (i) Is not complying with an existing court order; or
 - (ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill MAA or the client for a covered service when a third party pays a provider the same amount as or more than the MAA rate.

(5) When the provider receives payment from the third party after receiving reimbursement from MAA, the provider must refund to MAA the amount of the:

(a) Third-party payment when the payment is less than MAA's maximum allowable rate;
or

(b) MAA payment when the third-party payment is equal to or greater than MAA's maximum allowable rate.

(6) MAA is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills MAA, except as described under subsections (2) and (3) of this section.

(7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:

(a) Receives direct third-party reimbursement for such services; or

(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.

(8) MAA considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.

(9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.

(10) For third-party liability on personal injury litigation claims, MAA is responsible for providing medical services as described under WAC 388-501-0100.

08-22 The Department of Social and Health Services does not have adequate internal controls to ensure new applicants meet federal citizenship requirements before receiving Medicaid benefits.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number:	5-0805WA5028, 5-0805WA5048
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	None

Background

Medicaid is a jointly funded state and federal partnership providing health coverage for selected categories of people with low incomes who might otherwise go without medical care. The state of Washington Medicaid program spent more than \$6 billion during fiscal year 2008. Approximately half of Medicaid expenditures were paid with federal funds.

Under federal law, all U.S. citizens and certain legal immigrants who meet Medicaid’s financial and non-financial eligibility criteria are entitled to Medicaid. The Medicaid program requires states to establish that individuals applying for Medicaid are U.S. citizens or satisfy the immigration requirements, which are detailed in the regulations.

The state has always required that individuals be citizens or certain classes of federally designated immigrants to be eligible for Medicaid. Individuals have been allowed to “self-declare” citizenship on an application that is signed under a “penalty of perjury” statement. DSHS has not independently verified citizenship status, unless it found the client statement to be questionable based on information to the contrary.

The federal Deficit Reduction Act of 2005 made changes to the operations of many federal programs, including Medicaid. Among those changes is a requirement that all current Medicaid recipients and all new applicants who claim U.S. citizenship must provide evidence to prove their citizenship and identity, effective July 1, 2006, or at the first eligibility re-determination after the effective date of the Act. The regulation defines what constitutes acceptable proof in order of reliability, and requires the recipient or applicant to present original documents or copies certified by the issuing agency.

A rule issued by Centers for Medicare and Medicaid Services states individuals already enrolled in Medicaid must be given a “reasonable opportunity” to present the required documentation to verify citizenship before a state takes any action to terminate eligibility. Current Medicaid beneficiaries continue to receive benefits if they demonstrate a good faith effort to present satisfactory evidence of citizenship and identity. What constitutes a “good faith effort” is not defined by the rule, and so is left to the judgment of DSHS.

Under the Act, however, new applicants are not eligible until they have presented the required documentation or are otherwise determined to be exempt from the requirements as described in the regulation.

Description of Condition

During our audit of fiscal year 2007, we reported the Department had elected to not fully comply with the new requirements, and continued to provide Medicaid benefits to applicants prior to obtaining the required documentation to verify citizenship and identity. During that audit, we identified 28 out of 210 clients selected had received benefits without having provided the required documentation.

For our current audit, we found the Department had made no changes to its process, and continued to be out of compliance with the regulation during the audit period. Based on this, and the time and effort involved in detailed testing of Medicaid client eligibility, we determined that re-performing this testing would not be an effective use of our resources.

Cause of Condition

The Department stated that systems would be put into place to ensure that medical costs will not be charged to the Medicaid program until all requirements are met. However, the Department did not plan to have these measures in place until July 2008, after the fiscal year under audit.

Effect of Condition

The Department provided Medicaid benefits to applicants who did not meet citizenship requirements for the program.

Recommendations

We recommend the Department establish and follow adequate controls to ensure compliance with Medicaid citizenship requirements. We further recommend DSHS continue to take the necessary steps to verify the eligibility of new applicants who are receiving Medicaid benefits and have not provided the required documents.

Department's Response

The Department concurs with this finding.

As stated by the auditor, the department's corrective action plan was not completed during FY08, the time period reviewed by the auditor. Since the completion of State Auditor's work, the department completed the first two actions listed below by July 1, 2008 and the third and final action identified below by September 1, 2008. The department:

- Developed citizenship verification and identity processes to ensure accurate eligibility decisions for all applicants under and over 19 years of age;*
- Provided citizenship verification, identity training and communication related to eligibility for applicants under and over 19 years of age to staff who determine medical eligibility; and*
- Implemented a manual process for correctly charging medical costs to state only funds for individuals whose citizenship and/or identity is not documented. This process assures the department is not claiming federal match for medical services to these recipients.*

The new policies and procedures require citizenship verification and proof of identity for all applicants 19 years of age and older and for all non-pregnant applicants under the age of 19 prior to approval for Medicaid services. Applicants who are under the age of 19 and pregnant, or who are parents of non-pregnant children, who do not comply with the federally mandated documentation requirements,

are authorized to receive medical services under a non-Medicaid program. These services are paid for with state funds.

Auditor's Concluding Remarks

We appreciate the steps the Department has taken to address this issue. We look forward to reviewing the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 42 USC 1396b(i)(22) states:

With respect to amounts expended for medical assistance for an individual who declares under section 1137(d)(1)(A) [42 USCS § 1320b-7(d)(1)(A)] to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title [42 USCS §§ 1396 et seq.], unless the requirement of subsection (x) is met.

Title 42 USC 1396b(x)(1) states:

For purposes of subsection (i)(22), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

Title 42 CFR 435.406, Citizenship and alienage, states:

(a) The agency must provide Medicaid to otherwise eligible residents of the United States who are

(1) Citizens:

(i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and

(ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in §435.407.

(iii) An individual for purposes of the declaration and citizenship documentation requirements discussed in paragraphs (a)(1)(i) and (a)(1)(ii) of this section includes both applicants and recipients under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in their expenditures, as though the expenditures were for medical assistance.

(iv) Individuals must declare their citizenship and the State must document the individual's citizenship in the individual's eligibility file on initial applications and initial redeterminations effective July 1, 2006.

(v) The following groups of individuals are exempt from the requirements in paragraph (a)(1)(ii) of this section:

(A) Individuals receiving SSI benefits under title XVI of the Act.

(B) Individuals entitled to or enrolled in any part of Medicare.

(C) Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on the individual's disability (as defined in section 223(d) of the Act).

(D) Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are recipients of foster care maintenance or adoption assistance payments under Title IV-E of the Act.

(2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified aliens), qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified aliens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or recipient is an alien in a satisfactory immigration status.

(ii) The eligibility of qualified aliens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.

(b) The agency must provide payment for the services described in §440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified aliens subject to the 5-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria, except non-qualified aliens need not present a social security number or document immigration status.

Title 42 CFR 435.407, Types of acceptable documentary evidence of citizenship, states:

For purposes of this section, the term “citizenship” includes status as a “national of the United States” as defined by section 101(a)(22) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(22)) to include both citizens of the United States and non-citizen nationals of the United States.

(a) *Primary evidence of citizenship and identity.* The following evidence must be accepted as satisfactory documentary evidence of both identity and citizenship:

(1) *A U.S. passport.* The Department of State issues this. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. Note: Spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented. Exception: Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.

(2) *A Certificate of Naturalization (DHS Forms N-550 or N-570.)* Department of Homeland Security issues for naturalization.

(3) *A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561.)* Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.

(4) A valid State-issued driver's license, but only if the State issuing the license requires proof of U.S. citizenship before issuance of such license or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen. (This provision is not effective until such time as a State makes providing evidence of citizenship a condition of issuing a driver's license and evidence that the license holder is a citizen is included on the license or in a system of records available to the Medicaid agency. The State must ensure that the process complies with this statutory provision in section 6036 of the Deficit Reduction Act of 2005. CMS will monitor compliance of States implementing this provision.)

(b) *Secondary evidence of citizenship.* If primary evidence from the list in paragraph (a) of this section is unavailable, an applicant or recipient should provide satisfactory documentary evidence of citizenship from the list specified in this section to establish citizenship and satisfactory documentary evidence from paragraph (e) of this section to establish identity, in accordance with the rules specified in this section.

(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986 (NMI local time)). A State, at its option, may use a cross match with a State vital statistics agency to document a birth record. The birth record document may be issued by the State, Commonwealth, Territory, or local jurisdiction. It must have been recorded before the person was 5 years of age. A delayed birth record document that is recorded at or after 5 years of age is considered fourth level evidence of citizenship. (Note: If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories.) The following will establish U.S. citizenship for collectively naturalized individuals:

(i) *Puerto Rico:*

(A) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941; or

(B) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

(ii) *U.S. Virgin Islands:*

(A) Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession, or the U.S. Virgin Islands on February 25, 1927; or

(B) The applicant's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession, or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or

(C) Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or Territory, or the Canal Zone on June 28, 1932.

(iii) *Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):*

(A) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time); or

(B) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration before January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time); or

(C) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time).

(D)Note: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

(2) *A Certification of Report of Birth (DS-1350)*. The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, DC. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.

(3) *A Report of Birth Abroad of a U.S. Citizen (Form FS-240)*. The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.

(4) *A Certification of birth issued by the Department of State (Form FS-545 or DS-1350)*. Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.

(5) *A U.S. Citizen I.D. card*. (This form was issued until the 1980s by INS. Although no longer issued, holders of this document may still use it consistent with the provisions of section 1903(x) of the Act.) INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.

(6) *A Northern Mariana Identification Card (I-873)*. (Issued by the DHS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986.) The former Immigration and Naturalization Service (INS) issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.

(7) *An American Indian Card (I-872) issued by the Department of Homeland Security with the classification code "KIC."* (Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the United States/Mexican border.) DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship.

(8) *A final adoption decree showing the child's name and U.S. place of birth*. The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

(9) *Evidence of U.S. Civil Service employment before June 1, 1976.* The document must show employment by the U.S. government before June 1, 1976. Individuals employed by the U.S. Civil Service prior to June 1, 1976 had to be U.S. citizens.

(10) *U.S. Military Record showing a U.S. place of birth.* The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth.)

(11) *A data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens.* A State may conduct a verification with SAVE to determine if an individual is a naturalized citizen, provided that such verification is conducted consistent with the terms of a Memorandum of Understanding or other agreement with the Department of Homeland Security (DHS) authorizing verification of claims to U.S. citizenship through SAVE, including but not limited to provision of the individual's alien registration number if required by DHS.

(12) *Child Citizenship Act.* Adopted or biological children born outside the United States may establish citizenship obtained automatically under section 320 of the Immigration and Nationality Act (8 U.S.C. 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000). The State must obtain documentary evidence that verifies that at any time on or after February 27, 2001, the following conditions have been met:

(i) At least one parent of the child is a United States citizen by either birth or naturalization (as verified under the requirements of this Part);

(ii) The child is under the age of 18;

(iii) The child is residing in the United States in the legal and physical custody of the U.S. citizen parent;

(iv) The child was admitted to the United States for lawful permanent residence (as verified under the requirements of 8 U.S.C. 1641 pertaining to verification of qualified alien status); and

(v) If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 U.S.C. 1101(b)(1) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States)), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred).

(c) *Third level evidence of citizenship.* Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when both primary and secondary evidence is unavailable. Third level evidence may be used only when the applicant or recipient alleges being born in the U.S. A second document from paragraph (e) of this section to establish identity must also be presented:

(1) *Extract of a hospital record on hospital letterhead established at the time of the person's birth that was created 5 years before the initial application date and that indicates a U.S. place of birth.* (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) Do not accept a souvenir "birth certificate" issued by the hospital.

(2) *Life, health, or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date that indicates a U.S. place of birth.* (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) Life or health insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

(3) *Religious record recorded in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made.* The record must be an official record recorded with the religious organization. CAUTION: In questionable cases (for example, where the child's religious record was recorded near a U.S. international border and the child may have been born outside the U.S.), the State must verify the religious record and/or document that the mother was in the U.S. at the time of birth.

(4) *Early school record showing a U.S. place of birth .* The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of birth of the applicant's parents.

(d) *Fourth level evidence of citizenship.* Fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence should only be used in the rarest of circumstances. This level of evidence is used only when primary, secondary and third level evidence is unavailable. With the exception of the affidavit process described in paragraph (d)(5) of this section, the applicant may only use fourth level evidence of citizenship if alleging a U.S. place of birth. In addition, a second document establishing identity must be presented as described in paragraph (e) of this section.

(1) *Federal or State census record showing U.S. citizenship or a U.S. place of birth.* (Generally for persons born 1900 through 1950.) The census record must also show the applicant's age. Note: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or State should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Medicaid eligibility. This form requires a fee.

(2) *One of the following documents that show a U.S. place of birth and was created at least 5 years before the application for Medicaid.* (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) This document must be one of the following and show a U.S. place of birth:

(i) Seneca Indian tribal census.

(ii) Bureau of Indian Affairs tribal census records of the Navajo Indians.

(iii) U.S. State Vital Statistics official notification of birth registration.

(iv) A delayed U.S. public birth record that is recorded more than 5 years after the person's birth.

(v) Statement signed by the physician or midwife who was in attendance at the time of birth.

(vi) The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.

(3) *Institutional admission papers from a nursing facility, skilled care facility or other institution created at least 5 years before the initial application date that indicates a U.S. place of birth .* Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

(4) *Medical (clinic, doctor, or hospital) record created at least 5 years before the initial application date that indicates a U.S. place of birth .* (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.)

Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. (Note: An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.)

(5) *Written affidavit.* Affidavits should ONLY be used in rare circumstances. If the documentation requirement needs to be met through affidavits, the following rules apply:

(i) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship (the two affidavits could be combined in a joint affidavit).

(ii) At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient.

(iii) In order for the affidavit to be acceptable the persons making them must be able to provide proof of their own citizenship and identity.

(iv) If the individual(s) making the affidavit has (have) information which explains why documentary evidence establishing the applicant's claim or citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well.

(v) The State must obtain a separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained.

(vi) The affidavits must be signed under penalty of perjury and need not be notarized.

(e) *Evidence of identity.* The following documents may be accepted as proof of identity and must accompany a document establishing citizenship from the groups of documentary evidence of citizenship in the groups in paragraphs (b) through (d) of this section.

(1) Identity documents described in 8 CFR 274a.2(b)(1)(v)(B)(1).

(i) Driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color.

(ii) School identification card with a photograph of the individual.

(iii) U.S. military card or draft record.

(iv) Identification card issued by the Federal, State, or local government with the same information included on drivers' licenses.

(v) Military dependent's identification card.

(vi) Certificate of Degree of Indian Blood, or other American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. Acceptable if the document carries a photograph of the applicant or recipient, or has other personal identifying information relating to the individual such as age, weight, height, race, sex, and eye color.

(vii) U.S. Coast Guard Merchant Mariner card.

Note to paragraph (e)(1): Exception: Do not accept a voter's registration card or Canadian driver's license as listed in 8 CFR 274a.2(b)(1)(v)(B)(1). CMS does not view these as reliable for identity.

(2) At State option, a State may use a cross match with a Federal or State governmental, public assistance, law enforcement or corrections agency's data system to establish identity if the agency establishes and certifies true identity of individuals. Such agencies may include food stamps, child support, corrections, including juvenile detention, motor vehicle, or child protective services. The State Medicaid Agency is still responsible for assuring the accuracy of the identity determination.

(3) At State option, a State may accept three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the individual's citizenship and the individual submitted second or third tier evidence of citizenship. The State must first ensure that no other evidence of identity is available to the individual prior to accepting such documents. Such documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity. All documents used must contain consistent identifying information. These documents include employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees and property deeds/titles.

(f) *Special identity rules for children.* For children under 16, a clinic, doctor, hospital or school record may be accepted for purposes of establishing identity. School records may include nursery or daycare records and report cards. If the State accepts such records, it must verify them with the issuing school. If none of the above documents in the preceding groups are available, an affidavit may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent, guardian or caretaker relative (as defined in the regulations at 45 CFR 233.90(c)(v)) stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided. The affidavit is not required to be notarized. A State may accept an identity affidavit on behalf of a child under the age of 18 in instances when school ID cards and drivers' licenses are not available to the individual in that area until that age.

(g) *Special identity rules for disabled individuals in institutional care facilities.* A State may accept an identity affidavit signed under penalty of perjury by a residential care facility director or administrator on behalf of an institutionalized individual in the facility. States should first pursue all other means of verifying identity prior to accepting an affidavit. The affidavit is not required to be notarized.

(h) *Special populations needing assistance.* States must assist individuals to secure satisfactory documentary evidence of citizenship when because of incapacity of mind or body the individual would be unable to comply with the requirement to present satisfactory documentary evidence of citizenship in a timely manner and the individual lacks a representative to assist him or her.

(i) *Documentary evidence.* (1) All documents must be either originals or copies certified by the issuing agency. Uncertified copies, including notarized copies, shall not be accepted.

(2) States must maintain copies of citizenship and identification documents in the case record or electronic data base and make these copies available for compliance audits.

(3) States may permit applicants and recipients to submit such documentary evidence without appearing in person at a Medicaid office. States may accept original documents in person, by mail, or by a guardian or authorized representative.

(4) If documents are determined to be inconsistent with pre-existing information, are counterfeit, or altered, States should investigate for potential fraud and abuse, including but not limited to, referral to the appropriate State and Federal law enforcement agencies.

(5) Presentation of documentary evidence of citizenship is a one time activity; once a person's citizenship is documented and recorded in a State database subsequent changes in eligibility should not require repeating the documentation of citizenship unless later evidence raises a question of the person's citizenship. The State need only check its databases to verify that the individual already established citizenship.

(6) CMS requires that as a check against fraud, using currently available automated capabilities, States will conduct a match of the applicant's name against the corresponding Social Security number that was provided. In addition, in cooperation with other agencies of the Federal government, CMS encourages States to use automated capabilities to verify citizenship and identity of Medicaid applicants. Automated capabilities may fall within the computer matching provisions of the Privacy Act of 1974, and CMS will explore any implementation issues that may arise with respect to those requirements. When these capabilities become available, States will be required to match files for individuals who used third or fourth tier documents to verify citizenship and documents to verify identity, and CMS will make available to States necessary information in this regard. States must ensure that all case records within this category will be so identified and made available to conduct these automated matches. CMS may also require States to match files for individuals who used first or second level documents to verify citizenship as well. CMS may provide further guidance to States with respect to actions required in a case of a negative match.

(j) *Record retention.* The State must retain documents in accordance with 45 CFR 74.53.

(k) *Reasonable opportunity to present satisfactory documentary evidence of citizenship.* States must give an applicant or recipient a reasonable opportunity to submit satisfactory documentary evidence of citizenship before taking action affecting the individual's eligibility for Medicaid. The time States give for submitting documentation of citizenship should be consistent with the time allowed to submit documentation to establish other facets of eligibility for which documentation is requested. (*See* §435.930 and §435.911.)

08-23 The Department of Social and Health Services does not have adequate internal controls to ensure people receiving Medicaid benefits have valid Social Security numbers.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number: 5-0805WA5028, 5-0805WA5048
Applicable Compliance Component: Eligibility
Questioned Cost Amount: None

Background

Medicaid is a jointly funded state and federal partnership providing health coverage for low- income individuals who might otherwise go without medical care. The state spent more than \$6.4 billion on the Medicaid program during fiscal year 2008; approximately half was paid with federal funds.

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

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

Along with the use of SOLQ, every Social Security number entered in the Automated Client Eligibility System (ACES) 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 DSHS Community Service Office.

In our audits for fiscal years 2004 through 2007, we reported findings regarding the Department's lack of controls to ensure people receiving Medicaid benefits have valid Social Security numbers.

Description of Condition

During our current audit, we found most of those who work on eligibility verification used SOLQ to validate Social Security numbers prior to admitting clients into the Medicaid program. While we found improvements, we still found deficiencies in internal controls. Key internal controls that are intended to ensure all Medicaid applicants have a valid Social Security number did not operate as designed:

- The Department could not demonstrate that staff consistently and properly resolved in a timely manner Social Security number mismatch alerts sent by the Administration.
- All Department field offices do not follow the policy that requires monitoring of staff responses to Social Security number mismatch alerts.

- Employees do not consistently follow the policy that requires workers to follow up on all cases in monthly “No SSN” reports.

Cause of Condition

Due to the lack of uniform monitoring, the Department cannot ensure the controls designed to validate Social Security numbers are working.

Effect of Condition

To determine the effect of the control deficiencies, we independently verified all Medicaid client Social Security numbers in the Department’s Medicaid claims processing systems by running a computerized cross-match with the Social Security Administration’s database.

We identified 561 numbers in the Department’s Medicaid Management Information system (MMIS) and Social Service Payment System (SSPS) which, according to the Social Security Administration’s database, have never been issued and are therefore invalid. The Department was able to resolve 528 of these; most were due to data entry or other error. Thirty-three remain unresolved.

We also found 8,738 clients that had no Social Security numbers in MMIS and SSPS. We randomly selected 180 and performed testing to determine whether the clients have valid social security numbers. Through follow up, the Department was able to resolve 141 of those. Thirty-nine remain unresolved.

We used Computer Assisted Audit Techniques to identify payments for services provided to individuals using the Social Security number of a deceased person and found 690 clients doing so. We performed a preliminary review of the 690 clients and selected 64 for Department verification and follow up. The Department was able to resolve 57 of those. Seven remain unresolved.

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

The Department was unable to locate a valid SSN for the client	MMIS		SSPS	
	Number of Social Security numbers	Payments	Number of Social Security numbers	Payments
Invalid SSN testing	28	\$24,946.82	5	\$15,207.35
No SSN testing	25	\$42,811.47	14	\$28,497.03
SSN of deceased person testing	7	\$31,996.73	0	\$0.00
Total	60	\$99,755.02	19	\$43,704.38

The focus of our work was to evaluate the Department’s controls over and compliance with federal requirements for verifying recipients’ Social Security numbers upon initial application and their follow up on daily mismatch alerts. Our audit work was not designed to determine if recipients were eligible for Medicaid.

Under federal laws and regulations, a disallowance of federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State’s Medicaid Eligibility Quality Control program, a federally mandated Medicaid eligibility review process. Because of this, and the fact that we did not

perform work to determine if the clients associated with the invalid numbers were or are Medicaid-eligible, we are not questioning payments associated with the services for those clients.

Recommendation

We recommend the Department:

- Monitor all alerts regarding Social Security numbers to ensure they are resolved.
- Establish a uniform policy regarding monitoring of staff responses to Social Security number mismatch alerts.
- Monitor to ensure staff reviews all cases in a monthly “No SSN” report.
- Follow up on 79 clients for whom the Department could not give us evidence of correct Social Security Numbers.

Department’s Response

The Department concurs with the finding.

Resolve mismatch alerts - *The Department agrees that workers are not consistent in resolving mismatch alerts. The Economic Service Administration (ESA) Community Service Division (CSD) will send a reminder memo to their field staff on the importance of working the alerts; Health and Recovery Services Administration (HRSA) will send a reminder to their eligibility staff.*

Establish a Uniform Policy regarding staff monitoring of mismatch alerts - *The Department agrees that a uniform policy to establish clear and uniform monitoring expectations are needed. ESA/CSD will develop a monitoring policy that establishes clear and uniform monitoring expectations for supervisors for monitoring staff responses to Social Security number mismatch alerts; HRSA already has a process in place.*

Monitor No Social Security Alerts - *ESA/CSD has been receiving a monthly No Social Security Number (SSN) report from the HRSA since February 2007. CSD field workers are required to work the list and report to CSD headquarters when actions are completed. Because the list was not being completed consistently by the field, CSD headquarters staff began to complete a random sample of the report to ensure appropriate actions were taken and the list worked. CSD is auditing cases identified on the report as being open on assistance for over 2 months without a Social Security Number (SSN) on file. The minimum audit will be 10 cases per region. Results from this effort were not realized during this audit cycle since the sample audited was prior to implementation of the new process. CSD headquarter staff did not begin to monitor the report until March 2008; therefore, not enough time had passed to reflect improvement.*

Follow up on the 79 clients for whom DSHS did not supply evidence of a correct Social Security Number (SSN) - *The Department agrees that not all SSNs were supplied to the auditor during the audit review process. The department conducted a post-audit review and determined that many clients thought not to have a SSN did in fact have a valid SSN. The results of our post-audit reviews are as follows.*

Of the 25 SSNs that were not found in ACES and CAMIS for the MMIS testing, 17 of those were Adoption Subsidy cases, and are highly confidential. The 17 SSNs in question are for children who were wards of the state but were adopted into permanent families. The children’s names were changed when they were adopted and extreme confidentiality exists to protect the safety of the children and their new families. The department does keep a table of pre and post adoption names that allows for cross matching from pre-adoption to post adoption activities. This allows the department to obtain

the SSN from CAMIS. For the 17 Adoption Subsidy cases reviewed, all 17 SSNs were found in CAMIS by using the pre-adopted name for the search instead of the post-adoption name provided by the auditor for their testing. For the remaining 8 SSNs not found during the audit for the No SSN review in MMIS, 3 of the 8 were subsequently found in CAMIS or ACES with the aide of the previously mentioned cross-match listing.

Thirty of the 33 invalid SSNs on the exception list for MMIS and SSPS cases belonged to individuals who were no longer receiving assistance at the time of the review. Due to the fact that new information cannot be inserted into a closed case, annotations have been made to the respective closed case files to alert DSHS employees of the need to verify the correct SSN in the event the client reapplies for benefits. The remaining 3 exceptions were for cases that the department never approved and were subsequently closed because the client did not provide a SSN.

Auditor's Concluding Remarks

We thank the Department for its response, and look forward to reviewing the status of its corrective action during our next audit.

Applicable Laws and Regulations

The Code of Federal Regulations is explicit regarding obtaining and verifying Social Security numbers as a condition of Medicaid eligibility.

42 CFR 435.910 (a) specifically states in part:

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

42 CFR 435.910 (g) states:

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

If a Medicaid applicant cannot remember or has not been issued a Social Security number, 42 CFR 435.910 (e) (1-3) states that 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.

42 CFR 435.916 (a) states in part:

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

42 CFR 435.920 (a-c) states:

- (a) In re-determining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN.

(b) If the case record does not contain the required SSNs, the agency must require the recipient to furnish them and meet other requirements of 435.910.

If the agency initially established eligibility without verification of the Social Security number, 42 CFR 435.920 (c) requires:

For any recipient whose SSN was established as part of the case record without evidence required under the SSN regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with 435.910.

The Medicaid State Plan incorporates the above references as applicable to Washington State's coverage and eligibility criteria when it states the following:

The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

08-24 The Department of Social and Health Services, Health and Recovery Services Administration's internal controls are insufficient to ensure payment rates to its Healthy Options managed care providers are based on accurate data.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number: 5-0805WA5028, 5-0805WA5048
Applicable Compliance Component: Special Tests and Provisions: Managed Care
Questioned Cost Amount: None

Background

Managed care providers receive a uniform, pre-determined, per-patient monthly rate regardless of the number of times they see the patient each month and regardless of services provided, as long as the services are covered under the plan. Although these providers are not paid based on the types of procedures, they still must report that information to the Health and Recovery Services Administration. This data is to include demographic, diagnostic and geographic information, as well as actual costs on a summary level.

The Administration contracts with an actuary to analyze the data from managed care providers and to develop actuarially sound capitation, or per-person, rates. From this information, the Administration determines a rate for each managed care plan. In general, the plans including more seriously ill people will receive higher rates and the plans including healthier people will be given lower rates.

In fiscal years 2003 through 2007, we reported concerns regarding the Administration's controls over the accuracy of data received from providers that is used to determine the rates for its managed care program.

From July 2007 through June 2008, the state made more than \$1.17 billion in payments to managed care providers, approximately 50 percent of which was paid with federal funds. This is an increase of \$64 million over the previous one-year period.

Description of Condition

During our current audit, we found no changes in the conditions that we reported in our audits of fiscal years 2006 and 2007. We found the Administration relies on providers to accurately report the data used to determine the rates managed care plans will receive and does not verify its accuracy. Although the Administration has an actuarially sound process for calculating rates, if the underlying data used is inaccurate or incomplete, the results will be inaccurate.

Cause of Condition

The Department believed that because its calculation method is in compliance with federal requirements, no corrective action was required.

Effect of Condition

When the accuracy of data used to establish rates cannot be reasonably assumed to be correct, the risk of paying inflated rates to managed care providers is increased.

Recommendation

We recommend the Department establish and follow controls to provide reasonable assurance that the data used in rate-setting is accurate and complete.

Department's Response

The Department does not agree with the finding.

Although the Department does not directly review costs reported by managed care organizations (MCO) to our actuaries, there is a significant and sufficient verification of the accuracy and completeness of the information. Each MCO must have the submitted information certified in writing as accurate and complete by an independent actuary. Our actuary then validates the information submitted by comparison to the audited financials submitted to the Office of the Insurance Commissioner. The actuary also compares costs between MCOs and resolves outliers.

Additionally, the rate setting methodology and rates have been approved by the Centers for Medicare and Medicaid Services (CMS) annually as a part of contract approval and CMS, in an audit of Healthy Options, had no findings in regard to rate setting.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

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

The auditee shall:

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

Title 42, Code of Federal Regulations, Section 456.3 states, in part:

The Medicaid agency must implement a statewide surveillance and utilization control program that –

a. Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments

Title 42 CFR 438.6 Contract requirements, states in parts:

(c) *Payments under risk contracts* —(1) *Terminology*. As used in this paragraph, the following terms have the indicated meanings:

(i) *Actuarially sound capitation rates* means capitation rates that—

(A) Have been developed in accordance with generally accepted actuarial principles and practices;

(B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and

(C) Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

(3) *Requirements for actuarially sound rates*. In setting actuarially sound capitation rates, the State must apply the following elements, or explain why they are not applicable:

(i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.

(4) *Documentation.* The State must provide the following documentation:

(i) The actuarial certification of the capitation rates.

(ii) An assurance (in accordance with paragraph (c)(3) of this section) that all payment rates are—

(A) Based only upon services covered under the State plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).

(B) Provided under the contract to Medicaid-eligible individuals.

08-25 The Department of Social and Health Services, Health and Recovery Services Administration, does not comply with the state law (RCW 74.09A) and the federal Deficit Reduction Act of 2005 to identify all third parties liable for payment of Medicaid services.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number: 5-0805WA5028, 5-0805WA5048
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 that other payment sources should be identified and used 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 the existence of third party coverage for Medicaid recipients. The Act directs states, as a condition of receiving Medicaid funding, to have laws in effect which require health insurers doing business in that state to provide the eligibility and coverage information.

To comply with this requirement, in July of 2007 the state Legislature passed a law (RCW 74.09A) which requires DSHS 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 DSHS. The law requires this process to be performed no less than twice per year.

The state had Medicaid expenditures of approximately \$6.4 billion in fiscal year 2008, of which approximately \$3.4 billion was federal dollars.

Description of Condition

DSHS’ Health and Recovery Services Administration, Office of Coordination of Benefits, is responsible for identifying third-party liability coverage for Medicaid-eligible individuals. The Office performs data matches with other state and federal agencies to identify clients with potential insurance coverage, and verification of coverage with employers when employment of clients is noted by health service providers.

The Department also verifies third-party liability coverage at the time of a client’s application for Medicaid. This may be done via phone, e-mail or through an on-line inquiry access the Department has with insurance companies.

Although DSHS takes these actions to identify third-party coverage, it is not following all of the requirements of the law, which provides a mechanism that allows the Department to identify all third parties obligated to cover the cost of health care coverage of joint beneficiaries.

Cause of Condition

The Department believes that it is meeting the requirements of state law through the functions it currently performed.

Effect of Condition

While the Department does have processes in place to identify third-party liability, these processes focus on the time of initial application for Medicaid benefits, and upon notification by care providers of potential third-party coverage. The requirements of the Act and state law, if followed, would provide for a more comprehensive and ongoing review and identification of potential third-party payers. When Medicaid-eligible individuals with third-party liability coverage are not identified, Medicaid is no longer the payer of last resort and the Department is not ensuring that third-party resources are meeting their legal obligation to pay claims

Recommendation

Although the Department indicated that its current processes were adequate, it also stated it intends to meet the requirements of the law when its new claims system, ProviderOne, becomes operational. This system's original launch date has been delayed; no new start date has been provided.

While acknowledging the Department's stated intention, we also note that compliance with the Act and state law is not contingent on the functionality of a particular system. We recommend the Department comply with state law and the Deficit Reduction Act of 2005 in order to better identify all third parties liable for Medicaid beneficiary claims.

Department's Response

The Department does not agree with this finding. DSHS/HRSA does comply with the Deficit Reduction Act (DRA) of 2005 and Washington state law RCW 74.09A to aggressively identify third party liability for Medicaid services. In fact, through the combined efforts of all of these methods, HRSA's Coordination of Benefits (COB) has generated the following cost avoidance for the past three years: SFY06 - \$211,432,369, SFY07 - \$293,607,103 and SFY08 - \$355,524,467. These results compare favorably to any state with similar sized Medicaid populations.

More specifically, Chapter 179, Laws of 2007 applied the provisions of the Deficit Reduction Act (DRA) of 2005 requires states to enact state law to accomplish the following tasks: (1) clarify entities considered to be "third parties" and "health insurers," (2) identify required data elements necessary for third party insurers use in submitting data to DSHS/HRSA, and (3) prescribe a method of data transmission.

HRSA met the requirement of the DRA by enacting RCW 79.09A and ensuring that the content of RCW 79.09A included all of the required elements described in DRA Chapter 179, Laws of 2007. Washington State passed the Coordination of Benefits portions of the DRA as Substitute House Bill 1826 effective July 1, 2007. Our State Plan was modified and subsequently approved by the Centers for Medicare and Medicaid Services (CMS) on July 2007.

More specifically, as required by the DRA, RCW 79.09A:

- 1. Defined the term "Health Insurer" to include third party administrators (TPAs), fiscal intermediaries, and managed care contractors. [See RCW 79.09A.010 (3)]*
- 2. Provided notice to Health Insurers that necessary data elements and a compatible database would be jointly developed by health insurers and the stated. Further, CMS has been facilitating this joint development effort by working with state and industry representatives to determine precise data elements needed by states to effectively implement the requirements of the new law. Once finalized by CMS, HRSA will include them in trading partner agreements. HRSA cannot complete this item until CMS has finalized the required list. [See RCW 79.09A.020 (2)]*

3. *Provided notice to Health Insurers that common computer standards will be used for data transmission purposes. Currently, this state's health insurers provide information to DSHS/HRSA either directly from their own systems or through One Health Port, which is a secure web access point for insurance companies. The law further communicates that updates to this data will be at a mutually agreed upon frequency with Health Insurers. HRSA is currently online (real time) with the majority of payers, in this state and nationally, and meets DRA expectations and requirements. [See RCW 79.09A.020 (3) and (5)]*
4. *RCW 79.09A.020 (6) speaks to the necessity for security of data necessary to support data and information sharing. Health insurers are required to provide information to HRSA through the HIPAA-defined (Health Insurance Portability and Accountability Act) trading partner agreements.*

*Lastly, DSHS/HRSA understands that RCW 74.09A.005(3) states, "It is in the best interest of the state, providers, and health insurers to identify **all** [emphasis added] third parties that are obligated to cover the cost of health care coverage of joint beneficiaries..." However, the clear spirit of the law is to ensure Medicaid is the payer of last resort to the greatest extent possible. As described above, DSHS/HRSA meets this standard by making data available to "all" insurers to use for TPL reporting and by matching data directly with those insurers most likely to provide third party coverage to our clients. While DSHS believes it meets legal requirements now, with the implementation of its new payments system we will further enhance our data matching activities.*

Auditor's Concluding Remarks

We appreciate the Department's acknowledgment of the legislative intent that the tax-payer funded Medicaid program be the payer of last resort. To that end, and to comply with federal requirements, a state law was passed which requires the Department to perform this data share at least twice per year with health insurers, which includes private health insurance companies doing business in this state. The Department does not perform this semi-annual data share with private health insurance companies and is therefore not in compliance with state law. We look forward the improvements the Department intends to make upon implementation of its new payment system.

Applicable Laws and Regulations

The Revised Code of Washington (RCW) 74.09A.005 states:

The legislature finds that:

- (1) Simplification in the administration of payment of health benefits is important for the state, providers, and health insurers;
- (2) The state, providers, and health insurers should take advantage of all opportunities to streamline operations through automation and the use of common computer standards;
- (3) It is in the best interests of the state, providers, and health insurers to identify all third parties that are obligated to cover the cost of health care coverage of joint beneficiaries; and
- (4) Health insurers, as a condition of doing business in Washington, must increase their effort to share information with the department and accept the department's timely claims consistent with 42 U.S.C. 1396a(a)(25).

Therefore, the legislature declares that to improve the coordination of benefits between the department of social and health services and health insurers to ensure that medical insurance benefits are properly utilized, a transfer of information between the department and health insurers should be instituted, and the process for submitting requests for information and claims should be simplified.

RCW 74.09A.020 states:

Computerized information — Provision to health insurers.

- (1) The department shall provide routine and periodic computerized information to health insurers regarding client eligibility and coverage information. Health insurers shall use this information to

identify joint beneficiaries. Identification of joint beneficiaries shall be transmitted to the department. The department shall use this information to improve accuracy and currency of health insurance coverage and promote improved coordination of benefits.

(2) To the maximum extent possible, necessary data elements and a compatible database shall be developed by affected health insurers and the department. The department shall establish a representative group of health insurers and state agency representatives to develop necessary technical and file specifications to promote a standardized database. The database shall include elements essential to the department and its population's health insurance coverage information.

(3) If the state and health insurers enter into other agreements regarding the use of common computer standards, the database identified in this section shall be replaced by the new common computer standards.

(4) The information provided will be of sufficient detail to promote reliable and accurate benefit coordination and identification of individuals who are also eligible for department programs.

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

(6) The health insurers and the department shall safeguard and properly use the information to protect records as provided by law, including but not limited to chapters 42.48, 74.09, 74.04, 70.02, and 42.56 RCW, and 42 U.S.C. Sec. 1396a and 42 C.F.R. Sec. 43 et seq. The purpose of this exchange of information is to improve coordination and administration of benefits and ensure that medical insurance benefits are properly utilized.

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

Deficit Reduction Act of 2005, Title VI, Subtitle A, Chapter 3, SEC. 6035. ENHANCING THIRD PARTY IDENTIFICATION AND PAYMENT states:

(a) CLARIFICATION OF THIRD PARTIES LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR SERVICE.—

Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i)—

(A) by inserting “, self-insured plans” after “health insurers”; and

(B) by striking “and health maintenance organizations” and inserting “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”; and

(2) in subparagraph (G)—

(A) by inserting “a self-insured plan,” after “1974,”; and

(B) by striking “and a health maintenance organization” and inserting “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”.

(b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS DATA.—Section 1902(a)(25) of such Act (42 U.S.C. 1396a(a)(25)) is amended—

(1) in subparagraph (G), by striking “and” at the end;

(2) in subparagraph (H), by adding “and” after the semicolon at the end; and

(3) by inserting after subparagraph (H), the following:

“(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

“(i) provide, with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, 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;”.

(c) EFFECTIVE DATE.—Except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2006.

WAC 388-501-0200 states:

(1) MAA requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(2) MAA pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:

(a) Prenatal care;

(b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or

(c) Preventive pediatric services as covered under the EPSDT program.

(3) MAA pays for medical services and seeks reimbursement from any liable third party when both of the following apply:

(a) The provider submits to MAA documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and

(b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:

(i) Is not complying with an existing court order; or

(ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill MAA or the client for a covered service when a third party pays a provider the same amount as or more than the MAA rate.

(5) When the provider receives payment from the third party after receiving reimbursement from MAA, the provider must refund to MAA the amount of the:

(a) Third-party payment when the payment is less than MAA's maximum allowable rate; or

(b) MAA payment when the third-party payment is equal to or greater than MAA's maximum allowable rate.

(6) MAA is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills MAA, except as described under subsections (2) and (3) of this section.

(7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:

(a) Receives direct third-party reimbursement for such services; or

(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.

(8) MAA considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.

(9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.

(10) For third-party liability on personal injury litigation claims, MAA is responsible for providing medical services as described under WAC 388-501-0100.

08-26 The Department of Social and Health Services does not have adequate internal controls to ensure non-emergency medical transportation expenditures are allowable and adequately supported.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number: 5-0805WA5028, 5-0805WA5048
Applicable Compliance Component: Activities Allowed or Unallowed and Allowable Costs/Cost Principles
Questioned Cost Amount: None

Background

The Department of Social and Health Services (DSHS) provides eligible Medicaid recipients transportation to and from non-emergency healthcare appointments that are medically necessary. Medicaid clients who qualify are provided transportation or are reimbursed for their travel costs. These appointments must be for services the Medicaid program will pay for in order for the recipient to be reimbursed.

Transportation services include public transit, client and volunteer mileage reimbursement, wheel chair-equipped vans, taxis, ferries and fuel vouchers. In less frequent cases, if out-of-state transportation is necessary, lodging and food may be included.

Since 1989, Washington State has used a brokerage system to provide non-emergency medical transportation for eligible Medicaid clients. Brokers contract with DSHS to deal directly with the clients to arrange, authorize and deny transportation services. Brokers take phone calls from clients, authorize or deny trips based on eligibility criteria, and decide the form of transportation a client receives. Brokers also decide who will transport the client.

The Department relies on brokers to make the appropriate transportation determinations. The broker is expected to verify the client's eligibility in the DSHS database and to authorize or deny the transportation request based on whether or not it is medically necessary. As brokers are responsible for authorizing and denying requests, all documentation to support those determinations are kept by the broker.

It is responsibility of the Department to monitor the brokers to ensure they comply with federal and state Medicaid regulations and that transportation services are legitimate, allowable and adequately supported.

Currently, the state of Washington has eight brokers for 13 regions. Approximately \$68 million was spent in fiscal year 2008 to fund the program, which approved 3.2 million trips.

Description of Condition

During our audit, we found the Department does not have internal controls to ensure non-emergency medical transportation expenditures are legitimate, allowable, and adequately supported. The Department relies on brokers to carry out the responsibility of making appropriate determinations. However, the Department does not monitor brokers to ensure all Medicaid rules are followed and costs are appropriate.

Cause of Condition

The Department stated it relies on the belief that brokers comply with the terms of the contracts.

Effect of Condition

Without adequate monitoring, the Department can not ensure that non-emergency medical transportation expenditures are legitimate, allowable, and adequately supported.

Recommendation

We recommend the Department establish a process for monitoring broker contracts to ensure all Medicaid rules are followed and services the brokers provided are legitimate, allowable, and supported.

Department's Response

The Department does not agree with this finding.

The department would like to clarify that Washington State's Non-emergency Transportation (NEMT) services are categorized per the Medicaid State Plan and the Centers for Medicare and Medicaid Services (CMS) as "administrative" services and not "medical" services. Being categorized as administrative services grants the state greater latitude on how to provide and monitor the financial and service quality aspects of this program. The federal Deficit Reduction Act of 2005 supports the distinction between "medical" and "administrative" by requiring states operating brokered NEMT "medical" services to complete fiscal audits of NEMT brokers. Neither the Act, nor any corresponding requirement in CFR or other regulation, specifies similar oversight requirements for "administrative" NEMT services. As an administrative service, Washington's NEMT transportation services facilitate access to medically covered services, but are not in themselves a medical service. Therefore, by definition these transportation services are not required to meet a medically necessary standard as stated in the State Auditor's Office (SAO) finding because transportation is not a medical service.

The department does not agree that we do not have adequate internal controls to ensure NEMT expenditures are legitimate, allowable and adequately supported, or that the department does not monitor brokers to ensure all Medicaid rules are followed and costs are appropriate. The department does perform the following activities in line with DSHS administrative policy for risk assessment and contract monitoring:

- Annual pre-contract risk assessments for all brokers. These contracts are defined as client service contracts and not sub-recipients. Contracts that are designated as sub-recipients require a higher standard of fiscal monitoring;*
- Department staff review monthly broker invoices, back-up documentation, and reports before the invoices are approved for payment;*
- Program managers review monthly for service delivery patterns and trends including use of low-cost modes of transportation as well as cost per trip;*
- Program managers monitor and respond to "daily operations" activities including inquiries, complaints, and all client incident/accident reports;*
- The team of program managers prioritizes, based on risk assessment and historical information, which brokers need on-site reviews for consultation, technical assistance, and compliance monitoring to ensure broker activities comply with state and federal regulations;*
- Annually, the program managers rotate on-site reviews of the 8 brokers; each broker is reviewed every other year for specific issues or general contract compliance. Six of eight total brokers were visited in 2008. These on-site reviews include direct observation, documentation review, interviews with broker managers, bookkeeping, and direct-service staff;*
- Annually, program managers review broker service delivery and service expenditures in detail, looking at multi-year historical data and reviewing broker regions against others of similar size*

- and characteristics. This in-depth review is done in preparation for contract/budget negotiations for the next contract year in order to negotiate the best value for the State;*
- The department requires all WA NEMT brokers, by contract, to annually complete and provide the state with copies of independent audits. Seven of eight brokers are required to complete A-133 level audits. The eighth broker is very small and must meet single audit requirements. All brokers are in compliance with this annual audit requirement.*

Auditor's Concluding Remarks

We appreciate the Department's comments. Regardless of whether the state's non-emergency medical transportation is categorized as administrative services or medical services, the Department has a responsibility to ensure federal and state funds are being used only for allowable purposes. Under the brokerage transportation system, brokers determine allowability of expenditures and receive administrative fees plus reimbursements for direct trip costs. Without proper fiscal monitoring of brokers the Department can not ensure all expenditures are allowable. During the audit, the Department could not evidence that it performs fiscal monitoring of brokers.

Applicable Laws and Regulations

Circular No. A-133, Subpart C, §_300 Auditee responsibilities. states in part:

The auditee shall:

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

OMB Circular A-87: Cost Principles for State, Local and Indian Tribal Governments; 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 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.

WAC 388-546-5100 Nonemergency transportation program scope of coverage

- (1) The department's health and recovery services administration (HRSA) covers transportation that is necessary for its clients to receive medically necessary HRSA covered services. See WAC [388-546-0100](#) through [388-546-1000](#) for Ambulance transportation that covers emergency ambulance transportation and limited nonemergency ground ambulance transportation as medical services.
- (2) Licensed ambulance providers, who contract with HRSA's transportation brokers, may be reimbursed for nonemergency transportation services under WAC [388-546-5200](#) as administrative services.
- (3) HRSA covers nonemergency transportation under WAC [388-546-5000](#) through [388-546-5500](#) as an administrative service as provided by the Code of Federal Regulations (42 CFR 431.53 and 42 CFR 440.170 (a)(2)). As a result, clients may not select the transportation provider(s) or the mode of transportation (service mode).
- (4) Prior authorization by HRSA is required for all out-of-state nonemergency transportation. Border areas as defined by WAC [388-501-0175](#) are considered in-state under this section and subsequent sections.
 - (a) HRSA reviews requests for out-of-state nonemergency transportation in accordance with regulations for covered healthcare services, including WAC [388-501-0180](#), [388-501-0182](#) and [388-501-0184](#).
 - (b) Nonemergency transportation is not provided to or from locations outside of the United States and U.S. territories, except for the limitations for British Columbia, Canada, identified in WAC [388-501-0184](#).
- (5) HRSA requires all nonemergency transportation to and from covered services to meet the following:
 - (a) The covered service must be medically necessary as defined in WAC [388-500-0005](#);
 - (b) It must be the lowest cost available service mode that is both appropriate and accessible to the client's medical condition and personal capabilities; and
 - (c) Be limited to the local provider of type as follows:
 - (i) Clients receiving services provided under HRSA's fee-for-service program may be transported only to the local provider of type. HRSA's transportation broker is responsible for considering and authorizing exceptions.
 - (ii) Clients enrolled in HRSA's managed care (healthy options) program may be transported to any provider supported by the client's managed care plan. Clients may be enrolled in a managed care plan but are obtaining a specific service not covered under the plan. The requirements in subsection (5)(c)(i) apply to these fee-for-service services.
- (6) HRSA does not cover nonemergency transportation services if the covered medical services are within three-quarters of a mile walking distance from the client's residence. Exceptions to this rule may be granted by HRSA's transportation broker based on the client's documented medical condition or personal capabilities, or based on safety or physical accessibility concerns, as described in WAC [388-546-5400](#)(1).
- (7) A client must use personal or informal transportation alternatives if they are available and appropriate to the client's needs.
- (8) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed-route public transportation system unless the need for more specialized transportation is present and documented. Examples of such a need are the client's use of a portable ventilator, a walker or a quad cane.
- (9) HRSA does not cover any nonemergency transportation service that is not addressed in WAC [388-546-1000](#) or in 388-546-5000 through 388-546-5500. See WAC [388-501-0160](#) for information about obtaining approval for noncovered transportation services, known as exception to rule (ETR).
- (10) If a medical service is approved by ETR, both the broker and MAA must separately prior approve transportation to that service.
- (11) HRSA may exempt members of federally recognized Indian tribes from the brokered transportation program. Where HRSA approves the request of a tribe or a tribal agency to

administer or provide transportation services under WAC [388-546-5000](#) through [388-546-5400](#), tribal members obtain their transportation services as provided by the tribe or tribal agency.

(12) A client who is denied service under this chapter may request a fair hearing per chapter [388-02](#) WAC.

WAC 388-546-5200 Nonemergency transportation program broker and provider requirements.

(1) MAA requires that all nonambulance transportation providers serving MAA clients be under subcontract with the department's contracted transportation broker. MAA's transportation brokers may subcontract with ambulance providers for nonemergency trips in licensed ground ambulance vehicles as administrative services. See WAC [388-546-5100](#)

(2) MAA requires all contracted and subcontracted transportation providers under this chapter to be licensed, equipped, and operated in accordance with applicable federal, state, and local laws.

(3) MAA's transportation brokers determine the level of transportation service needed by the client and the mode of transportation to be used for each authorized trip.

(4) MAA's transportation brokers must comply with the terms specified in their contracts.

(5) MAA's transportation brokers may require up to forty-eight hours advance notice of a requested trip (see WAC [388-546-5300](#)(2)) with the exception of hospital requests or urgent care trips. MAA allows its transportation brokers to accommodate requests that provide less than forty-eight hours advance notice, within the limits of the resources available to a broker at the time of the request.

(6) If MAA's transportation broker is not open for business and unavailable to give advance approval for a hospital discharge or urgent care request as described in subsection (5), the subcontracted transportation provider must either:

(a) Provide the transportation in accordance with the broker's instructions and request an after-the-fact authorization from the transportation broker within seventy-two hours of the transport; or

(b) Deny the transportation, if the requirements of this section cannot be met.

(7) If the subcontracted transportation provider provides transportation as described in subsection (6), the broker may agree to grant retroactive authorization as provided in WAC [388-546-5300](#)(3). Such retroactive authorization must be:

(a) Documented as to the reasons retroactive authorization is needed; and

(b) Agreed to by the broker within seventy-two hours after the transportation to a medical appointment.

(8) MAA, through its transportation brokers, does not pay for transportation under the following conditions:

(a) Clients are not eligible for transportation services when medical services are within reasonable walking distance (normally three-quarters of a mile actual traveling distance), taking into account the client's documented medical condition and personal capabilities (see WAC [388-546-5100](#)(6));

(b) Clients must use personal or informal transportation alternatives if they are available and appropriate to the clients' needs (see WAC [388-546-5100](#)(7));

(c) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed route public transportation under the terms of WAC [388-546-5100](#)(8);

(d) MAA or MAA's transportation broker may deny transportation services requested if the request is not necessary, suitable, or appropriate to the client's medical condition (see WAC [388-546-5100](#)(1) and (5)(a));

(e) The medical services requiring transportation must be services that are covered by the client's medical program (see WAC [488-546-5100](#)(1)); or

(f) The transportation selected by the broker for the client must be the lowest cost available alternative that is both appropriate and accessible to the client's medical condition and personal capabilities.

(9) The transportation broker mails a written notice of denial to each client who is denied coverage of transportation within three business days of the denial.

WAC 388-546-5300 Nonemergency transportation program client requirements.

(1) Clients must be compliant with MAA's transportation brokers, the brokers' subcontracted transportation providers, and MAA's medical services providers. A client who is in noncompliance may have limited transportation service mode options available. The broker mails the client a written notice of limited transportation service mode options within three business days of the broker's decision that transportation service mode options are limited.

(2) Clients must request, arrange and obtain authorization for transportation forty-eight hours in advance of a medical appointment. Exceptions to the forty-eight-hour advance arrangements are described in subsection (3) of this section and in WAC [388-546-5200](#) (5) and (6).

(3) If MAA's contracted broker is not open for business at the time nonemergency transportation is needed, the client must follow the transportation broker's instructions to obtain transportation service.

(4) MAA will cover a clients transportation to medically necessary covered services with local providers of type. Transportation services will be covered to nonlocal providers of type in the following circumstances:

(a) The client is enrolled in a healthy options managed health care plan and the client's primary care provider (PCP) or a PCP referred provider is not the closest available provider;

(b) The client's service is covered by a third party payer and the payer requires or refers the client to a specific provider;

(c) A charitable or other voluntary program (e.g., Shriners) is paying for the client's medical service;

(d) The medical service required by the client is not available within the local healthcare service area;

(e) The total cost to MAA is lower when the services are obtained outside of the local healthcare service area; or

(f) The out-of-area service is required to provide continuity of care for the client's ongoing care as:

(i) Documented by the client's primary care provider; and

(ii) Agreed to by MAA's contracted transportation broker.

(5) MAA may require transportation brokers to refer any of the exception categories listed in subsection (4) to MAA's medical director or the medical director's designee for review and/or prior authorization of the medical service.

(6) If local medical services are not available to a client because of noncompliance with MAA's transportation brokers, the brokers' subcontracted transportation providers, or MAA's medical services providers, MAA does not cover nonemergency transportation to out-of-area medical services for the client. MAA's contracted broker mails a written notice to the client within three business days of the broker's determination that the client's documented noncompliance results in a denial to out-of-area transportation services.

WAC 388-546-5400 Nonemergency transportation program general reimbursement limitations.

(1) To be reimbursed, MAA requires that a trip be a minimum of three-quarters of a mile from pick-up point to drop off point (see WAC [388-546-5100](#)(6)). MAA's transportation broker may grant exceptions to the minimum distance requirement for any of the following conditions:

(a) When there is medical justification for a shorter trip;

(b) When the trip involves an area that MAA's contracted broker considers to be unsafe for the client, other riders, or the driver; or

(c) When the trip involves an area that the broker determines is not physically accessible to the client.

(2) MAA reimburses for return trips from covered medical services if the return trips are directly related to the original trips. MAA, through its transportation broker, may deny coverage of a return trip if any delays in the return trip are for reasons not directly related to the original trip.

- (3) MAA does not reimburse any costs related to intermediate stops that are not directly related to the original approved trip.
- (4) MAA's transportation broker may authorize intermediate stops that are directly related to the original approved trip if the broker determines that the intermediate stop is likely to limit or eliminate the need for supplemental covered trips. MAA considers the following reasons to be related to the original trip:
 - (a) Transportation to and from an immediate subsequent medical referral; or
 - (b) Transportation to a pharmacy to obtain one or more prescriptions when the pharmacy is within a reasonable distance of the original medical appointment route.
- (5) MAA may pay the costs of meals and lodging for clients who must be transported to out-of-area medical services. MAA's transportation brokers make the determination that meals and lodging are necessary based on client need and the reasonableness of costs (as measured against state per diem rates).
- (6) MAA may pay transportation costs, including meals and lodging, for authorized escorts. MAA's transportation brokers make the determination that the costs of escorts are necessary based on client need and reasonableness of costs (as measured against state per diem rates).
- (7) MAA does not provide escorts or pay the wages of escorts. MAA does not pay for the transportation of an escort when the client is not present unless the broker documents exceptional circumstances causing the broker to determine that the service is necessary to ensure that the client has access to medically necessary care.
- (8) MAA may reimburse for the transportation of a guardian with or without the presence of the client if the broker documents its determination that such a service is necessary to ensure that the client has access to medically necessary care.

WAC 388-546-5500 Modifications of privately owned vehicles.

- (1) MAA may cover and reimburse the purchase of vehicle driving controls, a vehicle wheelchair lift conversion, or the purchase or repair of a vehicle wheelchair lift, when:
 - (a) The requested item is necessary for the client's transportation to medically necessary MAA-covered services; and
 - (b) The client owns a vehicle that MAA determines is suitable for modification; and
 - (c) Medical transportation provided under WAC 388-546-5000 through 388-546-5400 cannot meet the client's need for transportation to and from medically necessary covered services at a lower total cost to the department (including anticipated costs); and
 - (d) Prior approval from MAA is obtained.
- (2) Any vehicle driving controls, vehicle wheelchair lift conversion or vehicle wheelchair lift purchased by MAA under this section becomes the property of the client on whose behalf the purchase is made. MAA assumes no continuing liability associated with the ownership or use of the device.
- (3) MAA limits the purchase of vehicle driving control(s), vehicle wheelchair lift conversion or vehicle wheelchair lift to one purchase per client. If a device purchased under this section becomes inoperable due to wear or breakage and the cost of repair is more than the cost of replacement, MAA will consider an additional purchase under this section as long as the criteria in subsection
 - (1) of this section are met.
 - (4) MAA must remain the payer of last resort under this section.
 - (5) MAA does not cover the purchase of any new or used vehicle under this section or under this chapter.

08-27 The Department of Social and Health Services, Aging and Disability Services Administration, Home and Community Based Services division, does not have internal controls to ensure Medicaid payments to in-home service providers are allowable and supported.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number:	5-0805WA5028, 5-0805WA5048
Applicable Compliance Component:	Activities Allowed or Unallowed
Questioned Cost Amount:	\$472,432

Background

The Department of Social and Health Services, Aging and Disability Services Administration, administers the Home and Community Based Services program for the state. This program permits the state to furnish home and community-based services to assist Medicaid beneficiaries needing long-term care in avoiding institutionalization. These services are provided by individuals or agencies often chosen by the Medicaid client.

The Department determines the level of care needed and authorizes an appropriate number of service hours for that care, which forms the basis of the allowable payment to the provider.

Depending on their financial resources, clients may be required to pay a portion of the costs of services they receive. The Department pays the remainder of the costs up to the authorized amount.

The service provider is required to keep a record of actual hours worked on a standard timesheet, signed by both the client and the provider, and retained for two years. The state paid more than \$400 million for these services during the fiscal year 2008.

Description of Condition

The Department does not have a system in place to reconcile providers' timesheets with payments the Department makes. The Department stated timesheets signed by the client are reviewed by case managers during annual client reviews. However, during our audit, we did not see any evidence this occurred.

Cause of Condition

The Department stated that it considers the Medicaid client to be the "employer" of the service provider, and therefore the responsibility for verifying allowability and legitimacy of payments belongs to the client.

Effect of Condition

Although the client may be the employer of the service provider, Medicaid clients do not regularly receive detailed information on payment claims submitted to the Department. Therefore, a client would not be in a position to know if a provider submitted an incorrect or false claim.

To determine the effect of the control deficiencies we randomly selected 209 providers and asked the Department to obtain timesheets from these providers for July 1, 2007 through March 31, 2008. We obtained detailed payment information from the Department and attempted to reconcile it to the timesheets to determine whether all payments were legitimate and supported. Of the 209 providers reviewed, we

found 68 provided adequate documentation to support the payment claims submitted to the Department. Seven did not provide service hours or submit claims during the month, and so were eliminated from the review. Of the remaining 134, we noted:

Description of exceptions	Number of exceptions	Related Expenditures
Payments were not supported with timesheets.	61	\$924,650
Providers provided incomplete timesheets and did not have all timesheets for the period requested.	24	\$301,878
Timesheets were not totaled or incorrectly totaled.	14	\$211,677
Timesheets with at least one month in which timesheet hours were less than the authorized hours on the Social Services Payment System.	23	\$97,925
Timesheets showed no variances from month to month, and appear to be copies.	9	\$170,509
Timesheets without client and/or provider signatures.	3	\$46,804
Total	141	\$1,753,443

We identified \$1,753,443 in payments related to these exceptions. However, we are only questioning the \$924,650 in payments made to the 61 individual providers that were not supported with timesheets signed by the client. In the other instances, we found enough documentation to support the costs.

Approximately half of the questioned amount, or \$472,432, was funded by federal dollars.

Recommendation

We recommend the Department implement establish and follow internal controls to ensure:

- Payments made to individual providers are legitimate and supported.
- Individual providers maintain accurate timesheets to support payments they receive in keeping with federal requirements and state and department records retention schedules.

Department’s Response

As the auditor noted above, the client is the employer of record for individual providers. This employer relationship is addressed in RCW 74.39(A)270. Client/employer responsibilities include selecting, hiring, supervising and terminating their individual providers. The RCW is explicit that individual providers are not “employees of the state, its political subdivisions, or an area agency on aging for any purpose” (RCW 74.39(A)270(3)). Responsibility for scheduling, tracking and time keeping rightly belongs with the client.

We agree with the auditor on the importance of assuring that payments for personal care are accurate and reasonable. There are significant safe guards in place to prevent fraudulent claims by individual providers.

- *Personal care services by definition provides assistance with very basic needs such as eating, bathing, transferring, turning and ambulation. It is readily apparent if a client is not receiving these services. Medicaid funded personal care does not claim to cover the entire spectrum of client needs 24 hours per day 7 days a week. The plan produced by the CARE assessment covers a very basic and limited number of hours related to necessary assistance with activities of daily living. It would be close to impossible to complete the tasks in the care plan in a number of hours significantly under the authorization.*

- *Consistent with statute, the client supervises their care provider, the assessment includes information as to whether the client is able to supervise their provider and in the case where they are not able, agency managed personal care is available or the case manager will identify how the services will be monitored. Clients are given information on how to contact their case manager if there are concerns about service delivery. The department has the authority to terminate payment in the event there is a good faith belief that services are not being provided as authorized to a Medicaid client.*
- *SSPS will not pay over the authorized amount for any provider. Prior to invoices being validated, the system does a double check to assure that a more recent authorization change has not been made and will adjust the payment if the authorization has been changed.*
- *By submitting an invoice, providers attest to the accuracy of their claim. This provider attestation is no different than other types of Medicaid claims such as physician or durable medical equipment billing.*
- *The Department through its Payment Review Program runs algorithms to detect possibly fraudulent claims. Overpayments are initiated and referrals are made to the Medicaid Fraud Control Unit as indicated by findings.*
- *The Department tracks billing patterns and finds that claims for payment of personal care hours are consistently under the authorized amount system wide.*

While we think that the risk of fraudulent claims is low, in response to the auditor's recommendations the Department will issue a written communication to clients on employer responsibilities including time tracking and record keeping. The department will also issue a management bulletin to Area Agencies on Aging and the Division of Developmental Disabilities to remind them of the statutory mandate to review a sample of timesheets.

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We look forward to reviewing the improvements the Department has implemented during our next audit.

Applicable Laws and Regulations:

Circular No. A-133, Subpart C, §.300 Auditee responsibilities. states in part:

The auditee shall:

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

A-133 Compliance Supplement states in part:

General Audit Approach for Medicaid Payments

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.

OMB Circular A-87: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

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

- k. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
- l. Be allocable to Federal awards under the provisions of this Circular.
- m. Be authorized or not prohibited under State or local laws or regulations.
- n. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
- o. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
- p. Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.
- q. Except as otherwise provided for in this Circular, be determined in accordance with generally accepted accounting principles.
- r. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period, except as specifically provided by Federal law or regulation.
- s. Be the net of all applicable credits.
- t. Be adequately documented.

WAC 388-71-0515 states:

An individual provider or home care agency provider must:

- (1) Understand the client's plan of care that is signed by the client or legal representative and social worker/case manager, and translated or interpreted, as necessary, for the client and the provider;
- (2) Provide the services as outlined on the client's plan of care, as defined in WAC [388-106-0010](#);
- (3) Accommodate client's individual preferences and differences in providing care;
- (4) Contact the client's representative and case manager when there are changes which affect the personal care and other tasks listed on the plan of care;
- (5) Observe the client for change(s) in health, take appropriate action, and respond to emergencies;
- (6) Notify the case manager immediately when the client enters a hospital, or moves to another setting;
- (7) Notify the case manager immediately if the client dies;
- (8) Notify the department or AAA immediately when unable to staff/serve the client; and
- (9) Notify the department/AAA when the individual provider or home care agency will no longer provide services. Notification to the client/legal guardian must:
 - (a) Give at least two weeks' notice, and
 - (b) Be in writing.
- (10) Complete and keep accurate time sheets that are accessible to the social worker/case manager; and
- (11) Comply with all applicable laws and regulations.

Employment Reference Guide for Individual Providers (DSHS22-221(X) Page 8 states in part:

- § Make a check in all the personal care tasks listed on the form that you performed as defined in the Care Plan during that month.
- § After you have completed the form, have your employer review it for accuracy. If your employer agrees, he/she should sign their name under "CLIENT'S SIGNATURE".
- § Use your timesheet to fill out your SSPS Service Invoice accurately.
- § Keep one copy for your records (for two (2) years) and give one copy to your employer for his or her files.

RCW 74.39A.095 states:

(1) In carrying out case management responsibilities established under RCW [74.39A.090](#) for consumers who are receiving services under the medicaid personal care, community options programs entry system or chore services program through an individual provider, each area agency on aging shall provide oversight of the care being provided to consumers receiving services under this section to the extent of available funding. Case management responsibilities incorporate this oversight, and include, but are not limited to:

- (a) Verification that any individual provider who has not been referred to a consumer by the authority established under chapter 3, Laws of 2002 has met any training requirements established by the department;
- (b) Verification of a sample of worker time sheets;
- (c) Monitoring the consumer's plan of care to verify that it adequately meets the needs of the consumer, through activities such as home visits, telephone contacts, and responses to information received by the area agency on aging indicating that a consumer may be experiencing problems relating to his or her home care;
- (d) Reassessment and reauthorization of services;
- (e) Monitoring of individual provider performance. If, in the course of its case management activities, the area agency on aging identifies concerns regarding the care being provided by an individual provider who was referred by the authority, the area agency on aging must notify the authority regarding its concerns; and
- (f) Conducting criminal background checks or verifying that criminal background checks have been conducted for any individual provider who has not been referred to a consumer by the authority.

(2) The area agency on aging case manager shall work with each consumer to develop a plan of care under this section that identifies and ensures coordination of health and long-term care services that meet the consumer's needs. In developing the plan, they shall utilize, and modify as needed, any comprehensive community service plan developed by the department as provided in RCW [74.39A.040](#). The plan of care shall include, at a minimum:

- (a) The name and telephone number of the consumer's area agency on aging case manager, and a statement as to how the case manager can be contacted about any concerns related to the consumer's well-being or the adequacy of care provided;
- (b) The name and telephone numbers of the consumer's primary health care provider, and other health or long-term care providers with whom the consumer has frequent contacts;
- (c) A clear description of the roles and responsibilities of the area agency on aging case manager and the consumer receiving services under this section;
- (d) The duties and tasks to be performed by the area agency on aging case manager and the consumer receiving services under this section;
- (e) The type of in-home services authorized, and the number of hours of services to be provided;
- (f) The terms of compensation of the individual provider;
- (g) A statement by the individual provider that he or she has the ability and willingness to carry out his or her responsibilities relative to the plan of care; and
- (h)(i) Except as provided in (h)(ii) of this subsection, a clear statement indicating that a consumer receiving services under this section has the right to waive any of the case management services offered by the area agency on aging under this section, and a clear indication of whether the consumer has, in fact, waived any of these services.
- (ii) The consumer's right to waive case management services does not include the right to waive reassessment or reauthorization of services, or verification that services are being provided in accordance with the plan of care.

(3) Each area agency on aging shall retain a record of each waiver of services included in a plan of care under this section.

(4) Each consumer has the right to direct and participate in the development of their plan of care to the maximum practicable extent of their abilities and desires, and to be provided with the time and support necessary to facilitate that participation.

(5) A copy of the plan of care must be distributed to the consumer's primary care provider, individual provider, and other relevant providers with whom the consumer has frequent contact, as authorized by the consumer.

(6) The consumer's plan of care shall be an attachment to the contract between the department, or their designee, and the individual provider.

(7) If the department or area agency on aging case manager finds that an individual provider's inadequate performance or inability to deliver quality care is jeopardizing the health, safety, or well-being of a consumer receiving service under this section, the department or the area agency on aging may take action to terminate the contract between the department and the individual provider. If the department or the area agency on aging has a reasonable, good faith belief that the health, safety, or well-being of a consumer is in imminent jeopardy, the department or area agency on aging may summarily suspend the contract pending a fair hearing. The consumer may request a fair hearing to contest the planned action of the case manager, as provided in chapter [34.05](#) RCW. When the department or area agency on aging terminates or summarily suspends a contract under this subsection, it must provide oral and written notice of the action taken to the authority. The department may by rule adopt guidelines for implementing this subsection.

(8) The department or area agency on aging may reject a request by a consumer receiving services under this section to have a family member or other person serve as his or her individual provider if the case manager has a reasonable, good faith belief that the family member or other person will be unable to appropriately meet the care needs of the consumer. The consumer may request a fair hearing to contest the decision of the case manager, as provided in chapter [34.05](#) RCW. The department may by rule adopt guidelines for implementing this subsection.

08-28 The Department of Social and Health Services, Health and Recovery Services Administration, does not have adequate internal controls to ensure all controlled substances prescribed for Medicaid clients are authorized and allowable.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number:	5-0805WA5028, 5-0805WA5048
Applicable Compliance Component:	Activities Allowed or Unallowed
Questioned Cost Amount:	None

Background

All controlled substances are classified as scheduled drugs ranging from level 1-5; the number represents the potential risk of abuse the drug poses to the client. Schedule 1 drugs, such as heroin and marijuana, are illegal for use. The rest are considered legitimate for medical use, and range from drugs such as morphine (schedule 2), to cough syrup with codeine (schedule 5).

Individuals who prescribe controlled substances are required by federal regulations to register with the Drug Enforcement Administration (DEA). These individuals must have an active medical license in the state in which they practice. The purpose of this registration is to track all prescribers of controlled substances in a national database and to have the ability to monitor all prescriptions. When an individual registers with the DEA, he or she is authorized to prescribe or dispense controlled substances and assigned a DEA identification number.

The Department of Social Health and Services, Health and Recovery Services Administration, uses a point-of-sale system to process prescription drug claims submitted by pharmacies. When the dispensing pharmacy enters the prescriber's DEA number into the "Prescriber Identification" field of the system, the number is automatically validated through a computerized cross-match with the national DEA database. If the DEA number is valid, the claim will be processed and approved. If the system is unable to recognize the DEA number as valid, the claim will be denied.

The Department paid \$24,154,889.33 in claims for schedule 2 through 5 drugs between July 2007 and March 2008.

Description of Condition

The Department validates prescriber DEA numbers for all schedule 2 drugs by requiring pharmacists to include the prescriber's DEA number on claims which are then validated with the national DEA database.

The Department, however, does not have similar requirements for schedule 3-5 drugs. Claims for these medications are paid without assurance that the prescriber has proper authorization to prescribe.

Without adequate controls to validate prescriber's DEA number for scheduled drugs, the Department is unable to assure all expenditures related to the claims are properly authorized and allowable.

Cause of Condition

The Department stated it is not responsible for verifying DEA numbers of prescribing physicians. It believes this responsibility lies with medical licensing authorities and the dispensing pharmacies. The Department only validates DEA numbers for schedule 2 drugs because of the risk of abuse associated with these narcotics.

Effect of Condition

During our audit, we identified 7,420 pharmacy claims for scheduled drugs 2-5 resulting in a total of \$63,287.19 that were processed in the point-of-sale system without DEA numbers. This includes \$7,865.30 for schedule 2 drugs, \$26,011.94 for schedule 3 drugs, \$17,314.96 for schedule 4 drugs and \$12,094.99 for schedule 5 drugs.

Without procedures in place to verify prescribers are legally authorized to prescribe scheduled drugs, the Department cannot ensure claims paid are allowable expenditures of Medicaid funds.

Recommendation

We recommend the Department establish and follow internal controls that will reasonably ensure prescribers of controlled substances have valid DEA numbers that demonstrate they are authorized to provide this service in accordance with federal requirements.

Department's Response

The Department disagrees with this finding.

There aren't any federal or state statutes that require a payer (e.g. state) to validate the Drug Enforcement Administration (DEA) number of a prescriber. Therefore, the Department disagrees that the lack of an edit that validates DEA for Schedule 3-5 drugs constitutes inadequate internal controls or that the lack of such validation renders the payment unallowable.

As discussed with to State Auditor's Office (SAO) staff, the Department believes that responsibility for compliance with controlled substance requirements lies with the prescribing provider and the dispensing pharmacies. There aren't any provisions in the Controlled Substance Act (21 USC Sec. 821) or the State Uniform Controlled Substance Act (RCW 69.50) that could be interpreted as a requirement relating to payment of claims for controlled substances. Below is the Title 21 CFR Section 1306.04 which clearly states that the prescribing practitioner is responsible for making sure that the prescription conforms in all essential respects to the law and regulation:

(a) A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 USC 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances."

The Controlled Substances Act (CSA) is the federal drug policy under which the manufacture, importation, possession and distribution of certain drugs is regulated. Classification decisions are made on the criteria of potential for abuse, accepted medical use in the United States and potential for drug dependence. Registration with the DEA authorizes a pharmacy to sell controlled substances and allows for a method of

monitoring who is selling potentially addictive drugs. The CSA does not regulate payment for controlled substances.

The Department implemented a Pharmacy Point of Sale (POS) edit in July 2002 for the purpose of validating the DEA of the prescribing physician for Schedule II drugs. While the Department considered this to be an essential validation to add to the POS, it was not implemented because of any federal/state requirement. Rather, the Department implemented this because Schedule II drugs are subject to the highest risk of abuse and considered it prudent to provide this additional validation to guard against the potential for fraud and abuse.

In addition to the edit in the POS that validates the DEA for Schedule II drugs, DSHS has a set of robust Program Integrity activities that includes pharmacy utilization review, pharmacy rules-based algorithms that identify improper payments, and data mining activities that identify patterns outside the norm. In the absence of any requirement to validate DEA for controlled substances, DSHS considers that this set of Program Integrity activities provide adequate controls to ensure that controlled substances are authorized and allowable.

Auditor's Concluding Remarks

We thank the Department for its response. We agree the Department does not have a regulatory role over controlled substance prescribers. However, the Department does have a responsibility to ensure that services provided to Medicaid clients are allowable. In order for controlled substances to be an allowable Medicaid service, those substances must be prescribed by a provider with a valid DEA number. We will review this area during our next audit.

Applicable Laws and Regulations

Circular No. A-133, Subpart C, §_300 Auditee responsibilities. states in part:

The auditee shall:

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

OMB Circular A-87: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

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

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

Title 21, code of Federal Regulations, Section 1306 states in part:

1306.03 Persons entitled to issue prescriptions.

(a) A prescription for a controlled substance may be issued only by an individual practitioner who is:

- (1) Authorized to prescribe controlled substances by the jurisdiction in which he is licensed to practice his profession and
- (2) Either registered or exempted from registration pursuant to §§1301.22(c) and 1301.23 of this chapter.

(b) A prescription issued by an individual practitioner may be communicated to a pharmacist by an employee or agent of the individual practitioner.

§ 1306.21 Requirement of prescription.

(a) A pharmacist may dispense directly a controlled substance listed in Schedule III, IV, or V which is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act, only pursuant to either a written prescription signed by a practitioner or a facsimile of a written, signed prescription transmitted by the practitioner or the practitioner's agent to the pharmacy or pursuant to an oral prescription made by an individual practitioner and promptly reduced to writing by the pharmacist containing all information required in §1306.05, except for the signature of the practitioner.

(b) An individual practitioner may administer or dispense directly a controlled substance listed in Schedule III, IV, or V in the course of his/her professional practice without a prescription, subject to §1306.07.

(c) An institutional practitioner may administer or dispense directly (but not prescribe) a controlled substance listed in Schedule III, IV, or V only pursuant to a written prescription signed by an individual practitioner, or pursuant to a facsimile of a written prescription or order for medication transmitted by the practitioner or the practitioner's agent to the institutional practitioner-pharmacist, or pursuant to an oral prescription made by an individual practitioner and promptly reduced to writing by the pharmacist (containing all information required in Section 1306.05 except for the signature of the individual practitioner), or pursuant to an order for medication made by an individual practitioner which is dispensed for immediate administration to the ultimate user, subject to §1306.07.

§ 1306.22 Refilling of prescriptions.

(a) No prescription for a controlled substance listed in Schedule III or IV shall be filled or refilled more than six months after the date on which such prescription was issued and no such prescription authorized to be refilled may be refilled more than five times. Each refilling of a prescription shall be entered on the back of the prescription or on another appropriate document. If entered on another document, such as a medication record, the document must be uniformly maintained and readily retrievable. The following information must be retrievable by the prescription number consisting of the name and dosage form of the controlled substance, the date filled or refilled, the quantity dispensed, initials of the dispensing pharmacist for each refill, and the total number of refills for that prescription. If the pharmacist merely initials and dates the back of the prescription it shall be deemed that the full face amount of the prescription has been dispensed. The prescribing practitioner may authorize additional refills of Schedule III or IV controlled substances on the original prescription through an oral refill authorization transmitted to the pharmacist provided the following conditions are met:

- (1) The total quantity authorized, including the amount of the original prescription, does not exceed five refills nor extend beyond six months from the date of issue of the original prescription.
 - (2) The pharmacist obtaining the oral authorization records on the reverse of the original prescription the date, quantity of refill, number of additional refills authorized, and initials the prescription showing who received the authorization from the prescribing practitioner who issued the original prescription.
 - (3) The quantity of each additional refill authorized is equal to or less than the quantity authorized for the initial filling of the original prescription.
 - (4) The prescribing practitioner must execute a new and separate prescription for any additional quantities beyond the five refill, six-month limitation.
- (b) As an alternative to the procedures provided by subsection (a), an automated data processing system may be used for the storage and retrieval of refill information for prescription orders for controlled substances in Schedule III and IV, subject to the following conditions:
- (1) Any such proposed computerized system must provide on-line retrieval (via CRT display or hard-copy printout) of original prescription order information for those prescription orders which are currently authorized for refilling. This shall include, but is not limited to, data such as the original prescription number, date of issuance of the original prescription order by the practitioner, full name and address of the patient, name, address, and DEA registration number of the practitioner, and the name, strength, dosage form, quantity of the controlled substance prescribed (and quantity dispensed if different from the quantity prescribed), and the total number of refills authorized by the prescribing practitioner.
 - (2) Any such proposed computerized system must also provide on-line retrieval (via CRT display or hard-copy printout) of the current refill history for Schedule III or IV controlled substance prescription orders (those authorized for refill during the past six months.) This refill history shall include, but is not limited to, the name of the controlled substance, the date of refill, the quantity dispensed, the identification code, or name or initials of the dispensing pharmacist for each refill and the total number of refills dispensed to date for that prescription order.
 - (3) Documentation of the fact that the refill information entered into the computer each time a pharmacist refills an original prescription order for a Schedule III or IV controlled substance is correct must be provided by the individual pharmacist who makes use of such a system. If such a system provides a hard-copy printout of each day's controlled substance prescription order refill data, that printout shall be verified, dated, and signed by the individual pharmacist who refilled such a prescription order. The individual pharmacist must verify that the data indicated is correct and then sign this document in the same manner as he would sign a check or legal document (e.g., J. H. Smith, or John H. Smith). This document shall be maintained in a separate file at that pharmacy for a period of two years from the dispensing date. This printout of the day's controlled substance prescription order refill data must be provided to each pharmacy using such a computerized system within 72 hours of the date on which the refill was dispensed. It must be verified and signed by each pharmacist who is involved with such dispensing. In lieu of such a printout, the pharmacy shall maintain a bound log book, or separate file, in which each individual pharmacist involved in such dispensing shall sign a statement (in the manner previously described) each day, attesting to the fact that the refill information entered into the computer that day has been reviewed by him and is correct as shown. Such a book or file must be maintained at the pharmacy employing such a system for a period of two years after the date of dispensing the appropriately authorized refill.
 - (4) Any such computerized system shall have the capability of producing a printout of any refill data which the user pharmacy is responsible for

maintaining under the Act and its implementing regulations. For example, this would include a refill-by-refill audit trail for any specified strength and dosage form of any controlled substance (by either brand or generic name or both). Such a printout must include name of the prescribing practitioner, name and address of the patient, quantity dispensed on each refill, date of dispensing for each refill, name or identification code of the dispensing pharmacist, and the number of the original prescription order. In any computerized system employed by a user pharmacy the central recordkeeping location must be capable of sending the printout to the pharmacy within 48 hours, and if a DEA Special Agent or Diversion Investigator requests a copy of such printout from the user pharmacy, it must, if requested to do so by the Agent or Investigator, verify the printout transmittal capability of its system by documentation (e.g., postmark).

(5) In the event that a pharmacy which employs such a computerized system experiences system down-time, the pharmacy must have an auxiliary procedure which will be used for documentation of refills of Schedule III and IV controlled substance prescription orders. This auxiliary procedure must insure that refills are authorized by the original prescription order, that the maximum number of refills has not been exceeded, and that all of the appropriate data is retained for on-line data entry as soon as the computer system is available for use again.

(c) When filing refill information for original prescription orders for Schedule III or IV controlled substances, a pharmacy may use only one of the two systems described in paragraphs (a) or (b) of this section.

§ 1306.23 Partial filling of prescriptions.

The partial filling of a prescription for a controlled substance listed in Schedule III, IV, or V is permissible, provided that:

(a) Each partial filling is recorded in the same manner as a refilling,

(b) The total quantity dispensed in all partial fillings does not exceed the total quantity prescribed, and

(c) No dispensing occurs after 6 months after the date on which the prescription was issued.

Section 1301.11 Persons required to register.

(a) Every person who manufactures, distributes, dispenses, imports, or exports any controlled substance or who proposes to engage in the manufacture, distribution, dispensing, importation or exportation of any controlled substance shall obtain a registration unless exempted by law or pursuant to Secs. [1301.22-1301.26](#). Only persons actually engaged in such activities are required to obtain a registration; related or affiliated persons who are not engaged in such activities are not required to be registered. (For example, a stockholder or parent corporation of a corporation manufacturing controlled substances is not required to obtain a registration.)

08-29 The Department of Social and Health Services, Health and Recovery Services Administration, does not perform a quarterly retrospective drug use review as required by federal law.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number: 5-0805WA5028, 5-0805WA5048
Applicable Compliance Component: Utilization Control and Program Integrity
Questioned Cost Amount: None

Background

Pharmaceutical claims for Medicaid client prescriptions are processed through the Medicaid Management Information System (MMIS), which runs each request for payment through a series of criteria, known as edits, within the system. Claims are paid if they successfully pass all edits.

Federal law requires state Medicaid programs to have a retrospective drug use review program at least quarterly of pharmaceutical claims data in order to identify patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients. This examination must involve a pattern analysis, using predetermined standards, of physicians' prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies.

The state had Medicaid expenditures of approximately \$6.4 billion in fiscal year 2008, of \$3.4 billion of which was federal dollars.

Description of Condition

The Department does perform a review in order to determine therapeutic appropriateness of the medication, however it does not perform a retrospective review for the purpose of identifying fraud or misuse.

During our initial inquiry, the Department stated it indirectly learns of potential overuse and underuse of drugs, appropriate use of generic products, and clinical abuse or misuse by providers when it receives a complaint or reviews client data.

The Department later stated it performed a retrospective drug use review in November 2008 to identify the top 50 highest narcotic prescribers. The Department was unable to supply us with this review.

Cause of Condition

The Department does not have adequate procedures to ensure compliance with federal requirements to perform a retrospective drug use review. The Department established procedures to perform the therapeutic aspects of the review, believing this was sufficient.

Effect of Condition

The Department is not using the resources available to it to identify patterns of fraud, abuse, and misuse of pharmaceutical claims paid for with Medicaid funds, increasing the risk these situations could occur and not be detected.

Recommendation

We recommend the Department establish controls to comply with federal law and to identify patterns of fraud, abuse, and misuse of pharmaceuticals paid for with Medicaid funds.

Department's Response

The Department does not concur with this finding.

Title 42 CFR stipulates the department must perform quarterly retrospective Drug Utilization Review (DUR) via:

“(b) Use of predetermined standards. Retrospective DUR includes, but is not limited to, using predetermined standards to monitor for the following:

- (1) Therapeutic appropriateness, that is, drug prescribing and dispensing that is in conformity with the predetermined standards.*
- (2) **Overutilization and underutilization, as defined in Sec. 456.702.***
- (3) Appropriate use of generic products, that is, use of such products in conformity with State product selection laws.*
- (4) Therapeutic duplication as described in Sec. 456.705(b)(1).*
- (5) Drug-disease contraindication as described in Sec. 456.705(b)(2).*
- (6) Drug-drug interaction as described in Sec. 456.705(b)(3).*
- (7) Incorrect drug dosage as described in Sec. 456.705(b)(4).*
- (8) Incorrect duration of drug treatment as described in Sec. 456.705(b)(5).*
- (9) **Clinical abuse or misuse as described in Sec. 456.705(b)(7)**”*

The Department conducts retrospective review for this purpose every quarter. For each of the measures cited above an analysis is completed and the results of that analysis are reported to CMS Region 10. These results are reported on forms CMS specifically created for reporting the results of the analysis on each of these measures, including overutilization and abuse and misuse.

The Department's Pharmacy Administrator has attended in-services hosted by CMS to understand this requirement and assure the department has in place activities that will support our compliance.

The Pharmacy Administrator uses the data to determine which drug or class will be the focus for each quarter. Predetermined standards are used along with a professional drug advisory committee to monitor all the measures cited above, including overutilization and abuse and misuse of any medication for that quarter. If “Abuse” and “Misuse” is identified in the process the “suspected” abuser is referred to our internal resources: Office of Patient Review and Coordination (PRC), the Quality Management Team Unit (QMT), the Payment Review Program Unit (PRP) and the Office of Payment Review and Audit (OPRA).

The Department believed it had presented reports to the SAO which document our compliance with the CFR and will continue to work with the SAO to understand what additional documentation would meet their needs.

The department has designated the Office of Payment Review and Audit (OPRA), part of our payment integrity division, as the department's contact point for referrals to the Medicaid Fraud and Control Unit (MFCU). This was an internal protocol put into place in 2004 so there would be coordination and one source for this external body to interface with.

The CFR does not stipulate which drug class or specific drug(s) should be reviewed each quarter. It does not stipulate these reviews must be done looking at every physician's prescribing practices every quarter. Nor does it say the DUR must be conducted on every drug every quarter. The Department meets this requirement by looking at drug utilization by types of drugs or groups of drugs in a systematic way designed to identify the flags outlined above.

By performing these reviews by drug or drug classes, we can compare a physician's practice patterns for using the medication to treat like-conditions to his peers. If we were to conduct these reviews by looking at all prescriptions by all physicians the process the result would be a large volume of incomparable data.

Under that premise, the last time we included narcotics in our DUR process was in 2007. As a result of that analysis we pursued education interventions including the opioid guidelines developed to educate providers as to best practices in pain control and what could be considered indication of over utilization. Providers were provided clients specific narcotic utilization information so they could alter medication regimens. In addition, our contractor ACS's clinical pharmacists visited the highest prescribers of narcotics in face-to-face consultations to discuss the guidelines and the management of chronic pain.

There were no referrals made to MFCU via OPRA as a result of this narcotic specific DUR activity. The data did not clearly demonstrate intentional misuse, abuse or over utilization by any given physician, and it was deemed not warranted.

The process described above is just one method the department uses to identify abuse, misuse, and fraud of health care services. We also run algorithms, conduct provider modeling, conduct audits and use client specific prior authorization processes to identify inappropriate use of health care services.

This audit area continues to be one in which the auditors and DSHS disagree on the intent and focus of the CFR requirements. The department's focus is on the appropriateness of prescribing physicians drug selection; the auditors focus was on the usefulness of the utilization review in detecting fraud. The department will continue to work with the auditors and jointly request CMS review of the department efforts to comply with this CFR.

Auditor's Concluding Remarks

We thank the Department for its response and commitment to continuing discussions on this issue.

Retrospective Drug Utilization Review (DUR) is a two-part system. The first component is the ongoing periodic examination of claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and Medicaid recipients associated with specific drugs or groups of drugs. The purpose of this component of retrospective DUR is to reduce the frequency of misuse and overuse of Medicaid drug benefits.

The second component of retrospective DUR is an ongoing periodic examination of claims data and other records to assess the clinical quality of prescribing and dispensing of Medicaid-covered drugs. The purpose of this component of retrospective DUR is to reduce the frequency of therapeutic problems associated with the use of those drugs.

During our testing the Department was unable to supply us with any evidence showing that it performs ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, or gross overuse among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs.

The Department established procedures to perform the second component of retrospective DUR, believing this was sufficient. We re-affirm our finding, and look forward to continuing discussions with the Department and its grantor in order to achieve resolution.

Applicable Laws and Regulations

Title 42, Code of Federal Regulations, Section 456.703 states in part:

- (a) *General.* Except as provided in paragraphs (b) and (c) of this section, in order for FFP to be paid or made available under section 1903 of the Act for covered outpatient drugs, the State must have in operation, by not later than January 1, 1993, a DUR program consisting of prospective

drug review, retrospective drug use review, and an educational program that meets the requirements of this subpart. The goal of the State's DUR program must be to ensure appropriate drug therapy, while permitting sufficient professional prerogatives to allow for individualized drug therapy.

Title 42, Code of Federal Regulations, Section 456.709 states:

(a) General. The State plan must provide for a retrospective DUR program for ongoing periodic examination (no less frequently than quarterly) of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs. This examination must involve pattern analysis, using predetermined standards, of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies. This program must be provided through the State's mechanized drug claims processing and information retrieval systems approved by CMS (that is, the Medicaid Management Information System (MMIS)) or an electronic drug claims processing system that is integrated with MMIS. States that do not have MMIS systems may use existing systems provided that the results of the examination of drug claims as described in this section are integrated within their existing system.

(b) Use of predetermined standards. Retrospective DUR includes, but is not limited to, using predetermined standards to monitor for the following:

- (1) Therapeutic appropriateness, that is, drug prescribing and dispensing that is in conformity with the predetermined standards.
- (2) Overutilization and underutilization, as defined in Sec. 456.702.
- (3) Appropriate use of generic products, that is, use of such products in conformity with State product selection laws.
- (4) Therapeutic duplication as described in Sec. 456.705(b)(1).
- (5) Drug-disease contraindication as described in Sec. 456.705(b)(2).
- (6) Drug-drug interaction as described in Sec. 456.705(b)(3).
- (7) Incorrect drug dosage as described in Sec. 456.705(b)(4).
- (8) Incorrect duration of drug treatment as described in Sec. 456.705(b)(5).
- (9) Clinical abuse or misuse as described in Sec. 456.705(b)(7).

Title 42 Code of Federal Regulations 455.2 states in part:

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Title 42 Code of Federal Regulations 455.14 Preliminary investigation states:

If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

Title 42 Code of Federal Regulations 455.15 Full investigation states in part:

If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must take the following action, as appropriate:

- (a) If a provider is suspected of fraud or abuse, the agency must—

(1) In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit under the terms of its agreement with the unit entered into under Sec.

1002.309 of this title; or

(2) In States with no certified Medicaid fraud control unit, or in cases where no referral to the State Medicaid fraud control unit is required under paragraph (a)(1) of this section, conduct a full investigation or refer the case to the appropriate law enforcement agency.

(b) If there is reason to believe that a recipient has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.

(c) If there is reason to believe that a recipient has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

Title 42 Code of Federal Regulations 455.16 Resolution of full investigation states in part:

A full investigation must continue until—

(a) Appropriate legal action is initiated;

(b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or

(c) The matter is resolved between the agency and the provider or recipient. This resolution may include but is not limited to—

(1) Sending a warning letter to the provider or recipient, giving notice that continuation of the activity in question will result in further action;

(2) Suspending or terminating the provider from participation in the Medicaid program;

(3) Seeking recovery of payments made to the provider; or

(4) Imposing other sanctions provided under the State plan.

08-30 The Department of Social and Health Services, Economic Services Administration, Medicaid Eligibility Quality Control Unit (MEQC), did not retain documentation to support the results of its federally required audits of Medicaid client eligibility.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number:	5-0805WA5028, 5-0805WA5048
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	None

Background

The state is required to operate a Medicaid Eligibility Quality Control System to identify and reduce errors in Medicaid eligibility determinations and Medicaid claims processing. The system is required to audit a sample of active Medicaid cases and those that have been denied, suspended or terminated and to determine if the approval or denial was appropriate.

The Department is required to take action to correct any errors identified through the process, including potential recovery payments to ineligible claimants. The Department also is required to take administrative action to prevent and reduce errors and to submit to the federal grantor, the Centers for Medicare and Medicaid Services, a report on its error analysis and a corrective action plan.

In 1994, the federal grantor offered states the option of participating in a pilot project intended to allow states to develop alternative ways to:

- Effectively identify and reduce erroneous payments.
- Increase operational efficiencies.
- Streamline services delivery.
- Study and improve program operations.

States participating in this project must submit a request to the federal grantor annually. The request must include the areas proposed for audit, which must be approved by the grantor before they are eligible for the pilot project. The Department reports the audit results to the grantor.

Washington has participated in the pilot program since October 1994. For fiscal year 2008, the Centers for Medicare and Medicaid Services approved seven targeted areas for audit.

Description of Condition

The Department states it has completed audits of six of the targeted areas. However, Department staff did not retain any documentation to support its audit conclusions for all projects except for one project that had just recently been completed.

Without this documentation, which federal and state laws require to be retained, we were unable to review and assess the adequacy of the audits.

Cause of Condition

The Medicaid Eligibility Quality Control unit did not understand it was required to retain documentation to support its final reports, once the final reports were written.

Effect of Condition

Due to the lack of supporting documentation we can not audit this element of the Medicaid program. The Department cannot support that its quality control process was reliable, or that its conclusions were supported.

Recommendation

We recommend the Medicaid Eligibility Quality Control unit develop and follow policies that require retention of documentation necessary to support audit conclusions.

Department's Response

DSHS concurs with the auditor's finding. The Department has taken the following corrective actions:

- 1. The Medicaid Eligibility Quality Control unit received records retention training 7/10/08 from the DSHS Records Officer (DSHS Records Management).*
- 2. Beginning with the Project #58 DDD Waiver cases sample, the Medicaid Eligibility Quality Control unit has converted to electronic recordkeeping – with staff entering data directly into an electronic access database. Each project has its own unique database.*
- 3. The Medicaid Eligibility Quality Control unit has developed a formal records retention procedure in accordance with State and federal records retention requirements. All records pertaining to Medicaid eligibility quality control reviews are maintained as described. This procedure is described below:*

Filing Order

Paper surveys are filed first by project number, second by month and year, and third numerically by survey number.

Access Databases will be saved in the shared drive according to project number (example P58) with backup copies.

Records Retention Requirements

Audit Documentation and Working Papers (formerly Internal Audits, Working Papers and Reports) used to complete Medicaid Eligibility Quality Control projects will be retained six years after the Audit Report Date. This includes Paper Surveys and Access Databases:

- Paper Surveys will be sent to Records Retention after they have been located onsite for one year after the Audit Report Date and then held at Records Retention for five more years (a total of six years)*
- All Databases will be kept in the Operations Support Division's electronic shared drive for six years*

The Medicaid Eligibility Quality Control unit uses Disposition Authority Number (DAN) GS04001 in the General Records Retention Schedule. This schedule can be found on page 45 of Agencies of Washington State Government-General Records Retention Schedules or online at:

http://www.secstate.wa.gov/assets/archives/RecordsManagement/GSFinalVersion_2005_v9_2008.pdf

Auditor's Concluding Remarks

We thank the Department for its response, and appreciate the steps taken by the Department to address this issue. We will review the Department's corrective action during our next audit.

Applicable Laws and Regulations:

A-133 Compliance Supplement E.4 *Medicaid Eligibility Quality Control System (MEQC)* states in part:

(1) States are required to operate a MEQC system in accordance with requirements established by CMS. The MEQC system redetermines eligibility for individual sampled cases of beneficiary eligibility made by State Medicaid agencies, or their designees. Statistical sampling methods are used to select claims for review and project the number and dollar impact of incorrect payments to ineligible beneficiaries (42 USC 1396b; 42 CFR sections 431.800 through 431.865).

(2) However, most States are operating MEQC pilots or have been given a waiver from the traditional MEQC program described in regulation. The pilots and waivers differ from the traditional MEQC program by performing special studies, targeted reviews, or other activities that are designed to ensure program integrity or improve program administration (42 USC 1396b; 42 CFR sections 431.800 through 431.865).

The auditor will need to evaluate the reliability of the internal control provided by a particular State's MEQC program to ascertain if they can be tested and relied upon in meeting the applicable eligibility audit objectives and the extent to which other auditing procedures may be required.

Title 42, code of Federal Regulation, Section 431 states in part:

§ 431.810 Basic elements of the Medicaid eligibility quality control (MEQC) program.

(a) *General requirements.* The agency must operate the MEQC program in accordance with this section and §§431.812 through 431.822 and other instructions established by CMS.

(b) *Review requirements.* The agency must conduct MEQC reviews in accordance with the requirements specified in §431.812 and other instructions established by CMS.

(c) *Sampling requirements.* The agency must conduct MEQC sampling in accordance with the requirements specified in §431.814 and other instructions established by CMS.

§ 431.818 Access to records: MEQC program.

(a) The agency, upon written request, must mail to the HHS staff all records, including complete local agency eligibility case files or legible copies and all other documents pertaining to its MEQC reviews to which the State has access, including information available under part 435, subpart I, of this chapter.

(b) The agency must mail requested records within 10 working days of receipt of a request, unless the State has an alternate method of submitting these records that is approved by CMS or has received, on an as-needed basis, approval from CMS to extend this timeframe by 3 additional working days to allow for exceptional circumstances.

§ 431.820 Corrective action under the MEQC program.

The agency must—

(a) Take action to correct any active or negative case action errors found in the sample cases;

(b) Take administrative action to prevent or reduce the incidence of those errors; and

(c) By September 15 each year, submit to CMS a report on its error rate analysis and a corrective action plan based on that analysis. The agency must submit revisions to the plan within 60 days of identification of additional error-prone areas, other significant changes in the error rate (that is, changes that the State experiences that increase or decrease its error rate and necessitate immediate corrective action or discontinuance of corrective actions that effectively control the cause of the error rate change), or changes in planned corrective action.

General records Retentions Schedules, Agencies of the Washington State Government: Office of the Secretary of State, Division of Archives and Records Management states in part:

Record Series Title and Function/Description	Cut-off	Retention Period Of Official Copy	Disposition Authority Number	Special And/Or Disposition Instructions
<p>AUDIT DOCUMENTATION AND WORKING PAPERS</p> <p>Audit documentation, including support for findings, conclusions, and recommendations. May also include correspondence, memos, drafts, preliminary findings, notes, and other materials used in preparing internal or external audits, investigations and examinations. (Series Revised 2005.)</p> <p><i>Note: This series does not apply to State Auditor's Office audits.</i></p>	Audit Report Date	6 Years	GS 04001	
<p>EXTERNAL AUDIT, FINAL AUDIT OR EXAMINATION REPORT</p> <p>Final reports of customer audits, compliance audits, performance audits, external audits or examinations performed by or for a state agency. (Series Approved 2005.)</p> <p><i>Note: Agency retains primary record copy. This series does not include State Auditor's Office audits.</i></p>	Audit Report Date	6 Years	GS 04005	
<p>INTERNAL AUDIT, FINAL AUDIT OR EXAMINATION REPORT</p> <p>Final reports of internal audits, investigations or examinations. (Series Revised 2005.)</p> <p><i>Note: Agency retains primary record copy.</i></p>	Audit Report Date	6 Years	GS 04002	

08-31 The Department of Social and Health Services, Aging and Disability Services Administration, does not have adequate controls in place to ensure all assets applicants own are counted when Medicaid eligibility is determined.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number: 5-0805WA5028, 5-0805WA5048
Applicable Compliance Component: Eligibility
Questioned Cost Amount: None

Background

The Medicaid program provides coverage for long-term care services for individuals who are unable to afford it. In order to ensure the availability of long-term care services for people who truly need them, the federal Deficit Reduction Act of 2005 tightened Medicaid asset transfer rules to make it more difficult for individuals with resources to pay for their own long-term care services to inappropriately transfer assets for less than fair market value in order to qualify for Medicaid.

When an individual applies for Medicaid coverage for long-term care, the state conducts a review, or “look-back” to determine whether the individual (or his or her spouse) transferred assets to another person or party for less than fair market value to become eligible for Medicaid. The Act lengthened the “look-back period” to 60 months (five years) prior to the date the individual applies for Medicaid.

When individuals transfer assets at less than fair market value in order to qualify for or become eligible for Medicaid long-term care services, the individual is subject to a penalty that delays the date they can qualify to receive Medicaid long-term care services. Under the Act, the penalty period for transfers made on or after February 8, 2006, begins on either the date of the asset transfer, or the date the individual is found eligible for Medicaid coverage, whichever is later.

The Department of Social and Health Services, Aging and Disability Services Administration, administers long-term care services under Medicaid.

Description of Condition

Individuals seeking Medicaid benefits must complete an application for benefits that asks the applicant if they, their spouse, or someone the applicant is applying, for has sold, traded, given away, or transferred a resource in the last five years. As part of the application process financial eligibility staff reviews information kept at the state Department of Licensing and County Assessor Offices.

If no sale or transfer of property is declared on the application, financial eligibility staff ask for one to three months of bank statements on each account held by the applicant. They do not perform any other reviews. If the staff identifies anything irregular during its review of bank statements, it will ask for statements up to only six months old.

County Assessor Web sites are usually limited to addresses, so it is only possible to determine if the property at the address the applicant gives financial eligibility staff has changed ownership. In addition, financial documents the Department reviews do not provide a reasonable picture of the applicant’s financial situation over the five year look-back period.

Cause of Condition

The Department stated it does not have access to financial activity research tools such as searchable databases or other methods of investigation to identify applicant asset transfers that might have been made during the look-back period.

Effect of Condition

Lack of adequate procedures to identify the financial resources of applicants when Medicaid eligibility is determined increases the risk of ineligible individuals receiving long-term care through the Medicaid program.

Recommendation

We recommend the Department establish and follow internal controls that will reasonably ensure all assets applicants own during the look-back period are countable when Medicaid eligibility is determined.

Department's Response

The Department does not concur with this finding.

The department would like to clarify two misconceptions related to the Aging and Adult Disability Services eligibility procedures presented in the auditor's "Description of Condition" section:

- 1. The auditor's description states " If no sale or transfer of property is declared on the application, financial eligibility staff ask for one to three months of bank statements on each account held by the applicant. They do not perform any other reviews."*

Department clarification: Financial eligibility staff are directed to verify all assets and or resources identified on the application, regardless of whether a sale or transfer of an asset is declared. Documents requested for verification vary depending on the type of asset declared and information gained during the interview. Any inconsistencies discovered on the application or given during the interview are resolved through appropriate verification; this would include asset transfers as far back as 5 years or current bank accounts. For existing bank accounts workers typically request the 3 most recent months of bank statements; however, some circumstances may dictate a longer period of time. It is not at all uncommon for staff to request trust documents, bill of sale and other documents related to the status of an asset or transfer that took place anywhere from 1 to five years prior to the financial application.

- 2. The auditor's description further indicates that if staff identifies anything irregular during their review of the clients bank statements, "it will only ask for statements up to six months old."*

Department Clarification: This description implies that the department would only pursue additional documentation on bank accounts when an irregularity is identified in the application review process. The department's procedures require financial workers to research and resolve any indication of unreported assets or asset transfers found during the initial review of declared assets. Staff verification of suspected transfers extend to any point during the 5 year look-back period and is not limited to the six month period prior to application. This applies to bank accounts, other liquid assets and non-liquid assets.

ADSA has the following general comments regarding the descriptions and recommendation:

The department agrees that the financial documents we review for most applications do not provide a complete picture of the applicant's financial circumstances during the five years prior to the month of application. However, the department would point out that with the majority of the applications this is not necessary, because assets and assets transfers are not an issue. In addition, there is currently no

infrastructure that would allow the department to run an asset check on any applicant without specific information as to what the asset is and where the asset is located. Currently, the only means that the department has of obtaining that information is through the applicants self declaration on the application, their signature attesting to the applications accuracy and the interview with the client. The approved practice the department has been operating under for more than two decades relies on self declaration by the client for any asset transfers or sales within the five year look back period. The department is committed to ensuring that Medicaid clients are financially eligible for the programs that they receive and will continue to pursue and verify any declared asset transfers that it becomes aware of (either through the interview process or as declared by the applicant) to ensure that they were appropriate transfers and not done to qualify for Medicaid.

Auditor's Concluding Remarks

We thank the Department for its response, and will review this area during our next audit.

Applicable Laws and Regulations

42 United States Code section 1396p, as amended by the Deficit Reduction Act of 2005, states in part:

(c)(1)(B)(i) The look-back date specified in this subparagraph is a date that is ... (...in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005, 60 months) before the date specific in clause (ii).

(c)(1)(D)(ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

WAC 388-513-1363 evaluating the transfer of an asset for clients found eligible for long-term care (LTC) services on or after 5/1/2006

This section describes how the department evaluates asset transfers made on or after May 1, 2006 and their affect on LTC services. This applies to transfers by the client, spouse, a guardian or through an attorney in fact. Clients subject to asset transfer penalty periods are not eligible for LTC services. LTC services for the purpose of this rule include nursing facility services, services offered in any medical institution equivalent to nursing facility services, and home and community-based services furnished under a waiver program. Program of all-inclusive care of the elderly (PACE) and hospice services are not subject to transfer of asset rules. The department must consider whether a transfer made within a specified time before the month of application, or while the client is receiving LTC services, requires a penalty period.

- Refer to [WAC 388-513-1364](#) for rules used to evaluate asset transfers made on or after April 1, 2003 and before May 1, 2006.
 - Refer to [WAC 388-513-1365](#) for rules used to evaluate asset transfer made prior to April 1, 2003.
1. When evaluating the effect of the transfer of asset made on or after May 1, 2006 on the client's eligibility for LTC services the department counts sixty months before the month of application to establish what is referred to as the "look-back" period.
 2. The department does not apply a penalty period to transfers meeting the following conditions:

- a. The total of all gifts or donations transferred do not exceed the [average daily private nursing facility](#) rate in any month;
 - b. The transfer is an excluded resource described in [WAC 388-513-1350](#) with the exception of the client's home, unless the transfer of the home meets the conditions described in subsection (2)(d);
 - c. The asset is transferred for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:
 - i. An intent to transfer the asset at FMV or other adequate compensation. To establish such an intent, the department must be provided with written evidence of attempts to dispose of the asset for fair market value as well as evidence to support the value (if any) of the disposed asset.
 - ii. The transfer is not made to qualify for LTC services, continue to qualify, or avoid [Estate Recovery](#). Convincing evidence must be presented regarding the specific purpose of the transfer.
 - iii. All assets transferred for less than fair market value have been returned to the client.
 - iv. The denial of eligibility would result in an undue hardship as described in [WAC 388-513-1367](#).
 - d. The transfer of ownership of the client's home, if it is transferred to the client's:
 - i. Spouse; or
 - ii. Child, who:
 - A. Meets the disability criteria described in [WAC 388-475-0050](#) (1) (b) or (c); or
 - B. Is less than twenty-one years old; or
 - C. Lived in the home for at least two years immediately before the client's current period of institutional status, and provided care that enabled the individual to remain in the home; or
 - iii. Brother or sister, who has:
 - A. Equity in the home; and
 - B. Lived in the home for at least one year immediately before the client's current period of institutional status.
 - e. The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria described in [WAC 388-475-0050](#) (1) (b) or (c);
 - f. The transfer meets the conditions described in subsection (3), and the asset is transferred:
 - i. To another person for the sole benefit of the spouse;
 - ii. From the client's spouse to another person for the sole benefit of the spouse;
 - iii. To trust established for the sole benefit of the individual's child who meets the disability criteria described in [WAC 388-475-0050](#) (1) (b) or (c);
 - iv. To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in [WAC 388-475-0050](#) (1)(b) or (c); or
3. The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (1)(f), if the transfer or trust:
- a. Is established by a legal document that makes the transfer irrevocable;
 - b. Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and

- c. Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term or the trust, whichever is less; and
 - d. The requirements in subsection (2)(c) of this section do not apply to trusts described in WAC [388-561-0100](#) (6)(a) and (b) and (7)(a) and (b).
- 4. The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of long-term care service if:
 - a. The transfer is in exchange for care services the family member provided the client;
 - b. The client has a documented need for the care services provided by the family member;
 - c. The care services provided by the family member are allowed under the medicaid state plan or the department's waived services;
 - d. The care services provided by the family member do not duplicate those that another party is being paid to provide;
 - e. The FMV of the asset transferred is comparable to the FMV of the care services provided;
 - f. The time for which care services are claimed is reasonable based on the kind of services provided; and
 - g. Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.
- 5. The department considers the transfer of an asset in exchange for care services given by a family member that does not meet the criteria as described under subsection (4) as the transfer of an asset without adequate consideration.
- 6. If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services.
- 7. If a client or the client's spouse transfers an asset on or after May 1, 2006, the department must establish a penalty period by adding together the total uncompensated value of all transfers made on or after May 1, 2006. The penalty period:
 - a. For a LTC services applicant, begins on the date the client would be otherwise eligible for LTC services based on an approved application for LTC services or the first day after any previous penalty period has ended; or
 - b. For a LTC services recipient, begins the first of the month following ten-day advance notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or the first day after any previous penalty period has ended; and
 - c. Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the [statewide average daily private cost for nursing facilities](#) at the time of application or the date of transfer, whichever is later.
- 8. If an asset is sold, transferred, or exchanged, the portion of the proceeds:
 - a. That is used within the same month to acquire an excluded resource described in WAC [388-513-1350](#) does not affect the client's eligibility;
 - b. That remain after an acquisition described in subsection (8)(a) becomes an available resource as of the first day of the following month.
- 9. If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in [WAC 388-513-1330 \(6\) through \(8\)](#). If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:
- 10.

- a. The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;
 - b. The amount described in subsection (10)(a) is divided by the statewide average daily private cost for nursing facilities at the time of application; and
 - c. A penalty period equal to the number of whole days found by following subsections (7)(a), (b), and (c).
11. A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses are receiving LTC services. When both spouses are receiving LTC services;
 - a. We divide the penalty between the two spouses.
 - b. If one spouse is no longer subject to a penalty (e.g. the spouse is no longer receiving institutional services or is deceased) any remaining penalty that applies to both spouses must be served by the remaining spouse.
12. If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter [388-02](#) WAC.
13. Additional statutes which apply to transfer of asset penalties, real property transfer for inadequate consideration, disposal of realty penalties, and transfers to qualify for assistance can be found at:
 - a. [RCW 74.08.331](#) Unlawful practices -- Obtaining assistance -- Disposal of realty;
 - b. [RCW 74.08.338](#) Real property transfers for inadequate consideration;
 - c. [RCW 74.08.335](#) Transfers of property to qualify for assistance; and
 - d. [RCW 74.39A.160](#) Transfer of assets--Penalties.

08-32 The Department of Social and Health Services does not have internal controls in place to ensure errors identified by the Medical Eligibility Quality Control Unit (MEQC) are reviewed adequately and in a timely manner.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number:	5-0805WA5028, 5-0805WA5048
Applicable Compliance Component:	Eligibility
Questioned Cost Amount:	None

Background

The state is required to operate a Medicaid Eligibility Quality Control System (MEQC) to identify and reduce errors in Medicaid eligibility determinations and claims processing. The state has operated a MEQC pilot program since October 1994. These pilot projects are intended to allow states to develop alternative ways to effectively identify and reduce erroneous payments, increase operational efficiencies, streamline service deliveries and to study and improve program operations.

Once the MEQC has identified errors, the Department is required to correct them, including recovery of Medicaid funds paid on ineligible claims. The Department also is required to take administrative action to prevent and reduce the incidence of errors, and to submit to its federal grantor, the Centers for Medicare and Medicaid Services, a report of its error analysis and a corrective action plan.

For fiscal year 2008, the Department completed six projects through the MEQC system.

Description of Condition

During our audit we selected three projects for review: project 48 (Motorized Wheel Chair); project 49 (Non-Institutional Medicaid in an Alternate Living Facility); and project 53 (Take Charge Eligibility), to determine if the Department has made an appropriate response to the errors identified by MEQC.

We reviewed the reports and the Department response to those reports. We found that for projects 48 and 49, the Department took appropriate action to correct all the exceptions identified by MEQC in a timely manner. During our review of the project 53, however, we found inadequate communication between the MEQC and each administration and lack of monitoring to ensure adequate corrective action is being taken. Eighty-two of 136 errors MEQC identified were communicated to both the Medical Eligibility Determination Services unit and Take Charge program staff. However, 54 errors were communicated only to the Take Charge program staff who did not do any follow-up on those errors.

Cause of Condition

The Medical Eligibility Determination Services unit which does the follow-up on the errors believed it was receiving all errors identified by the MEQC. The Department did not perform any follow-up monitoring to ensure all errors are being reviewed.

Effect of Condition

The Department did not take appropriate action to correct 54 of 136 errors MEQC identified because the errors were not communicated to the Medical Eligibility Determination Services unit. Inadequate follow up on errors identified by MEQC increase risk of ineligible individuals receiving Medicaid benefits.

Recommendation

We recommend the Department establish internal controls and monitoring procedures to ensure errors identified by MEQC are reviewed appropriately and in a timely manner.

Department's Response

The Department partially concurs with the finding:

The Department agrees that communication between ESA and HRSA regarding Problem Reports and Information reports lacked clarity at the time of the review.

MEQC completes six to nine medical reviews or projects each State Fiscal Year.

MEQC reviewers complete discrepancy reports when they identify a problem in a case they have reviewed. These discrepancy reports can be either:

- a) Case errors, which are identified as Problem Reports, for active cases needing corrective action on actual or potential eligibility or payment errors, or*
- b) Informational responses (FYI Reports) for non-active cases, or for active cases needing corrective action on procedural errors. These errors are used to help identify procedures that may need adjusting.*

ESA conducted a review of the family planning services program, Take Charge, administered by the Health and Recovery Services Administration (HRSA). Once identified by the auditors, the department discovered that the 54 errors identified are procedural errors affecting providers, do not affect eligibility, and do not require corrective action on the part of the Department. However, staff inadvertently included these 54 non-eligibility errors (errors in Take Charge clinic procedures) when they compiled the MEQC P53 Problem Report. As a result, these non-eligibility errors were incorrectly identified as eligibility errors in the initial report distributed to HRSA eligibility and policy program managers. Because the errors were incorrectly included in the wrong report, it remains unclear as to whether follow up action was not taken because none was required, or because they simply failed to review the cases for follow up. MEQC is revising the Problem Report to correctly reflect only those errors that potentially impact eligibility. These 54 Take Charge clinical errors will then be appropriately reported in an FYI Report and sent only to the Take Charge program staff for a procedural analysis.

To preclude similar miscommunication in the future, and assure the appropriate review and response is given to both Problem Reports and FYI Reports, an automated discrepancy report log has now been developed to help staff track discrepancies and ensure that the appropriate representatives receive these reports. This log describes each error, and identifies the case, the Community Services Office involved, the survey number and the date the report was sent to the regional representative. At the end of each program review, MEQC staff review the discrepancy report log and information found in the Automated Client Eligibility System to determine whether eligibility staff has completed corrective action on individual cases. A log of all cases with outstanding corrective action is sent to the appropriate representative for follow-up.

Auditor's Concluding Remarks

We thank the Department for its response, and will review this area during our next audit.

Applicable Laws and Regulations:

Title 42, code of Federal Regulation, Section 431 states in part:

- § 431.810 Basic elements of the Medicaid eligibility quality control (MEQC) program.
- (a) General requirements. The agency must operate the MEQC program in accordance with this section and §§431.812 through 431.822 and other instructions established by CMS.
 - (b) Review requirements. The agency must conduct MEQC reviews in accordance with the requirements specified in §431.812 and other instructions established by CMS.
 - (c) Sampling requirements. The agency must conduct MEQC sampling in accordance with the requirements specified in §431.814 and other instructions established by CMS.
- § 431.818 Access to records: MEQC program.
- (a) The agency, upon written request, must mail to the HHS staff all records, including complete local agency eligibility case files or legible copies and all other documents pertaining to its MEQC reviews to which the State has access, including information available under part 435, subpart I, of this chapter.
 - (b) The agency must mail requested records within 10 working days of receipt of a request, unless the State has an alternate method of submitting these records that is approved by CMS or has received, on an as-needed basis, approval from CMS to extend this timeframe by 3 additional working days to allow for exceptional circumstances.
- § 431.820 Corrective action under the MEQC program.
- The agency must—
- (a) Take action to correct any active or negative case action errors found in the sample cases;
 - (b) Take administrative action to prevent or reduce the incidence of those errors; and
 - (c) By September 15 each year, submit to CMS a report on its error rate analysis and a corrective action plan based on that analysis. The agency must submit revisions to the plan within 60 days of identification of additional error-prone areas, other significant changes in the error rate (that is, changes that the State experiences that increase or decrease its error rate and necessitate immediate corrective action or discontinuance of corrective actions that effectively control the cause of the error rate change), or changes in planned corrective action.

08-33 The Department of Social and Health Services, Health and Recovery Services Administration, does not have adequate internal controls to ensure its verification process complies with federal intent.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	Medicaid Cluster 93.775 State Medicaid Fraud Control Units 93.776 Hurricane Katrina Relief 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number:	5-0805WA5028, 5-0805WA5048
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 Department of Social and Health Service, Health and Recovery Services Administration, is responsible for this process, including selecting claims for verification, sending verification surveys to clients and performing follow up when questions regarding the legitimacy of a claim are indicated on the returned survey. Federal regulations do not require 100 percent verification; a sampling method may be used. The Department contracts with an outside vendor to select its verification sample from all eligible claims paid each month. Under federal rule, certain types of claims are exempt from this process.

Although the federal regulation does not dictate the sample size, guidance provided by the federal grantor states sample sizes should be large enough to obtain an overall representation of the population of claims. The guidance states that samples sizes should be at a minimum 500, and up to 100 percent of the population.

The external vendor selects two samples from all eligible claims: one based on clients served and one based on providers paid. The vendor sends the selected samples to the Department. Sample sizes provided to the Department approximate 500 each month.

Description of Condition

During our review, we determined the Department does not survey the approximately 500 claims selected by the vendor each month. Instead, staff sends surveys to approximately 10 percent of the selected claims, or about 50 per month. Less than half of the surveys sent receive responses.

This table summarizes HRSA survey activities for each month in fiscal year 2008.

Month	Total Claims subject to Verification	Sample size received from Vendor	Total samples DSHS selected	Surveys responded/ returned to DSHS	Follow up required
2007-07	1,074,996	524	58	28	1
2007-08	960,306	511	57	29	3
2007-09	967,686	527	60	23	1
2007-10	1,103,443	456	55	25	1
2007-11	1,397,096	453	52	18	1
2007-12	1,065,095	387	47	24	-
2008-01	485,952	451	52	23	-
2008-02	1,108,102	508	60	31	1
2008-03	1,579,993	590	66	28	-
2008-04	621,185	614	65	25	1
2008-05	990,624	621	67	29	-
2008-06	1,593,722	579	62	28	-
Total	12,948,200	6,221	701	311	9

We also reviewed the 311 returned surveys and identified nine that required follow up based on the information provided. For six of the surveys, we found clear evidence that follow up had been performed by Department staff. For the three remaining surveys, we found only the reviewer's signature and no clear indication a full review was performed. HRSA staff are now required to document their follow up review.

Upon further inquiry, we were informed that the Department had not identified any Medicaid fraud through this process.

Cause of Condition

The Department stated it finds no value in the verification process and goes through the motions only to meet the federal requirement.

Effect of Condition

Due to the insufficient sampling size and the lack of follow-through on returned surveys, the verification the Administration performs contributes little to promoting program integrity. The Department spends time and resources on a process it neither believes in nor intends to improve.

Recommendations

We recommend the Department improve its verification process in order to provide a reasonable chance of meeting the intent of the rule, which is to identify fraud and abuse or petition its federal grantors to remove or amend the requirement.

Department's Response

The Department does not concur with this finding.

Title 42, of the Code of Federal Regulation (CFR) cited by the auditor does not prescribe a specific sampling size or methodology. Taken within the context of DSHS robust program integrity efforts, the Department considers that the current process for medical services verification meets both the requirement and the intent of the CFR.

The Department does not believe that the current manual survey process is as effective as other department controls designed to detect fraud. The Department sampled 711 claims out of 12,948,200 paid claims, which is .005%. Even if the Department sampled 500 claims per month as suggested by the guidelines, that would only represent .05% of the total paid claims which is not a significant threshold for detection of fraud, waste, and abuse. Instead of relying on this manual process, the DSHS Health and Recovery Services Administration (HRSA) has instituted other more automated, productive ways of soliciting information on Medicaid provider fraud, waste and abuse. These activities include:

- A toll-free fraud, waste and abuse hot-line. On a monthly basis, HRSA receives an average of eight (8) referrals that warrant further investigation/research based on calls received on the toll-free number; this is compared to the zero (0) valid investigations received via the survey process.*
- An e-mail address for external clients, stakeholders and internal state staff to report Medicaid provider complaints. On a monthly basis, HRSA averages eleven (11) referrals that warrant further investigation/research based on e-mails; this is compared to the zero (0) valid investigations received via the survey process.*
- A set of robust program integrity activities including utilization review and data mining activities. PRP runs proactive data analyses on paid claims to identify providers who appear to be billing aberrantly for certain services or billings vary greatly from their peers. Thousands of overpayments, audits and MFCU referrals have resulted from DSHS data reviews.*

Taken together, the Department believes it more than meets the intent of the rule with these additional proactive methods. The Department also performed an informal survey with twenty seven (27) other states during this audit and found that other states also do not believe that the federal survey sampling methodology is a highly effective means of detecting waste and abuse. We shared this information with the auditor. Results of the informal survey showed six states answered that they had very few MFCU referrals from surveys and twelve states have never had a MFCU referral generated from the surveys. Nine (9) states did not have information either way. Of the states informally surveyed, the number of surveys generated vary from 0% to 100% (mandated by the state legislature) of the client population. Thirteen (13) states that generate more surveys than Washington have had little to no referrals to MFCU generated from the surveys. Washington State agrees with our colleague in Massachusetts that stated "There is very little helpful feedback. We have many effective ways to monitor service delivery." It is very apparent from the survey that states generate client surveys to meet the CFR requirement but finds little benefit in the process and have other ways to identify fraud, waste and abuse.

The sampling methodologies that the State Auditor's Office cites below from the State Medicaid Manual are recommended but not mandated. HRSA's current survey process is a time-intensive manual process that costs more to the state than the benefit returned to Washington's program integrity efforts.

Finally, HRSA also disagrees with the statement that the Department does not intend to improve the process. The implementation of ProviderOne will enable the Department's survey function to generate an average of 2,500 automated surveys each month which will meet various federal requirements.

Auditor's Concluding Remarks

We re-affirm our finding, and will review any effort made by the Department to address this issue during our next audit.

Applicable Laws and Regulations

Circular No. A-133, Subpart C, §_300 Auditee responsibilities. states in part:

The auditee shall:

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

Title 42, code of Federal Regulations, Section 455 states in part:

§ 455.1 Basis and scope.

This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control.

(a) Under the authority of sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act, Subpart A provides State plan requirements for the identification, investigation, and referral of suspected fraud and abuse cases. In addition, the subpart requires that the State—

(1) Report fraud and abuse information to the Department; and

(2) Have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients.

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

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

§ 455.20 Recipient verification procedure.

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

(b) In States receiving Federal matching funds for a mechanized claims processing and information retrieval system under part 433, subpart C, of this subchapter, the agency must provide prompt written notice as required by §433.116 (e) and (f).

Title 42, code of Federal Regulations, Section 433.116 states:

FFP for operation of mechanized claims processing and information retrieval systems.

(a) Subject to 42 CFR 433.113(c), FFP is available at 75 percent of expenditures for operation of a mechanized claims processing and information retrieval system approved by CMS, from the first day of the calendar quarter after the date the system met the conditions of initial approval, as established by CMS (including a retroactive adjustment of FFP if necessary to provide the 75 percent rate beginning on the first day of that calendar quarter). Subject to 45 CFR 95.611(a), the State shall obtain prior written approval from CMS when it plans to acquire ADP equipment or services, when it anticipates the total acquisition costs will exceed thresholds, and meets other conditions of the subpart.

(b) CMS will approve the system operation if the conditions specified in paragraphs (c) through (h) of this section are met.

(c) The conditions of §433.112(b) (1) through (4) and (7) through (9), as periodically modified under §433.112(b)(2), must be met.

(d) The system must have been operating continuously during the period for which FFP is claimed.

(e) The system must provide individual notices, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the plan.

(f) The notice required by paragraph (e) of this section—

(1) Must specify—

- (i) The service furnished;
 - (ii) The name of the provider furnishing the service;
 - (iii) The date on which the service was furnished; and
 - (iv) The amount of the payment made under the plan for the service; and
- (2) Must not specify confidential services (as defined by the State) and must not be sent if the only service furnished was confidential.
- (g) The system must provide both patient and provider profiles for program management and utilization review purposes.
- (h) If the State has a Medicaid fraud control unit certified under section 1903(q) of the Act and §455.300 of this chapter, the Medicaid agency must have procedures to assure that information on probable fraud or abuse that is obtained from, or developed by, the system is made available to that unit. (See §455.21 of this chapter for State plan requirements.)

The State Medicaid Manual states in part:

11325 CLAIMS PROCESSING SUBSYSTEM

A. Basic Functions and Objectives.--Your claims processing system must:

- o Ensure that all input into the subsystem is captured at the earliest possible time and in an accurate manner.
- o Establish control over all transactions during their entire processing cycle, including claims in pending status.
- o Verify that all providers submitting input are properly enrolled.
- o Ensure that all recipients for whom input is submitted were eligible for the type of service at the time the service was rendered.
- o Ensure that all input submitted to the subsystem is processed completely.
- o Verify that charges submitted by providers are reasonable and within acceptable limits.
- o Ensure that reimbursements to providers are rendered promptly and correctly.
- o Maintain accurate and complete registers and audit trails of all processing.
- o Maintain all processed data necessary to satisfy legal requirements and the needs of other subsystems.
- o Respond to queries concerning recipient eligibility and benefit status.
- o Process approved prior authorization requests.
- o Process provider credits and adjustments.
- o Identify uniquely and be able to locate any provider claim.
- o Automatically suspend all transactions in error until corrections are made.
- o Check each claim prior to payment against all current and previously paid claims for which a duplicate payment could exist.
- o Provide a prompt response to all inquiries regarding the status of any claim.
- o Issue remittance statements to providers detailing claims and services covered by a given payment at the same time as the payment.
- o Provide EOB 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 as described in §11210. To assist MMIS States in implementing the option to send EOBs on a sample basis, the following sampling methods are recommended:
 - Sampling instructions are the Medicaid fraud guidelines on Verification of Services to Recipients. They provide for a sample of claims from high-volume providers and a sample of claims from low-volume providers. Sample sizes may be increased or decreased each month at your discretion. Note that each sample only represents each set of providers, not all claims paid.
 - One random sample from all claims you pay each month is large enough to obtain some overall representation of the population, at a minimum, a monthly sample ranging from 500 claims up to 100 percent of the State population. The distribution of claims in such a sample will tend to mirror that of the population, including many drug and doctor claims and relatively few hospital and nursing home claims.
 - A random sample of providers, then a sample of claims from each of the sampled providers. The sample of providers can be structured several ways, e.g., a specified number of each type of provider, or a random sample from all providers. A minimum sample of 100 providers each month, with at least five claims sampled from each provider, is suggested.
 - A random sample of recipients (or cases) with all claims paid in a month for each. This method would provide the most comprehensive list of services for each sampled recipient (or case). A sample of at least 400 recipients each

month is suggested. Structure the recipient sample according to your needs -- either a random sample of recipients, or a specified number of each type of recipient (AFDC, SSI, medically needy, etc.)

- Other sampling methods if approved by the HCFA RA.

08-34 The Department of Social and Health Services, Aging and Disability Services Administration, Home and Community Based Services Division, does not have adequate controls in place to ensure Medicaid recipients have received the services for which Medicaid is being billed.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number: 5-0805WA5028, 5-0805WA5048
Applicable Compliance Component: Utilization Control and Program Integrity
Questioned Cost Amount: None

Background

Federal regulations require state Medicaid agencies to have a process to use to verify with Medicaid clients that they received the services billed to Medicaid by providers. This process is intended to identify potential fraud or abuse of the Medicaid program.

The Medicaid program is the major source of public funding for long-term care services and supports providers in in-home and community settings. The Home and Community Based Services waiver program permits states to furnish in-home and community-based services to assist Medicaid beneficiaries in avoiding institutionalization. The individual who provide these services are chosen by the individual client or agencies working on behalf of the client.

The Department of Social and Health Services, Aging and Disability Services Administration (ADSA), administers long-term services and support and is responsible for instituting and following the recipient verification process.

ADSA paid more than \$400 million was for in-home services during fiscal year 2008.

Description of Condition

During our audit, we found the Administration does not have any procedures to verify with home- and community-based service Medicaid clients whether services billed by providers were received.

The Administration also stated that verification of services is primarily confirmed during case managers' face-to-face interviews with clients during annual needs assessments. During our audit, we did not find evidence that the case managers attempted to verify whether services had been provided.

Cause of Condition

The Administration stated it believes that when the case manager asks the client if the authorized hours are sufficient for the clients' well-being, verification has been done.

Effect of Condition

The lack of appropriate, required verification increases the risk of fraudulent claims being paid and not being detected in a timely manner, if at all.

Recommendation

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

Department's Response

We concur that the department does not have processes or procedures that provide Medicaid recipients with information on how many hours of care were billed to the department by the individual providers (IP) who provide their services.

Currently, we have no automated way of performing this function. The Department has requested funding in the 2008 Supplemental Budget and the 2009-2011 Biennial Budget to continue current planning efforts to procure and implement a new Provider Compensation Subsystem (PCS). The PCS will interface with the Provider 1 system and replace the Social Services Payment System as the payment vehicle for individual providers. The PCS will meet the service verification requirements through an automated process. If the client sees a discrepancy in the hours provided versus the hours billed they will be instructed to notify the department. Implementation of the PCS is dependent on approval by the Center for Medicaid and Medicare Services and legislative approval of the department's budget request.

In the interim, the department will have to rely on the controls that are currently in place. They are as follows:

- Case managers complete an assessment that results in an authorization of hours that cannot be exceeded by a provider invoice.*
- Clients are expected to keep timesheets for their individual providers and the Area Agency case managers perform random audits of this practice to ensure that it occurs.*
- Clients receive a copy of the service authorization that tells them the number of hours of service they are eligible to receive. Clients are advised and understand they can choose when those hours are provided and direct the IP when to provide them. Case Managers also advise clients to contact them if they are not receiving the hours (care) they are eligible for.*
- The Department through its Payment Review Program runs algorithms to detect possibly fraudulent claims. Overpayments are initiated and referrals are made to the Medicaid Fraud Control Unit as indicated by findings.*

The department understands the limitations of its current controls and believes an automated process is the most cost effective way to meet the requirement. Given the programming priorities and funding constraints of the existing Social Services Payment System (SSPS), the lack of staffing resources to conduct a manual survey process, and the planned replacement of SSPS with the PCS within the next 18-24 months, the department does not believe the development of an interim automation solution is prudent or cost effective.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations:

Circular No. A-133, Subpart C, §_300 Auditee responsibilities. states in part:

The auditee shall:

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

Title 42, code of Federal Regulations, Section 455 states in part:

§ 455.1 Basis and scope.

This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control.

(a) Under the authority of sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act, Subpart A provides State plan requirements for the identification, investigation, and referral of suspected fraud and abuse cases. In addition, the subpart requires that the State—

(1) Report fraud and abuse information to the Department; and

(2) Have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients.

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

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

[51 FR 34787, Sept. 30, 1986, as amended at 72 FR 67655, Nov. 30, 2007]

§ 455.20 Recipient verification procedure.

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

(b) In States receiving Federal matching funds for a mechanized claims processing and information retrieval system under part 433, subpart C, of this subchapter, the agency must provide prompt written notice as required by §433.116 (e) and (f).

08-35 The Department of Social and Health Services, Aging and Disability Services Administration, did not ensure evaluations or re-evaluations of level of care for clients receiving in-home care services have been performed at least once every 12 months.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number: 5-0805WA5028, 5-0805WA5048
Applicable Compliance Component: Utilization Control and Program Integrity
Questioned Cost Amount: \$54,215.06

Background

The Department of Social Health Services, Aging and Disability Services Administration, requires all clients who are seeking Medicaid assistance to meet eligibility criteria prior to receiving services. Eligibility is determined in part through an assessment of the client's ability to perform activities of daily living.

The Department uses the Comprehensive Assessment Reporting Evaluation (CARE) system to determine the level of care and to identify the type and amount of services needed by the client. Home and Community Service offices perform the initial evaluation on clients; case managers at the Area Agency on Aging agencies are to re-evaluate clients annually.

After the initial evaluation, the client is required to undergo an annual re-evaluation to determine the level of care and if they are still functionally eligible to receive assistance. Evaluations are determined to be complete and the client is authorized to receive services once the client has reviewed the results of his or her assessment and has either verbally agreed or given a signature of approval for the services that have been offered.

In fiscal year 2007 the Department provided services to over 11,000 clients.

Description of Condition

The Department did not monitor to ensure staff were completing evaluations for all clients receiving long-term services in a timely manner. During our audit we identified 15 clients who had exceeded their assessment due date by 60 days or more.

Cause of Condition

The Department stated that in most cases the face-to-face assessment was done within timeframe, but the case managers did not complete the assessments in a timely manner.

Effect of Condition

When services are provided without authorization, expenditures are not allowable. Total payments for services for these 15 clients after the re-evaluation due date were \$105,430.58. We are questioning \$54,215.06, which is the federal portion of the expenditures.

Recommendation

We recommend the Department:

- Monitor to ensure level of care assessment for clients receiving in-home care is performed at least once every 12 months.
- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid funds must be reimbursed.

Department's Response

The Department partially concurs with this finding.

Although the Department agrees that of the 15 exceptions noted, four assessment due dates were exceeded by 60 days or more, the Department does not agree that the expenditures for these clients are not allowable. All of the exceptions noted were eligible to receive care and therefore the expenditures are allowable under federal rule. The Department will work with the U.S. Department of Health and Human Services to ensure that we are in agreement that these are not considered questioned costs.

Several of the exceptions include clients for which assessments were completed within the required timeframe. However, the department acknowledges that the assessments were not moved to current status within the CARE tool. Assessments which are not moved to current status upon completion show as out of date when monitored. The Department will address this finding as an opportunity to provide additional training and direction to staff on the assessment process with emphasis on moving the assessment to current status upon completion. This information will be provided through a CARE Factsheet distributed to all applicable staff.

Two clients were erroneously included in the sample because they are not enrolled in the COPES waiver. These two clients reside in nursing facilities.

The Department will continue its monitoring process to ensure level of care assessment for clients receiving in-home services is completed at least once every 12 months. The Department implements a comprehensive monitoring system as part of the quality assurance monitoring cycle. A minimum of six percent of the active caseload is monitored on an 18 month cycle. Each file is reviewed for assessment timeliness and the monitoring tool includes the question, "Did the annual assessment occur within 12 months of the previous assessment?" The last monitoring cycle, which ended in December 2007, resulted in 95 percent compliance for assessment timeliness. The Department continues to prioritize the timeliness of annual assessments with the quality monitoring process. In the current monitoring cycle, which began in October 2008, preliminary data indicates that the Department's on time record will be at least as successful as the achieved in the previous cycle.

Auditor's Concluding Remarks

We appreciate the cooperation and assistance provided by the Department throughout the audit. We will review this area during our next audit.

Applicable Laws and Regulations

COPES Waiver Version 06-95 states in part:

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in the Executive Summary of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):

- Discharge planning team
- Physician (MD or DO)
- Registered nurse, licensed in the state
- Licensed social worker
- Qualified mental retardation professional, as defined in 42 CFR 483.430(a)
- Other (specify):
Social Workers, Case Managers

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (specify):

- Every 3 months
- Every 6 months
- Every 12 months
- Other (specify):
As indicated by a significant change in the client's condition or situation

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for all individuals performing reevaluations of level of care (specify):

- Physician (MD or DO)
- Registered nurse, licensed in the state
- Licensed social worker
- Qualified mental retardation professional, as defined in 42 CFR 483.430(a)
- Other (specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The state will employ the following procedures to ensure timely reevaluations of level of care (check below):

- "Tickler" file
- Edits in computer system
- Component part of case management
- Other (specify):

Quality assurance monitoring staff from ADSA headquarters conducts annual reviews of case management services provided by the Home and Community Services Division (HCS), Area Agencies on Aging (AAA) and Managed Care Organizations (MCO). Each HCS region ,AAA office and MCO is monitored. At the regional and local levels, HCS

and AAA case management supervisors also conduct regular quality reviews of their case management staff.

Title 42: Public Health

[PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES](#)

[Subpart G—Home and Community-Based Services: Waiver Requirements](#)

§ 441.302 State assurances.

Unless the Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted:

(a) *Health and Welfare* —Assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include—

- (1) Adequate standards for all types of providers that provide services under the waiver;
 - (2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver;
- and

(3) Assurance that all facilities covered by section 1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

(b) *Financial accountability*— The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

(c) *Evaluation of need*. Assurance that the agency will provide for the following:

(1) *Initial evaluation*. An evaluation of the need for the level of care provided in a hospital, a NF, or an ICF/MR when there is a reasonable indication that a recipient might need the services in the near future (that is, a month or less) unless he or she receives home or community-based services. For purposes of this section, “evaluation” means a review of an individual recipient’s condition to determine—

- (i) If the recipient requires the level of care provided in a hospital as defined in §440.10 of this subchapter, a NF as defined in section 1919(a) of the Act, or an ICF/MR as defined by §440.150 of this subchapter; and
- (ii) That the recipient, but for the provision of waiver services, would otherwise be institutionalized in such a facility.

(2) *Periodic reevaluations*. Reevaluations, at least annually, of each recipient receiving home or community-based services to determine if the recipient continues to need the level of care provided and would, but for the provision of waiver services, otherwise be institutionalized in one of the following institutions:

- (i) A hospital;
- (ii) A NF; or
- (iii) An ICF/MR.

(d) *Alternatives* —Assurance that when a recipient is determined to be likely to require the level of care provided in a hospital, NF, or ICF/MR, the recipient or his or her legal representative will be—

- (1) Informed of any feasible alternatives available under the waiver; and
- (2) Given the choice of either institutional or home and community-based services.

(e) *Average per capita expenditures*. Assurance that the average per capita fiscal year expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made in the fiscal year for the level of care provided in a hospital, NF, or ICF/MR under the State plan had the waiver not been granted.

- (1) These expenditures must be reasonably estimated and documented by the agency.

(2) The estimate must be on an annual basis and must cover each year of the waiver period.

(f) *Actual total expenditures.* Assurance that the agency's actual total expenditures for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to recipients under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals, absent the waiver, in—

- (1) A hospital;
- (2) A NF; or
- (3) An ICF/MR.

(g) *Institutionalization absent waiver.* Assurance that, absent the waiver, recipients in the waiver would receive the appropriate type of Medicaid-funded institutional care (hospital, NF, or ICF/MR) that they require.

(h) *Reporting.* Assurance that annually, the agency will provide CMS with information on the waiver's impact. The information must be consistent with a data collection plan designed by CMS and must address the waiver's impact on—

- (1) The type, amount, and cost of services provided under the State plan; and
- (2) The health and welfare of recipients.

(i) *Habilitation services.* Assurance that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver, are—

(1) Not otherwise available to the individual through a local educational agency under section 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730); and

(2) Furnished as part of expanded habilitation services, if the State has requested and received CMS's approval under a waiver or an amendment to a waiver.

(j) *Day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness.* Assurance that FFP will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are—

- (1) Age 22 to 64;
- (2) Age 65 and older and the State has not included the optional Medicaid benefit cited in §440.140; or
- (3) Age 21 and under and the State has not included the optional Medicaid benefit cited in §440.160.

[50 FR 10026, Mar. 13, 1985, as amended at 59 FR 37717, July 25, 1994; 65 FR 60107, Oct. 10, 2000]

WAC 388-106-0025

How do I apply for long-term care services?

To apply for long-term care services, you must request an assessment from the department and submit a Medicaid application.

WAC 388-106-0050

What is an assessment?

(1) An assessment is an in-person interview in your home or your place of residence that is conducted by the department to inventory and evaluate your ability to care for yourself. The department will assess you at least annually or more often when there are significant changes to your ability to care for yourself.

(2) Between assessments, the department may modify your current assessment without an in-person interview in your home or place of residence. The reasons that the department may modify your current assessment without conducting an in-person interview in your home or place of residence include but are not limited to the following:

- (a) Errors made by department staff in coding the information from your in-person interview;
- (b) New information requested by department staff at the time of your assessment and received after completion of the in-person interview (e.g. medical diagnosis);
- (c) Changes in the level of informal support available to you; or
- (d) Clarification of the coding selected.

(3) When the department modifies your current assessment, it will notify you using a Planned Action Notice of the modification regardless of whether the modification results in a change to your benefits. You will also receive a new service summary and assessment details.

WAC 388-106-0055

What is the purpose of an assessment?

The purpose of an assessment is to:

- (1) Determine eligibility for long-term care programs;
- (2) Identify your strengths, limitations, and preferences;
- (3) Evaluate your living situation and environment;
- (4) Evaluate your physical health, functional and cognitive abilities;
- (5) Determine availability of informal supports and other nondepartment paid resources;
- (6) Determine need for intervention;
- (7) Determine need for case management activities;
- (8) Determine your classification group that will set your payment rate for residential care or number of hours of in-home care;
- (9) Determine need for referrals; and
- (10) Develop a plan of care, as defined in WAC [388-106-0010](#).
- (11) In the case of New Freedom consumer directed services, the purpose of an assessment is to determine functional eligibility and for the participant to develop the New Freedom spending plan, as defined in WAC [388-106-0010](#).

WAC 388-513-1315

Eligibility for long-term care (institutional, waiver, and hospice) services.

This section describes how the department determines a client's eligibility for institutional, waiver, or hospice services under the categorically needy (CN) program and institutional or hospice services in a medical institution under the medically needy (MN) program. Also described are the eligibility requirements for these services under the general assistance (GA) program in subsection (12) and the alien emergency medical programs described in subsection (11).

(1) To be eligible for long-term care (LTC) services described in this section, a client must:

- (a) Meet the general eligibility requirements for medical programs described in WAC [388-503-0505](#)

(2) and (3)(a) through (f);

- (b) Attain institutional status as described in WAC [388-513-1320](#);
- (c) Meet functional eligibility described in chapter [388-106](#) WAC for waiver and nursing facility coverage; and

DSHS Long-Term Care Manual

Completing a CARE Assessment – Developing the Plan of Care

Background

Clients are able to choose from options for personal and healthcare services that are governed by eligibility criteria, payment source requirements, coverage options, and provider qualifications. Twenty-four hour, paid care is available only in residential or medical facility settings, so case managers must work with clients to maximize all available resources, both paid and unpaid, in order to develop a plan of care that addresses the health and safety needs of the client. The state identifies the essential tasks to be performed by formal providers in the care plan. How and when they are performed is determined by the client.

The state has an obligation to educate clients, family members, support systems, and other service providers, informing them that a plan of care is developed based on the resources available and that meeting all needs and providing all services is an expectation that neither the client, family, support system, or case manager may be able to achieve.

How do I get approval on the plan of care from the client?

Before authorizing services, you must [obtain the client's approval](#) on the plan of care.

How do I distribute the plan of care to the client/representative?

Distribute the Service Summary and CARE Results to the client along with a [Planned Action Notice](#) (PAN). Distribute Assessment Details if requested by the client/representative.

How and when do I distribute the plan of care to the provider(s)?

Mail or fax the Service Summary and Assessment Details prior to authorizing/reauthorizing services and document in the SER. Review the plan of care with the provider when the client has special or extraordinary needs due to cognitive issues. Distribute the Service Summary and Assessment Details to:

- Individual providers;
- Agency providers;
- Nursing services staff, if applicable;
- Residential providers;
- The nursing facility, if the client is placed there on Medicaid funding only;
- Adult Day Services providers;
- Nurse delegators.

Document in the SER when you distributed the documents and to whom.

How do I authorize services?

Complete all authorizations in CARE once the client has approved the plan of care. For:

- Initial assessments, the begin date may not precede the date the assessment was moved to *Current* status.
- Significant Change assessments, if extending services for one year, terminate the current line or lines (for example, if participation is also authorized) and create a new line(s) on the same authorization. Do not change the begin date on a current line since changing the begin date creates a risk of canceling outstanding payments or prevents invoicing from occurring. If there are not enough lines left on the authorization, open a new authorization.
- Annual assessments, you may not extend services beyond one year from the last day of the month in which it was moved to *Current*. A face-to-face assessment must occur and the assessment must be moved to *Current* prior to reauthorization of services.

08-36 Department of Social and Health Service, Health and Recovery Services Administration, does not have adequate controls to ensure providers meet ongoing eligibility requirements to participate in the Medicaid program.

Federal Awarding Agency: U.S. Department of Health and Human Services
Pass-Through Entity: None
CFDA Number and Title: Medicaid Cluster
93.775 State Medicaid Fraud Control Units
93.776 Hurricane Katrina Relief
93.777 State Survey and Certification of Health Care Providers and Suppliers
93.778 Medical Assistance Program (Medicaid: Title XIX)
Federal Award Number: 5-0805WA5028, 5-0805WA5048
Applicable Compliance Component: Provider Eligibility
Questioned Cost Amount: None

Background

The Department of Social and Health Services, Health and Recovery Services Administration Provider Enrollment Unit, reviews the qualifications of health care service providers who want to participate in the Washington Medicaid program.

All providers are required to complete a Core Provider Agreement (CPA) and an Enrollment Application. The Department has identified 49 different types of providers, such as medical equipment suppliers (i.e. wheelchairs), physicians, pharmacists, and others. Each type of service provider must submit certain basic information, as well as additional information specific to their field of service. The most common information required includes copies of the following:

- Business License
- Current professional license
- Internal Revenue Services W-9 form
- Liability Insurance (if applicable)
- Medicare certification (if applicable)
- Drug Enforcement Administration Certification (if applicable)
- Other additional documents as applicable to each type of provider

All applicable forms and supporting documents are submitted to the Provider Enrollment Unit where they are reviewed for accuracy and completeness. Upon completion of the enrollment process, approved providers receive a seven digit provider number.

During fiscal year 2008 the Department had over 43,000 providers that participated in the Medicaid programs.

Description of Condition

We judgmentally selected four types of providers that provide services to vulnerable populations to review for eligibility: respiratory therapy providers, adult day health providers, durable medical equipment providers, and substance abuse facilities.

We performed testing to determine whether the Department has adequate controls to ensure providers meet eligibility requirements to participate in the Medicaid program initially and throughout their enrollment.

Respiratory Therapy Providers

We reviewed 10 out of 26 providers and found the Department does not have adequate controls to ensure respiratory therapy providers have a current valid business license throughout their enrollment. We also

found the Department does not monitor whether each respiratory therapy provider has at least one qualified professional staff member with a current valid professional license as required

Additionally, we identified one Respiratory Therapy provider that did not have staff with a current, valid professional license.

Adult Day Health Providers

We reviewed 10 out of 22 providers and found the Department does not have adequate controls to ensure adult day health providers meet all requirements to participate in the Medicaid program throughout their enrollment. The Health and Recovery Services Administration relies on a different administration within the Department to determine ongoing eligibility of adult day health providers.

While this practice is reasonable, we found inadequate communication between the two administrations to ensure changes in provider eligibility status were accurately reflected within the Medicaid provider system. During our audit we found two adult day health providers with certifications that had lapsed, and yet still had valid Medicaid provider numbers.

Durable Medical Equipment Providers

The Department does not have any controls in place to ensure compliance with state regulations, which require all Durable Medical Equipment (DME) providers have appropriately trained, qualified staff to be eligible as a Medicaid provider. In response to our recommendation in 2007 the Department stated it would be seeking to eliminate the state requirement, and have initiated the amendment process. However, the requirement is still current and effective.

Substance Abuse Facility Providers

We noted no concerns in our review of substance abuse facility providers.

Cause of Condition

Respiratory Therapy Providers

The enrollment unit stated it doesn't have the resources to establish these controls to monitor whether respiratory therapy providers have current valid business license and at least one qualified professional staff throughout their enrollment.

Adult Day Health Providers

The Health and Recovery Services Administration relies on the expectation it will be notified of provider eligibility changes by another Department administration, instead of actively seeking positive confirmation for providers' eligibility.

Durable Medical Equipment Providers

We reported this issue during our 2007 audit. In response, the Department stated the regulation was not needed, and so it would seek to eliminate the state rule. However, the rule is currently still in place and therefore the Department is required to comply with it.

Effect of Condition

Provider eligibility requirements help ensure Medicaid clients receive qualified care and services. Inadequate controls to ensure providers are meeting eligibility requirements initially and throughout their enrollment increase the risk of ineligible providers providing services to Medicaid clients and not being identified in a timely manner, if at all.

Recommendation

We recommend the Department strengthen controls to ensure all providers meet eligibility requirements to participate in the Medicaid program throughout their enrollment. This includes:

- Monitoring providers required to have professional licenses on an on-going basis;

- Establishing procedures for improved communication between Administrations which rely on one another to establish provider eligibility; and
- Ensuring Department rules are current and reflect the Department's intent and obligations. Actual practices should be consistent with Department rules.

Department's Response

The Department concurs with this finding.

We intend to improve the monitoring of the following providers' licenses by:

- *Respiratory Therapy Providers: The current Medicaid Management Information System does not provide an automated review of provider licenses and would also require additional staffing resources. The implementation of ProviderOne (P1) will include a new functionality which will generate automated letters and a report based on the expiration dates of providers' licenses. The letters will be compared to the Department of Health website for current license status. These letters will be mailed to the providers' offices to alert the providers that their licenses will be expiring. The providers' status will then be updated in P1 based on the status of their license.*
- *Adult Day Health Providers: The Health and Recovery Services Administration (HRSA) will formalize the transfer process of licensing information with the Aging and Adults Services Administration to ensure timely and accuracy of licensing data.*
- *Durable Medical Equipment Providers: The HRSA is modifying WAC 388-530 to remove the requirement that all Durable Medical Equipment providers must have appropriately trained and qualified staff to be eligible as a Medicaid provider. The public hearing is scheduled for January 27, 2009 and the rule will be filed with an effective date of March 1, 2009.*

Auditor's Concluding Remarks

We thank the Department for its response, and look forward to reviewing the status of its corrective action during our next audit.

Applicable Laws and Regulations

WAC 388-502-0010

Payment — Eligible providers defined.

The department pays enrolled providers for covered healthcare services, equipment and supplies they provide to eligible clients.

(1) To be eligible for enrollment, a provider must:

(a) Be licensed, certified, accredited, or registered according to Washington state laws and rules; and

(b) Meet the conditions in this chapter and chapters regulating the specific type of provider, program, and/or service.

(2) To enroll, an eligible provider must sign a core provider agreement with the department and receive a unique provider number; a provider may also sign a contract to enroll. (Note: Section 13 of the core provider agreement, DSHS 09-048 (REV. 06/2002), is hereby rescinded. The department and each provider signing a core provider agreement will hold each other harmless from a legal action based on the negligent actions or omissions of either party under the terms of the agreement.)

WAC 246-928-410

Who must be licensed as a respiratory care practitioner with the department.

(1) Any person performing or offering to perform the functions authorized in RCW 18.89.040 must be licensed as a respiratory care practitioner. A certification, registration or other credential

issued by a professional organization does not substitute for licensure as a respiratory care practitioner in Washington state.

WAC 388-71-0706

Adult day health — Services.

Adult day health is a supervised daytime program providing skilled nursing and rehabilitative therapy services in addition to core services. Adult day health services are only appropriate for adults with medical or disabling conditions that require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician.

The adult day health center must offer and provide on site the following services:

- (1) All core services under WAC 388-71-0704;
- (2) Skilled nursing services other than routine health monitoring with nurse consultation;
- (3) At least one of the following skilled therapy services: physical therapy, occupational therapy, or speech-language pathology or audiology, as defined under chapters 18.74, 18.59 and 18.35 RCW; and
- (4) Psychological or counseling services, including assessing for psycho-social therapy need, dementia, abuse or neglect, and alcohol or drug abuse; making appropriate referrals; and providing brief, intermittent supportive counseling.

WAC 388-71-0724

Adult day services — Contracting and rates.

(1) The department, or an area agency on aging (or other department designee) as authorized by the department, must determine that the adult day care or day health center meets the applicable adult day care or day health requirements and any additional requirements for contracting with the area agency on aging through a COPES contract or with the department through a Medicaid provider contract. If a center is contracting for both day care and day health, requirements of both adult day services must be met.

(a) A prospective provider desiring to provide adult day services shall be provided an application form from the department or the area agency on aging.

(b) The prospective provider will provide the area agency on aging with evidence of compliance with, or administrative procedures to comply with, the adult day service rules under this chapter.

(c) The area agency on aging will conduct a site inspection of the adult day center and review of the requirements for contracting.

(d) Within thirty days of completing the site visit, the area agency on aging will advise the prospective provider in writing of any deficiencies in meeting contracting requirements.

(e) The area agency on aging will verify correction of any deficiencies within thirty days of receiving notice from the prospective provider that deficiencies have been corrected, before contracting can take place.

(f) The area agency on aging will provide the department with a written recommendation as to whether or not the center meets contracting requirements.

(3) The area agency on aging or other department designee monitors the adult day center at least annually to determine continued compliance with adult day care and/or adult day health requirements and the requirements for contracting with the department or the area agency on aging.

(a) The area agency on aging will send a written notice to the provider indicating either compliance with contracting requirements or any deficiencies based on the annual monitoring visit and request a corrective action plan. The area agency on aging will determine the date by which the corrective action must be completed

(b) The area agency on aging will notify the department of the adult day center's compliance with contracting requirements or corrected deficiencies and approval of the corrective action plan for continued contracting.

WAC 388-543-1200

Providers who are eligible to provide services.

(1) MAA requires a provider who supplies DME and related supplies, prosthetics, orthotics, medical supplies and related services to an MAA client to meet all of the following. The provider must:

(a) Have the proper business license;

(b) Have appropriately trained qualified staff; and

(c) Be certified, licensed and/or bonded if required, to perform the services billed to the department. Out-of-state prosthetic and orthotics providers must meet their state regulatory requirements

(2) MAA may reimburse qualified providers for DME and related supplies, prosthetics, orthotics, medical supplies, repairs, and related services on a fee-for-service (FFS) basis as follows:

(a) DME providers for DME and related repair services;

(b) Medical equipment dealers, pharmacies, and home health agencies under their medical vendor provider number for medical supplies, subject to the limitations in this section;

(c) Licensed prosthetics and orthotics providers who are licensed by the Washington state department of health in prosthetics and orthotics. This does not apply to medical equipment dealers and pharmacies that do not require licensure to provide selected prosthetics and orthotics;

(d) Physicians who provide medical equipment and supplies in the physician's office. MAA may pay separately for medical supplies, subject to the provisions in MAA's resource based relative value scale (RBRVS) fee schedule; and

(e) Out-of-state orthotics and prosthetics providers who meet their state regulations.

08-37 The University of Washington was reimbursed by its Vision Research Program for unallowable charges.

Federal Awarding Agency: National Institute of Health
Pass-Through Entity: None
CFDA Number and Title: 93.867 Vision Research
93.859 Pharmacology, Physiology and Biological Chem
Federal Award Number: EY000745, EY010578, EY014950, EY015046, EY006558 and P5RR000166
Applicable Compliance Component: Activities Allowed or Unallowed
Questioned Cost Amount: \$20,996

Background

The Vision Research Program supports eye and vision research. Money from this grant pays for salaries, consultant costs, equipment, supplies, travel, and other costs as stated in the application and grant award document.

The School of Medicine spent approximately \$500,000 per year on average in federal funds for this program during the five year period from 2002 through 2007. It spent \$708,272 in federal funds for the program in fiscal year 2008. The grant allows the University to perform surgical procedures on primates to support eye and vision research. Procedures performed on primates must comply with federal regulations on laboratory animal welfare.

Description of Condition

In 2007, the University investigated the program, including looking at procedures performed on primates to determine if they complied with federal regulations. The University's investigation found that departments within the School of Medicine conducted 39 unauthorized procedures on 16 primates between 2002 and 2007, at a cost of \$20,864 that were paid with grant money.

The University investigation also found \$132 was paid with money from the federal Biomedical Research and Research Training (CFDA 93.859) grant.

Although this condition was not found as part of our audit of the University's major federal programs, federal audit standards require that we report as a finding all known questioned costs found in non-major programs that exceed \$10,000.

The University has resolved all issues related to this condition with the National Institutes of Health (NIH) Office of Laboratory Animal Welfare. The University is awaiting word from specific NIH Institutes regarding what repayment, if any, is required.

Cause of Condition

The University did not have adequate controls in place over pre-approval of certain surgery elements.

Effect of Condition and Questioned Costs

Without adequate monitoring of the Program, the University cannot be sure it complies with federal grant requirements. The University requested and received reimbursement from the grantor for the cost of surgical procedures that were unallowable. We question \$20,996 charged to this program. As noted above, the University is taking action to repay this amount.

Recommendation

We recommend the University strengthen internal controls to ensure only activities allowed are reimbursed by the grant funds

University's Response

The University agrees with the finding. The University has already augmented existing internal controls in the areas of increased communication, training, and monitoring, development of guidelines and revisions to forms and standard operating procedures.

Auditor's Concluding Remarks

We appreciate the University's commitment to resolve this finding and thank the University for its cooperation and assistance during the audit. We will review the corrective action taken during our next regular 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

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(a)

The auditor shall report the following as audit findings in a schedule of findings and questioned costs:

- ...(4) ...if the auditor does become aware of questioned costs for a Federal program which is not audited as a major program (e.g., as part of audit follow-up or other audit procedures) and the known questioned costs are greater than \$10,000, then the auditor shall report this as an audit finding.

Title 42 Code of Federal Regulations, Part 52a.8 refers to Public Health Service Policy on Humane Care and Use of Laboratory Animals, Office of Laboratory Animal Welfare, Office of Extramural Research, NIH (Revised September 2002)

NIH Grants Policy Statement; Part 11: Terms and Conditions of NIH Grant Awards Subpart A: General File 2 of 5 states in part:

Animal Welfare

The *PHS Policy on Humane Care and Use of Laboratory Animals* (the Policy) requires applicants proposing to use vertebrate animals in NIH-supported activities to file a written Animal Welfare Assurance with OLAW. The Policy defines "animal" as any live, vertebrate animal used or intended for use in research, research training, experimentation, biological testing, or related purposes. Under the Policy, the applicant/grantee is responsible for the humane care and treatment of animals in NIH grant-supported activities. The Policy implements and supplements the U.S. Government Principles for the Care and Utilization of Vertebrate Animals used in

Testing, Research, and Training. The Policy also requires the applicant to establish appropriate policies and procedures for the humane care and use of animals, based on the Guide for the Care and Use of Laboratory Animals, and to comply with the Animal Welfare Act and its implementing regulations. This includes appointing an IACUC with specified responsibilities.