Federal Findings and Questioned Costs

2017-002 The Department of Social and Health Services improperly charged about $4.1 million to multiple federal grants.

Federal Awarding Agency:	U.S. Department of Agriculture U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	10.551 Supplemental Nutrition Assistance Program (SNAP) 10.561 State Administrative Matching Grants for the Supplemental Nutrition Assistance Program 93.558 Temporary Assistance for Needy Families (TANF) 93.566 Refugee and Entrant Assistance – State-Administered Programs
Federal Award Number:	201616S806947, 2015IS251447, 201616S251447, 201717S251447, 201717Q750347, 201616S251947 201717S251947, 201616Q750347, 201616S252047 201717S252047, 201616S803647, 201717S803647 201717S802647, 2015IQ390347, 201616Q390347 201717Q390347, 1601WATANF, 1701WATANF, 1601WARCMA, 1601WARSOC, 1701WARCMA 1701WARSOC
Applicable Compliance Component:	Period of Performance
Known Questioned Cost Amount:	$4,061,653

Background

The Department of Social and Health Services (Department) administers multiple federal grant programs and spent about $5.2 billion in federal grant funds during fiscal year 2017. The Department is responsible for ensuring grant money is used for costs that are allowable and related to each grant's purpose. Each federal grant specifies a performance period during which program costs may be obligated. These periods typically align with the federal fiscal year of October 1 through September 30. Payments for costs obligated before a grant's beginning date are not allowed without the grantor's prior approval.

The Department uses a financial system that is heavily automated and assigns expenditures to a specific grant year. In the prior three audits, we found that the Department improperly charged multiple federal grants before their effective dates. These were reported as finding numbers 2016-002, 2015-003 and 2014-022. In those audits, we determined the improper charges were for centralized costs that are allocated throughout the Department.

During fiscal year 2017, the Department implemented a new manual process to identify and move unallowable charges to the proper grant.

Description of Condition

We found the Department identified and reversed $17.6 million in improper charges to the 2017 grants. However, we also found almost $4.1 million in expenditures were charged to grants for activities that occurred before the grants were open. The grant programs and amounts improperly charged were:

- Temporary Assistance for Needy Families: $1,504,929
- Supplemental Nutrition Assistance Program Cluster: $2,515,277
- Refugee and Entrant Assistance: $41,447

The Department did not have prior authorization from the grantor to charge pre-award costs to these grants.

Cause of Condition

The Department said it did not fully correct this problem because of limitations in its automated systems. Additionally, while the Department made changes to its procedures that helped correct the problem, these changes were not sufficient to ensure all improper charges were identified and reversed.

Effect of Condition and Questioned Costs

We are questioning improperly charged expenditures of $4,061,653 made before the start of the performance periods for the three grant programs described above.

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to supports its expenditures. When an agency does not comply with grant regulations, the grantor may require it to repay unallowable charges.

Recommendations

We recommend the Department only charge expenditures to federal grants if they are obligated during the period of performance. We also recommend the Department consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid.

Agency's Response

The Department concurs with this finding.

The Department will utilize the journal voucher process to correct the remaining $4.1 million by moving the expenditures to the proper grant year.

The Department implemented a mandatory process for Economic Services Administration staff to include the Month of Service (MOS) on the Agency and Financial Reporting System (AFRS)

transactions. The Department utilizes the MOS to perform a monthly review of AFRS transactions to identify unallowable charges and move them via the journal voucher process to the proper grant year. For FY17, the Department identified almost $21.7 million in expenditures that were charged to grants for activities that occurred before the grants were open. At the time of this audit, the Department had already reversed $17.6 million of the improper charges. However, due to the time-consuming, manual process and competing priorities, $4.1 million in charges remained.

In addition to the aforementioned processes, the Department implemented a procedure for FFY18 to aid in the automatic charging of costs to the appropriate grant year through cost allocation by changing when the automated cost allocation plan is updated for the applicable federal fiscal year. This process assists with ensuring transactions outside ESA's control, such as Payroll and Benefits and other Administrations' transactions, are applied to the appropriate grant year.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.
(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

(a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Title 2 U.S. Code of Federal Regulations section 200.309 Period of performance, states:

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

Title 2 U.S. Code of Federal Regulations Part 200, Appendix XI Compliance Supplement, states in part:

H. Period of Performance

Compliance Requirements

A non-Federal entity may charge to the Federal award only allowable costs incurred during the period of performance and any costs incurred before the Federal awarding

agency or pass-through entity made the Federal award that were authorized by the Federal awarding agency or pass-through entity (2 CFR section 200.309).

Unless the Federal awarding agency or pass-through entity authorizes an extension, a non-Federal entity must liquidate all obligations incurred under the Federal award not later than 90 calendar days after the end date of the period of performance as specified in the terms and conditions of the Federal award (2 CFR section 200.343(b)). When used in connection with a non-Federal entity's utilization of funds under a Federal award, "obligations" means orders placed for property and services, contracts and subawards made, and similar transactions during a given period that require payment by the non-Federal entity during the same or a future period (2 CFR section 200.71).

2017-003 The Department of Health did not have adequate internal controls over and could not demonstrate it complied with requirements to perform risk assessments for all subrecipients of the Special Supplemental Nutrition Program for Woman, Infants and Children program.

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

Background

The Department of Health (Department) operates the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). WIC reaches more than 294,000 women and children in over 200 clinics throughout the state and is funded exclusively with federal grants from the U.S. Department of Agriculture.

WIC serves pregnant, postpartum and breastfeeding women, and children up to 5 years old, who are at or below 185 percent of the federal poverty level. WIC provides:

- Nutrition ideas and tips on how to eat well and be more active
- Breastfeeding support, such as access to a peer counselor (varies by agency)
- Health reviews and referrals
- Monthly checks for healthy food, such as fruit, vegetables and milk

The Department passes grant funds to local health districts, non-profit organizations and tribes that administer the program and provide services. The Department performs fiscal monitoring at each of these entities once every two years. The Department spent about $131 million in federal grant funds during fiscal year 2017, and it passed through about $37 million to local WIC agencies as subrecipients of grant funds.

To determine the appropriate level of monitoring, federal regulations require the Department to evaluate each subrecipient's risk of noncompliance with federal statutes and regulations, and the terms and conditions of the subaward. The Department must perform a risk assessment every time it issues a new subaward.

Description of Condition

The Department of Health did not have adequate internal controls over and could not demonstrate it complied with requirements to perform risk assessments for all subrecipients of the Special Supplemental Nutrition Program for Woman, Infants and Children program.

During the audit period, the Department issued 37 new subawards, all of which were to existing WIC agencies. The Department had documentation showing it performed risk assessments for seven subrecipients identified as high or moderate-risk during their previous assessment. The other 30 subawards went to subrecipients with low-risk assessments from previous awards. The Department said it conducted informal risk assessments based on the results of its ongoing monitoring of these subrecipients. Because of a lack of supporting documentation, we were unable to determine if any risk assessments were performed for these 30 subrecipients.

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

This condition was not reported in the prior audit.

Cause of Condition

Management said the reason risk assessments were not documented in all cases was that informal risk assessments were performed by staff and the Department's procedures did not require staff to document those activities.

While the Department had written procedures in place, they did not explicitly require staff to conduct risk assessments for all new subawards. The procedures state staff are to consider filling out a new risk assessment if the subrecipient's risk has changed, before issuing a subaward to an existing subrecipient. The procedures did not specify what information was to be included in this consideration and did not require the staff member to document their assessments.

During the audit period, the program was in the process of a reorganization that included the staff responsible for performing risk assessments. Management said that during the reorganization, the roles were shifting and no one owned the risk assessment process. Both Department management and staff said they performed the required risk assessments, but were unable to provide documentation for us to verify they took place.

Effect of Condition

If risk assessments are not performed, the Department increases its risk of not detecting whether local WIC agencies are at a higher risk of not complying with grant terms and federal regulations. Without documenting its risk assessment activities, Department management cannot as effectively monitor if staff perform the assessments in compliance with federal regulations and agency policy.

Recommendations

We recommend the Department establish adequate internal controls to ensure required risk assessments are performed. Examples include:

- Maintain documentation to show required risk assessments were performed, which would allow management to monitor the results

- Amend its internal policies to clearly require staff to conduct risk assessments for all new subawards and provide examples of factors that should be considered by staff when they perform assessments

Agency's Response

We appreciate the State Auditor's Office (SAO) audit of our WIC program. Our Agency is committed to ensuring our programs comply with federal regulations, and understand it is SAO's point of view documentation must be maintained in order to verify the Agency's compliance. We will work with the necessary parties to develop a system for documenting risk assessments of subrecipients which not only meet audit standards, but provides benefit to the agency.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

Section 200.331 Requirements for pass-through entities, states in part:

All pass-through entities must:

(b) Evaluate each subrecipient's risk of noncompliance with Federal statutes, regulations, and the terms and conditions of the subaward for purposes of determining the appropriate subrecipient monitoring described in paragraphs (d) and (e) of this section, which may include consideration of such factors as:

(1) The subrecipient's prior experience with the same or similar subawards;

(2) The results of previous audits including whether or not the subrecipient receives a Single Audit in accordance with Subpart F—Audit Requirements of this part, and the extent to which the same or similar subaward has been audited as a major program;

(3) Whether the subrecipient has new personnel or new or substantially changed systems; and

(4) The extent and results of Federal awarding agency monitoring (e.g., if the subrecipient also receives Federal awards directly from a Federal awarding agency).

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

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

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

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

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

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

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

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

Office of Management and Budget's Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards 2 CFR 200 – Frequently Asked Questions (updated July 2017)

.331-10 Requirements for Pass-Through Entities. Timing of Subrecipient Risk Assessments, states in part:

Section §200.331 (b) indicates that pass-through entities must "evaluate each subrecipient's risk of noncompliance with Federal statutes, regulations, and the terms and conditions of the subaward for purposes of determining the appropriate subrecipient monitoring…" Are pass-through entities required to assess the risk of non-compliance for each applicant prior to issuing a subaward?

No. While section §200.331 (b) requires risk assessments of subrecipients, there is no requirement for pass-through entities to perform these assessments before making subawards. Under the Uniform Guidance, the purpose of these risk assessments is for pass-through entities to determine appropriate subrecipient monitoring. Pass-through entities may use judgment regarding the most appropriate timing for the assessments. Regardless of the timing chosen, the pass-through entity should document its procedures for assessing risk. Section §200.331 (b) (1) – (4) includes factors that a pass-through entity may consider when assessing subrecipient risk.

2017-004 The Department of Social and Health Services did not have adequate internal controls over and did not comply with public assistance cost allocation plan requirements.

Federal Awarding Agency:	U.S. Department of Agriculture U.S. Department of Housing and Urban Development U.S. Department of Justice U.S. Department of Labor U.S. Department of Education U.S. Department of Health and Human Services U.S. Social Security Administration
Pass-Through Entity:	None
CFDA Number and Title:	Numerous, see list at end of finding
Federal Award Number:	Numerous, see list at end of finding
Applicable Compliance Component:	Allowable Costs/Cost Principles
Known Questioned Cost Amount:	Undetermined

Background

The Department of Social and Health Services (Department) is required to submit a public assistance cost allocation plan to the U.S. Department of Health and Human Services (HHS). Public assistance cost allocation plans are used to allocate administrative costs between federal and state programs. Once the Department submits a plan, HHS reviews and approves it. If HHS does not approve a plan promptly, the Department can follow the submitted plan until it is informed otherwise. The Department can update its plan throughout the year, but it must submit amendments with these changes to HHS and submit a new plan each year that there are changes.

It is common for the Department to negotiate with HHS before plans are approved. Negotiations take place in consecutive order, because changes to one plan may affect the next. HHS approved the fiscal year 2015 plan in March 2017 and the fiscal year 2016 plan in August 2017.

In the prior audit, we reported the Department did not have adequate internal controls over and did not comply with public assistance cost allocation plan requirements. The prior finding number was 2016-004.

Description of Condition

The Department did not submit a cost allocation plan for fiscal year 2017 by July 1, 2016, as federal law required. We followed up with the Department and determined it submitted the fiscal year 2017 plan on April 28, 2017.

We consider this control deficiency to be a material weakness.

Cause of Condition

The Department said that in fiscal year 2014, a HHS employee verbally requested that the Department stop submitting public assistance cost allocation plans and updates until HHS approved the prior plans. We contacted HHS to attempt to verify this statement, but the staff member the Department spoke to is no longer with that agency.

The Branch Chief for HHS told us the agency does not have the authority to grant exceptions to the regulations requiring the plans to be submitted. The Department became aware of this in the middle of the fiscal year and was not able to finalize and submit the public assistance cost allocation plan until April 2017.

Effect of Condition and Questioned Costs

About $1.1 billion in costs are distributed to federal and state programs using the public assistance cost allocation plan. We determined at least $544 million of that amount was federal costs. HHS could disallow all of the federal costs.

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

Recommendations

We recommend the Department establish internal controls to ensure the required public assistance cost allocation plans and amendments are created and submitted promptly. We also recommend the Department submit all required plans and amendments before charging affected costs to a federal grant.

Agency's Response

The Department concurs with this finding.

Last year, the Department was provided verbal directions from DCA's negotiator to stop submitting Plans until DCA finished approving those previous year's Plans. The Department had worked with the same negotiator for several years and constantly based our actions off of the information we received from her. Therefore, when the Department was directed to stop submitting new plans, we stopped.

After last year's finding, 2016-004, the Department received written directions from DCA and ensured, prior to July 1, 2017, that all outstanding plans, up through FY18 would be submitted to DCA. Per the 2016-004 corrective action plan, the Centers for Medicare and Medicaid Services' (CMS), Region 10, Division of Cost Allocation (DCA) would be in possession of the Department's cost allocation plans by July 1, 2017. The plans were received by DCA on the following dates:

- *FY16 cost allocation plan on February 28, 2017*
- *FY17 cost allocation plan on April 28, 2017*
- *FY18 cost allocation plan on June 30, 2017.*

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

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(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.
(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.
(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

(a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
(3) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.
(4) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.
(5) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

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

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> **Deficiency in internal control over compliance.** A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.
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> **Material weakness in internal control over compliance.** A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:
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> **Reasonably possible**. The chance of the future event or events occurring is more than remote but less than likely.
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> **Probable**. The future event or events are likely to occur.
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> **Significant deficiency in internal control over compliance.** A deficiency, or a combination of deficiencies, in internal control over compliance that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.
>
> **Material noncompliance**. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Title 45 U.S. Code of Federal Regulations Part 95, *General Administration – Grant Programs (Public Assistance, Medical Assistance and State Children's Health Insurance Programs)* subpart E established requirements for cost allocation plans.

> Section 95.501 Purpose.
>
> This subpart establishes requirements for:
>
> (a) Preparation, submission, and approval of State agency cost allocation plans for public assistance programs; and
>
> (b) Adherence to approved cost allocation plans in computing claims for Federal financial participation.

Section 95.509 Cost allocation plan amendments and certifications.

(a) The State shall promptly amend the cost allocation plan and submit the amended plan to the Director, DCA if any of the following events occur:
   (1) The procedures shown in the existing cost allocation plan become outdated because of organizational changes, changes in Federal law or regulations, or significant changes in program levels, affecting the validity of the approved cost allocation procedures.
   (2) A material defect is discovered in the cost allocation plan by the Director, DCA or the State.
   (3) The State plan for public assistance programs is amended so as to affect the allocation of costs.
   (4) Other changes occur which make the allocation basis or procedures in the approval cost allocation plan invalid.

(b) If a State has not submitted a plan or plan amendment during a given State fiscal year, an annual statement shall be submitted to the Director, DCA certifying that its approved cost allocation plan is not outdated. This statement shall be submitted within 60 days after the end of that fiscal year.

Section 95.511 Approval of the cost allocation plan or plan amendment.

(a) The Director, DCA, after consulting with the affected Operating Divisions, shall notify the State in writing of his/her findings. This notification will be made within 60 days after receipt of the proposed plan or amendment and shall either: (1) Advise the State that the plan or plan amendment is approved or disapproved, (2) advise the State of the changes required to make the plan or amendment acceptable, or (3) request the State to provide additional information needed to evaluate the proposed plan or amendment. If the DCA cannot make a determination within the 60-day period, it shall so advise the State.

(b) For purpose of this subpart, State agency cost allocation plans which have been approved by an authorized official of the Department of HHS prior to the effective date of this regulation are considered approved until such time as a new plan or plan amendment is required by §95.509(a).

Section 95.515 Effective date of a cost allocation plan amendment.

As a general rule, the effective date of a cost allocation plan amendment shall be the first day of the calendar quarter following the date of the event that required the amendment (See §95.509). However, the effective date of the amendment may be earlier or later under the following conditions:

(a) An earlier date is needed to avoid a significant inequity to either the State or the Federal Government.

(b) The information provided by the State which was used to approve a previous plan or plan amendment is later found to be materially incomplete or inaccurate, or the previously approved plan is later found to violate a Federal statute or regulation. In either situation, the effective date of any required modification to the plan will be the same as the effective date of the plan or plan amendment that contained the defect.

(c) It is impractical for the State to implement the amendment on the first day of the next calendar quarter. In these instances, a later date may be established by agreement between the State and the DCA.

Section 95.517 Claims for Federal financial participation.

(a) A State must claim FFP for costs associated with a program only in accordance with its approved cost allocation plan. However, if a State has submitted a plan or plan amendment for a State agency, it may, at its option claim FFP based on the proposed plan or plan amendment, unless otherwise advised by the DCA. However, where a State has claimed costs based on a proposed plan or plan amendment the State, if necessary, shall retroactively adjust its claims in accordance with the plan or amendment as subsequently approved by the Director, DCA. The State may also continue to claim FFP under its existing approved cost allocation plan for all costs not affected by the proposed amendment.

Section 95.519 Cost disallowance.

If costs under a Public Assistance program are not claimed in accordance with the approved cost allocation plan (except as otherwise provided in §95.517), or if the State failed to submit an amended cost allocation plan as required by §95.509, the costs improperly claimed will be disallowed.

(a) (1) If the issue affects the program(s) of only one Operating Division and does not affect the programs of other Operating Divisions or Federal departments, that Operating Division will determine the amount of the disallowance and will also inform the State of its opportunity for reconsideration of the determination in accordance with the Operating Division's procedures. Prior to issuing the notification, however, the Operating Division shall consult with the DCA to ensure that the issue does not affect the programs of other Operating Divisions or Federal departments.

(2) If the State wishes to request a reconsideration of the Operating Division's determination, it must submit the request in accordance with the Operating Division's procedures.

(b) If the issue affects the programs of more than one Operating Division, or Federal department or the State, the Director, DCA, after consulting with the Operating Divisions, shall determine the amount inappropriately claimed under each program. The Director, DCA will notify the State of this determination, of the dollar affect of the determination on the claims made under each program, and will inform the State of its opportunity for appeal of the determination under 45 CFR part 16. The State will subsequently be notified by the appropriate Operating Division as to the disposition of the funds in question.

CFDA Numbers and Titles Material to program:

16.727	Enforcing Underage Drinking Laws Program
93.048	Special Programs for the Aging Title IV_and Title II_Discretionary Projects
93.558	Temporary Assistance for Needy Families
93.563	Child Support Enforcement
93.564	Child Support Enforcement Research
93.566	Refugee and Entrant Assistance State Administered Programs
93.584	Refugee and Entrant Assistance Targeted Assistance Grants
93.597	Grants to States for Access and Visitation Programs
93.628	Affordable Care Act Implementation Support for State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees
93.643	Children's Justice Grants to States
93.658	Foster Care Title IV-E
93.659	Adoption Assistance
93.667	Social Services Block Grant
93.669	Child Abuse and Neglect State Grants
93.791	Money Follows the Person Rebalancing Demonstration
96.001	Social Security Disability Insurance

CFDA Numbers and Titles Not material to the program:

10.561	State Administrative Matching Grants for the Supplemental Nutrition Assistance Program
10.580	Supplemental Nutrition Assistance Program, Outreach/Participation Program
10.596	Pilot Projects to Promote Work and Increase State Accountability in SNAP
14.008	Transformation Initiative: Choice Neighborhoods Demonstration Small Research Grant Program
16.540	Juvenile Justice and Delinquency Prevention Allocation to States
16.593	Residential Substance Abuse Treatment for State Prisoners
16.827	Justice Reinvestment Initiative
17.235	Senior Community Service Employment Program
84.126	Rehabilitation Services Vocational Rehabilitation Grants to States
93.044	Special Programs for the Aging Title III, Part B_Grants for Supportive Services and Senior Centers
93.052	National Family Caregiver Support, Title III, Part E
93.072	Lifespan Respite Care Program
93.090	Guardianship Assistance
93.150	Projects for Assistance in Transition from Homelessness (PATH)
93.243	Substance Abuse and Mental Health Services Projects of Regional and National Significance
93.517	Affordable Care Act – Aging and Disability Resource Center

93.575	Child Care and Development Block Grant
93.596	Child Care Mandatory and Matching Funds of the Child Care and Development Fund
93.599	Chafee Education and Training Vouchers Program (ETV)
93.609	The Affordable Care Act – Medicaid Adult Quality Grants
93.671	Family Violence Prevention and Services/Grants for Battered Women's Shelters Grants to States and Indian Tribes
93.674	Chafee Foster Care Independence Program
93.734	Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs – financed by 2012 Prevention and Public Health Funds (PPHF-2012)
93.767	Children's Health Insurance Program
93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
93.778	Medical Assistance Program
93.958	Block Grants for Community Mental Health Services
93.959	Block Grants for Prevention and Treatment of Substance Abuse

Federal Award Numbers:

2011AHFX0059, 2012JFFX0017, 2013MUFX0046, 2013RTBX0022, 2014RTBX0051, 2015IE320321, 2015IQ390347, 2015IS251447, 2015RTBX0016, 201616Q390347, 201616Q750347, 201616S251447, 201616S251947, 201616S252047, 201616S603121, 201616S803647, 2016RTBX0049, 2016ZBBX0013, 201717Q390347, 201717Q750347, 201717S251447, 201717S251947, 201717S252047, 201717S802647, 201717S803647, 2-14AAWAT3FC, 2-14AAWAT3SS, 2-15AAWAT3FC, 2-15AAWAT3SS, 2-16AAWAT3FC, 2-16AAWAT3SS, 2-17AAWAT3FC, 2-17AAWAT3SS, 2-90CS006201, 2-90JI001001, 2-90LI001701, 2-90LI001702, 2-90LI001703, 2-90LRLI000601, 2-90NWPG003001, 2-90RO003002, 2-90RO003003, 2-90RO003004, 4-1404WADI00, 4-1504WADI00, 4-1604WADI00, 4-1704WADI00, 5-1065WA5MAP, 5-1505WA5001, 5-1605WA5000, 5-1605WA5001, 5-1605WA5021, 5-1605WA5ADM, 5-1705WA0301, 5-1705WA5000, 5-1705WA5001, 5-1705WA5ADM, 5-1705WA5MAP, 5-1I1331234A, 5-AMQG131118, 5-MFP300141A, C-11TI23477A, C-12SM61237A, C-12TI24265A, C-13SP20155A, C-13TI25342A, C-14C1WACMHS, C-14SM61705A, C-14TI25570A, C-15B1WASAPT, C-15C1WACMHS, C-15SM16048A, C-15TI26138A, C-15TI2995A, C-16B1WASAPT, C-16C1WACMHS, C-16SM16048A, C-16SP22135A, C-U9SM57468A, E-H126A150071, E-H126A160071, E-H126A170071, G-1061WASOSR, G-1401WASAVP, G-1501WACETV, G-1501WACILP, G-1501WACJA1, G-1501WAFVPS, G-1501WASAVP, G-15TAWARTAG, G-1601WAADPT, G-1601WACA01, G-1601WACETV, G-1601WACILP, G-1601WACJA1, G-1601WAFOST, G-1601WAFVPS, G-1601WAGARD, G-1601WARCMA, G-1601WARSOC, G-1601WASAVP, G-1601WATANF, G-1601WATANF, G-1604WACEST, G-1604WACSES, G-16TAWARTAG, G-1701WAADPT, G-1701WACA01, G-1701WACILP, G-1701WAFOST, G-1701WAGARD, G-1701WARCMA, G-1701WARSOC, G-1701WASOSR, G-1701WATANF, G-1701WATANF, G-1704WACEST, G-1704WACSES, G-90FD019402, G-90FD019403, G-90FD019802, G-90FD019803, H-12645RG, T-AD287994S0, T-AD304399K0

2017-005 The Employment Security Department did not have adequate internal controls over and did not comply with requirements to ensure only eligible claimants of the Unemployment Insurance program received weekly benefits.

Federal Awarding Agency:	U.S. Department of Labor
Pass-Through Entity:	None
CFDA Number and Title:	17.225 Unemployment Insurance
Federal Award Number:	UI-29874-17-55-A-53, UI30252-17-60-A-53, UI-28010-16-55-A-53, UI-28165-16-60-A-53, UI-26568-15-55-A-53, UI-27138-15-55-A-53, UI-27935-15-55-A-53, UI-26427-14-55-A-53
Applicable Compliance Component:	Eligibility
Known Questioned Cost Amount:	None

Background

The Employment Security Department (Department) administers the Unemployment Insurance (UI) program that provides benefits to workers during periods of involuntary unemployment. The federal government and employers in Washington primarily fund the program.

To be eligible to receive UI benefits, a claimant must:

- Have worked 680 hours in the base year
- Have an allowable reason for being unemployed
- Be able and available for work

A claimant must also meet continued eligibility requirements to receive weekly benefit payments. Claimants must contact the Department weekly and report that they are still unemployed, any wages earned and if they completed the required minimum of three job searches that week.

Claimants must keep a weekly job search log that documents what jobs they applied for, the date of contact and how the contact was made. The Department is responsible for monitoring weekly job search activities of claimants. To meet this requirement, the Department randomly selects claimants and requires them to submit their job search logs for a specific week. Staff then review the logs to ensure they contain all required information and appear to meet the job search requirements.

Department policy states that 10 percent of claimants selected to submit logs for the week will also be selected for a verification of their job search activity. Automated systems select the logs for verification, then the job search review is performed. Once a claimant indicates in the system that a job search review has been completed, that information is automatically forwarded for verification. Department staff contact employers listed on the job search log to verify the claimant inquired with their company about employment. This is a key step to ensure that claimants are meeting continued eligibility requirements and meeting job search requirements.

In January 2017, the Department implemented a new benefit payment system, Unemployment Tax and Benefit (UTAB). This system allows staff to perform and document the job search review and the job search verification processes. The Department performed 10,197 job search log reviews in fiscal year 2017. To ensure it met the 10 percent job search verification policy, the Department selected 1,045 job logs for verification. Of these, 414 were documented in the Department's old system and 631 were documented in UTAB.

In fiscal year 2017, the Department paid about $1.1 billion in grant funds, with over $1 billion paid for benefits to workers.

Description of Condition

The Department did not have adequate internal controls in place to ensure verifications were performed and adequately documented, and that the weekly job search verification process was effectively designed.

We used a statistical sampling method to randomly select and examine 44 job search verifications. We selected 17 from the Department's old system and 27 from UTAB and found:

- Five instances (11 percent) when a verification was not performed because the UTAB system did not identify them as ready for verification
- One instance (2 percent) when the work search review process could not be completed because the claimant submitted the wrong weekly log. The Department did not detect this error and accepted the job search log during review, and no issue was set.
- One instance (2 percent) when UTAB contained inadequate documentation to support how the reviewer contacted the employers and why the Department considered the contacts unverifiable.

We further analyzed the 631 job search verifications documented in UTAB and found 116 pulled for verification were not marked in the system as having a completed job search review. This caused the cases to not be forwarded for the job search verification process. We determined the Department only verified at most 929 (91 percent) of the required 1,019 job search verifications. Because of limitations in UTAB, the Department was not able to determine how many cases were marked as complete but not moved forward for verification. Because this error affected three of the 27 (11 percent) cases we examined that were documented in UTAB, we estimate 56 additional cases were not properly verified.

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

This condition was not reported in the prior audit.

Cause of Condition

Design flaws in the UTAB system resulted in cases selected for the job search verification process not being forwarded for verification. Additionally, management did not effectively monitor or review the work of Department staff to ensure the verification process was performed and adequately documented. Management also did not effectively monitor that at least 10 percent of job search reviews were verified, instead relying on the system.

Effect of Condition

By not adequately performing the weekly work search verification process, the Department increases its risk of providing benefits to ineligible claimants and not detecting improper payments.

Recommendations

We recommend the Department:

- Address the system errors that were detected during the audit and continue to analyze system data to detect additional internal control weaknesses
- Monitor to ensure all selected work search verifications are complete and that staff adequately document their reviews

Agency's Response

The Department concurs with the finding. The Department has corrected the design flaws in UTAB that were identified by the audit. The Department has established new monitoring procedures to help ensure all work search verifications are completed and staff have adequately documented their reviews.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

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

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

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

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

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

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

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

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

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

The Social Security Act, Section 303 [42 U.S.C. 503(a)], states in part:

> The Secretary of Labor shall make no certification for payment to any State unless he finds that the law of such State, approved by the Secretary of Labor under the Federal Unemployment Tax Act, includes provision for—
>
> (12) A requirement that, as a condition of eligibility for regular compensation for any week, a claimant must be able to work, available to work, and actively seeking work.

Revised Code of Washington 50.20.240 Job search monitoring, states:

(1) (a) To ensure that following the initial application for benefits, an individual is actively engaged in work, the employment security department shall implement a job search monitoring program. Effective January 4, 2004, the department shall contract with employment security agencies in other states to ensure that individuals residing in those states and receiving benefits under this title are actively engaged in searching for work in accordance with the requirements of this section. The department may use interactive voice technology and other electronic means to ensure that individuals are subject to comparable job search monitoring, regardless of whether they reside in Washington or elsewhere.

(b) Except for those individuals with employer attachment or union referral, individuals who qualify for unemployment compensation under *RCW 50.20.050 (1)(b)(iv) or (2)(b)(iv), as applicable, and individuals in commissioner-approved training, an individual who has received five or more weeks of benefits under this title, regardless of whether the individual resides in Washington or elsewhere, must provide evidence of seeking work, as directed by the commissioner or the commissioner's agents, for each week beyond five in which a claim is filed. With regard to claims with an effective date before January 4, 2004, the evidence must demonstrate contacts with at least three employers per week or documented in-person job search activity at the local reemployment center. With regard to claims with an effective date on or after January 4, 2004, the evidence must demonstrate contacts with at least three employers per week or documented in-person job search activities at the local reemployment center at least three times per week.

(c) In developing the requirements for the job search monitoring program, the commissioner or the commissioner's agents shall utilize an existing advisory committee having equal representation of employers and workers.

(2) Effective January 4, 2004, an individual who fails to comply fully with the requirements for actively seeking work under RCW 50.20.010 shall lose all benefits for all weeks during which the individual was not in compliance, and the individual shall be liable for repayment of all such benefits under RCW 50.20.190.

Washington Administrative Code 192-180-020, states:

Monitoring job search activities – RCW 50.20.240

(1) Will my job search activities be monitored: Every week that you file a claim for benefits, you must certify whether you met the job search requirements. The department may review your job search activities at any time. Once you have been paid benefits for five or more weeks in any benefit year, you must provide the department with a copy of your job search log upon request.

(2) Will the department verify the information on my job search log? Employer contacts and other job search activities on your log may be verified by the department.

The Unemployment Insurance Resource Manual, section 5815 – Job Search Review, states in part:

> Ten percent of the claimants selected for the JSR interview are also selected for verification of their job search activities.

2017-006 The Department of Services for the Blind did not have adequate internal controls over and was not compliant with federal requirements to establish timely individual plans of employment for Vocational Rehabilitation program clients.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Rehabilitation Services – Vocational Rehabilitation Grants to States
Federal Award Number:	H126A150072, H126A1600072, H126A170072
Applicable Compliance Component:	Special Tests and Provisions – Completion of Individual Plans for Employment
Known Questioned Cost Amount:	None

Background

The Department of Services for the Blind's Vocational Rehabilitation program provides services for individuals who are blind, are going blind or have low vision so that such individuals may prepare for and engage in gainful employment. These services are primarily funded by the Vocational Rehabilitation Grant.

The Department operates and administers the program in accordance with federal laws and regulations, as well as a State Plan that is approved every fiscal year. It is responsible for ensuring that, once an individual is determined eligible, an Individual Plan for Employment (IPE) is created as soon as possible but no later than 90 days after the date they were determined eligible. The creation of the IPE can extend past 90 days only if the Department and the individual agree to an extension with a specific date by which it must be completed. When this happens, Department staff must document the extension in their case management system.

To ensure IPEs are created within 90 days, the Department uses monthly reports to identify clients who are nearing or have exceeded their IPE deadline. The reports are distributed to team leaders who ensure any issues are properly resolved by completing the IPE, or documenting the agreement to the extension and the specific date of completion.

In the prior audit, we reported the Department did not implement adequate internal controls over, and was not compliant with, federal requirements to establish timely individual plans of employment for Vocational Rehabilitation program clients. The prior audit finding number was 2016-010.

Description of Condition

We found the Department did not implement adequate internal controls to ensure it completed IPE development within 90 days as required. The Department provided us with reports from its case management system showing 277 clients entered into an IPE during the audit period. We used a non-statistical sampling method and randomly sampled 25 of these clients to determine if they entered into the IPE within 90 days or, if not, whether the Department and the client agreed to an extension with a

specific date. In eight cases, we found the Department did not enter into the IPE within the 90-day limit and did not obtain the client's agreement to an extension. This resulted in a noncompliance rate of 32 percent.

To more precisely determine the rate of noncompliance, we separately tested cases in which the IPE took more than 90 days to complete. Reports from the Department's case management system showed 83 applicants did not receive their IPE within 90 days. We used a non-statistical sampling method and randomly selected 14 of the late determinations for examination. In 13 cases, the Department's internal controls failed (93 percent), resulting in the IPE development exceeding 90 days without client agreement. In these cases, the IPEs were completed between one and 306 days after the 90-day limit.

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

Cause of Condition

There is not an adequate review process to ensure the cases identified in the monthly reports are addressed and adequately documented by staff. The program's procedure manual does not contain any guidance on how the monthly reports should be addressed or how a review process to ensure completion is supposed to be performed.

Effect of Condition

Because it has not implemented adequate internal controls, the Department is not always making timely IPE determinations in accordance with federal law. By extrapolating our identified error rate on overdue IPEs (92.9 percent) to the total overdue population of 83 clients, we estimate 77 client cases were noncompliant with federal requirements during the audit period.

This condition may lead to a delay in clients receiving services and puts the Department at risk the federal grantor will withhold grant funds.

Recommendations

We recommend the Department:

- Improve its internal controls to ensure IPEs are created promptly
- Ensure extensions are agreed upon by the client and are properly documented
- Ensure supervisory reviews are properly documented and effective
- Update its procedures to include the federal requirements and the process for supervisory review

Agency's Response

The agency understands the perspective of the above audit report. The agency had taken the 2016 audit finding (completed in February 2017) seriously, and we have been improving our internal controls to be able to reduce delays in completing plans for eligible individuals, and to be inserting appropriate documentation to justify a delay when a delay is necessary.

The agency understands the intent of this 90-day timeline is to not unreasonably delay an individual into a planned status where they might begin to receive services and engage actively in their vocational rehabilitation process. We strive for expedience in moving towards planned services, and acknowledge the gap that still exists in more closely meeting the expected timelines to plan, and in inserting the necessary justification documentation that describes the reason for delayed plan development, the client agreement to the delay, and the specific expected date that plan completion will be finalized.

Of the 278 individuals who developed individual plans for employment with agency staff in SFY2017, there were delays for 82 eligible individuals. The average number of days for all individuals was 78 days to plan development.

While the number of delayed plans remains a higher ratio than desired, this represents a marked reduction in delays and average time to plan from the previous year:
Percent of delayed plans: SFY2017 = 29.5%; SFY2016 = 38.9%
Average number of days to plan: SFY2017 = 78 days; SFY2016 = 107 days

These statistics demonstrate that there has been some success in internal controls to diminish the impact of delayed plan development. While our internal controls may not have been perfect, we have been applying internal controls and making a significant improvement in time to plan.

The system for internal controls has been evolving since we received the completed SFY2016 audit in February of this year. Management had been relying on a system of reviewing reports on a monthly basis with staff to identify delayed plans. After the audit, the agency realized the limitations of the monthly report, which showed a snapshot in time and missed alerting staff to delayed plans that had been resolved before the date the report was pulled. Managers thus often missed identifying a case that had a delayed plan that was missing the required documentation: the applicant's agreement to the delay, the justification for why the delay was necessary, and a specific date for expected plan completion.

The customer management system has an "actions-due" feature called a dashboard, but historically the data values provided by the tool had been incomplete or inaccurate. Through testing, the agency determined the tool was more reliable than it had been in the past, and managers have since trained staff to utilize the tool on a weekly basis, and to manage their own caseloads in real-time. As a result, we have discontinued the monthly reporting/alert system.

In the past two or three months, managers have developed systems in alerting staff on a weekly basis if a plan is coming due that week, and to remind counselors of the need for all the necessary components for documenting a delay justification if a plan can't be developed within the 90 days. The managers have installed the "actions-due" tool on their computers, and monitor for their entire team each week.

The policy revision (within the Washington Administrative Code, or WAC, structure) which highlights the new requirements for documenting a delay justification is in a final draft stage, and is out to the State Rehab Council, the Client Assistance Program, the general VR agency, and Tribal VR partners for initial feedback, expected by mid-November. After that initial input, the proposed revised WAC will be published for public comment before becoming adopted as final policy for the agency.

The relevant language in the drafted policy revision is as follows:

> *"WAC 67-25-230 Individualized plan for employment – Timeline and criteria*
> *(1) The individualized plan for employment is a written agreement that documents important decisions made between the participant and a vocational rehabilitation counselor concerning activities towards achievement of the participant's competitive and integrated employment goal including responsibilities agreed upon by the department and the participant, and the vocational rehabilitation services to be provided.*
> *(2) The individualized plan for employment is developed and implemented in a timely manner for each eligible individual, and no later than 90 days after eligibility except:*
> *(a) When the department is operating under an order of selection, in accordance with WAC 67-25-190, or;*
> *(b) The eligible individual and VR counselor agree to a delayed plan completion, with specific expected date of completion documented…."*

In 2018, the agency's Vocational Rehabilitation Procedures Manual will need to be revised to align with new regulations and the finalized agency policy. Chapters for the revised Procedures Manual are planned to be formatted with consideration towards five main elements of each significant process (including plan development):

- *Fundamental Overview of process*
- *Philosophy and Intent of process*
- *Processes – how to enact element*
- *Internal Controls – how completed processes will be reviewed and which required elements will be expected*
- *Definitions of relevant terms*

The work necessary for revising the Procedures Manual is extensive, and will be occurring in tandem with the agency's project for implementing a new case management system, so a final product likely won't be completed until end of 2018.

Thank you for the input. We value the most efficient and expedient entry into services for agency participants, and equally recognize the individualized nature of services. The agency recognizes a need to improve the consistency of documenting the justification for delay, and to include the expected date for determination, and we believe we have systems developing to better address those issues in a more real-time fashion. We recognize our improvement this past year over the previous, and recognize more improvement can be achieved.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, state in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

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

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

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in design

exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

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

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

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

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

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requir4ements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

29 United State Code 722 Eligibility and individualized plan for employment, states in part:

(b) Development of an individualized plan for employment

(3) Mandatory procedures

(F) Timeframe for completing the individualized plan for employment

The individualized plan for employment shall be developed as soon as possible, but not later than a deadline of 90 days after the date of the determination of eligibility described in paragraph (1), unless the designated State unit and the eligible individual agree to an extension of that deadline to a specific date by which the individualized plan for employment shall be completed.

2017-007 The Department of Services for the Blind did not have adequate internal controls over, and was not compliant with, federal requirements to determine client eligibility for the Vocational Rehabilitation program within a reasonable time period.

Federal Awarding Agency:	U.S Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Rehabilitation Services – Vocational Rehabilitation Grants to States
Federal Award Number:	H126A150072, H126A1600072, H126A170072
Applicable Compliance Component:	Eligibility
Known Questioned Cost Amount:	None

Background

The Department of Services for the Blind's Vocational Rehabilitation program provides services for individuals who are blind, are going blind or have low vision so that such individuals may prepare for and engage in gainful employment. These services are primarily funded by the Vocational Rehabilitation Grant.

The Department operates and administers the program in accordance with federal laws and regulations, as well as with a State Plan that is approved every fiscal year. In most cases, clients must be determined eligible within a reasonable time period not to exceed 60 days. There are two exceptions to the 60-day requirement:

- An exceptional or unforeseen circumstance occurred beyond the Department's control, and the individual agreed to a specific time extension.
- The Department is assessing the client's ability to perform in work situations through trial work experience.

When either of these exceptions is met, Department staff must document the determination in its case management system. In the case of an unforeseen circumstance, Departmental procedures require staff to enter the following information into the case management system:

- Clear justification for the exception
- An outline of the action needed to complete the determination
- How the individual was informed of the need for an extension
- That the individual accepts the justification and agrees to an extension

The system must be updated to address the above four points every 30 days after the initial entry until either the individual is found eligible or the case is closed.

To ensure eligibility decisions are made within 60 days, Department staff use monthly reports from its case management system to identify clients who are nearing or have exceeded the deadline. The reports are distributed to team leaders, who resolve the issues.

In the prior audit, we reported the Department failed to establish internal controls over, and was not compliant with, federal requirements to determine client eligibility within the required timelines. The prior finding number was 2016-009.

Description of Condition

We found the Department did not have adequate internal controls to ensure eligibility determinations were made within 60 days as required. The Department gave us case management system reports of all clients who were determined to be eligible during the audit period. The reports showed 22 of 300 determinations exceeded the 60-day limit. We examined all 22 of these eligibility determinations and found 19 cases (86 percent) in which the Department's internal controls failed, resulting in the eligibility determination exceeding the 60-day limit without evidence the required criteria for an extension were met.

For these 19 cases, we specifically found:

- 13 cases in which no exceptional circumstance for the delay was documented
- 16 cases in which there was no documentation to show the client agreed to the extension
- In all 19 cases, no extension date was documented

We additionally found 28 clients who applied for benefits during the audit period, but the case management indicated they were not determined eligible nor their case closed. We tested 12 of them and determined that in seven cases, the Department exceeded the 60-day limit without evidence the required criteria for an extension were met. In five cases, none of the criteria was present and the other two were missing all criteria except documentation of an exceptional circumstance.

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

Cause of Condition

The Department did not establish a formal confirmation or review process to ensure the monthly reports that identify cases coming due or overdue are addressed and adequately documented by staff. The Department's procedure manual does not contain any guidance on how the review process should be performed. In late April 2017, a review process was implemented, but we found it did not ensure all elements required to allow an exception were met, ensuring only that the team leader confirmed the case had been updated in the case management system.

Effect of Condition

Because it has not implemented adequate internal controls, the Department is not always making timely eligibility decisions in accordance with federal law. We identified 26 clients (9 percent) who were not determined to be eligible within federally required timelines.

This condition might lead to eligible clients not receiving services promptly and puts the Department at risk that the federal grantor will withhold grant funds.

Recommendations

We recommend the Department:

- Improve its internal controls to ensure eligibility determinations are made promptly
- Ensure that exceptional and unforeseen circumstances are properly documented
- Ensure that extensions are supported with a client agreement that includes a specific period of time
- Ensure supervisory reviews are effective and properly documented
- Update its procedures to include the federal requirements and the process for supervisory review

Agency's Response

The agency understands the perspective of the above audit report. The agency has taken the 2016 finding (completed in February 2017) seriously, and we have been improving our internal controls to be able to reduce delays in determining eligibility, and to be inserting appropriate documentation to justify a delay when a delay is necessary.

The agency understands the intent of this 60 day timeline is to not unreasonably delay an individual into a status where they might begin to receive services and engage in their vocational planning process. We believe in expedience in entering services – of the 300 individuals determined eligible in SFY2017, 203 individuals (or 67.7%) were determined eligible within 30 days, and 95 individuals (or 31.6%) had an eligibility determination in a week or less. Our average time to eligibility determination for all 300 individuals was 26 days.

Of the 300 eligibilities in SFY2017, 25 cases (or 8.3%) were delayed, of which eight were delayed a week or less. In calculating the total number of cases where eligibility determination was a factor, including cases closed as not eligible, the total percent of delayed cases is 9.8% (42 delayed cases out of 428 total).

We note the numbers of delayed eligibilities in order to highlight a marked reduction in delayed eligibilities from the previous year SFY2016. In that year, of all cases determined as eligible, 12.5% were delayed (as compared to 8.3% for SFY2017). In calculating the total number of cases where eligibility determination was a factor in SFY2016, including cases closed as not eligible, the delay rate was 16.1% (as compared to 9.8% for SFY2017). The ratio of eligibilities determined in less than 30 days, and less than a week, also improved in SFY2017 from the previous year:
Determinations < 30 days: SFY2017 = 67.7%; SFY2016 = 60.4%
Determinations < one week: SFY2017 = 31.6%; SFY2016 = 24.4%

These statistics demonstrate that there has been success in internal controls to diminish the impact of delayed eligibilities. While our internal controls may not have been perfect, we clearly have been applying internal controls and making a significant improvement in time to eligibility.

The system for internal controls has been evolving since we received the completed SFY2016 audit in February of this year. Management had been relying on a system of reviewing reports on a monthly basis with staff to identify delayed eligibilities. After the audit, the agency realized the limitations of the monthly report, which showed a snapshot in time and missed alerting staff to delayed eligibilities that had been resolved before the date the report was pulled. Managers thus often missed identifying a case that had a delayed eligibility and was missing the required documentation, which indicated the applicant's agreement to the delay, the justification for why the delay was necessary, and a specific date for expected eligibility determination.

The customer management system has an "actions-due" feature called a dashboard, but historically the data values provided by the tool had been incomplete or inaccurate. Through testing, the agency determined the tool was more reliable than it had been in the past, and managers have since trained staff to utilize the tool on a weekly basis, and to manage their own caseloads real-time. As a result, we have discontinued the monthly reporting/alert system.

In the past two or three months, managers have developed systems in alerting staff on a weekly basis if an eligibility is coming due that week, and to remind counselors of the need for all the necessary components for documenting a delay justification if a determination can't be made within the 60 days. They have installed and monitor the "actions-due" tool for their entire team each week.

The policy revision (within the Washington Administrative Code, or WAC, structure) which highlights the new requirements for documenting a delay justification is in a final draft stage, and is out to the State Rehab Council, the Client Assistance Program, the general VR agency, and Tribal VR partners for initial feedback, expected by mid-November. After that initial input, the proposed revised WAC will be published for public comment before becoming adopted as final policy for the agency.

The relevant language in the drafted policy revision is as follows:

> *"WAC 67-25-110 Eligibility - Timeline.*
> *(1) Once an individual has submitted an application for vocational rehabilitation services, including applications made through common intake procedures in one-stop centers under section 121 of the Workforce Innovation and Opportunity Act (WIOA), an eligibility determination must be made within sixty (60) days, unless:*
> *(a) Exceptional and unforeseen circumstances beyond the control of the department preclude making an eligibility determination in 60 days and the department and the individual agree to a specific extension of time; or*
> *(b) An exploration of the individual's abilities, capabilities, and capacity to perform in work situations is carried out in a trial work assessment in accordance with WAC 67-25-140. …"*

In 2018, the agency's Vocational Rehabilitation Procedures Manual will need to be revised to align with new regulations and the finalized agency policy. Chapters for the revised Procedures Manual are planned to be formatted with consideration towards five main elements of each significant process (including determination of eligibility):

- *Fundamental Overview of process*
- *Philosophy and Intent of process*

- *Processes – how to enact element*
- *Internal Controls – how completed processes will be reviewed and which required elements will be expected*
- *Definitions of relevant terms*

The work necessary for revising the Procedures Manual is extensive, and will be occurring in tandem with the agency's project for implementing a new case management system, so a final product likely won't be completed until end of 2018.

Thank you for the input. We value the most efficient and expedient entry into services, and equally recognize the individualized nature of services. We believe that, when an applicant is driving their own need to delay an eligibility determination - and ensuring the agency is not responsible for exacerbating the need for delay – then some delays will be expected, such as when they find it a challenge to complete a necessary eye exam in a timely manner. To move automatically to close the case of an individual who is driving their own delay would most often be detrimental to the individual. The agency recognizes a need to improve the consistency of documenting the justification for delay, and to include the expected date for determination, and we believe we have systems developing to better address those issues in a more real-time fashion. We recognize our improvement this past year over the previous, and recognize more improvement can be achieved.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls.

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, state in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

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

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

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

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

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

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

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

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requir4ements that results in

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

29 United States Code section 722. Eligibility and individual plan for employment, states in part:

(a) Eligibility
(6) Timeframe for making an eligibility determination
The designated State unit shall determine whether an individual is eligible for vocational rehabilitation services under this subchapter within a reasonable period of time, not to exceed 60 days, after the individual has submitted an application for the services unless—
(A) exceptional and unforeseen circumstances beyond the control of the designated State unit preclude making an eligibility determination within 60 days and the designated State unit and the individual agree to a specific extension of time; or
(B) the designated State unit is exploring an individual's abilities, capabilities, and capacity to perform in work situations under paragraph (2)(B).

Washington Administrative Code 67-25-025 Eligibility for services, states:

(1) The department shall determine whether an individual is eligible for vocational rehabilitation services within sixty days after receipt of an application for services, unless, exceptional and unforeseen circumstances beyond the control of the department preclude completion of the determination within sixty days, in which case, the department will notify the applicant.
(2) The applicant must agree to an extension of eligibility determination or, must agree to participate in trial work experience or extended evaluation in accordance with WAC 67-25-065 and 67-25-070. If the applicant does not agree to an extension of the eligibility determination or does not agree to participate in trial work experience or extended evaluation, the applicant will be determined ineligible for vocational rehabilitation services and the case service record will be closed in accordance with WAC 67-25-055.

Washington State Department of Services for the Blind Vocational Rehabilitation Procedures states:

3. ELIGIBILITY (WAC 67-25-025)
Eligibility Timelines
The Rehabilitation Act requires that eligibility determination be made within 60 days after receiving an application. The only exception is if unforeseen circumstances beyond the control of the VR Team prevent completion of the determination within 60 days. Case note E60 “Eligibility Determination over 60 Days” is used to document this exception and must:
• Provide clear justification for the exception;
• Outline needed action to complete the determination;
• Indicate how the individual was informed of the need for an extension; and
• Indicate that the individual accepts the justification and agrees to an extension.
Case note E60 must be completed to address the above four points (ideally as bullet points) every 30 days after the initial entry until the individual is found eligible, or the case is closed.

2017-008 The Department of Services for the Blind did not have adequate internal controls to ensure cash draws were accurate and federal spending requirements were met for the Vocational Rehabilitation program.

Federal Awarding Agency:	U.S Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Rehabilitation Services – Vocational Rehabilitation Grants to States
Federal Award Number:	H126A150072, H126A1600072, H126A170072
Applicable Compliance Component:	Cash Management Matching Level of Effort Period of Performance
Known Questioned Cost Amount:	None

Background

The Department of Services for the Blind's Vocational Rehabilitation program provides services for individuals who are blind, are going blind or have low vision so that such individuals may prepare for and engage in gainful employment. These services are primarily funded by the Vocational Rehabilitation Grant.

The Department operates and administers the program in accordance with federal laws and regulations, as well as with a State Plan the federal grantor approves every fiscal year. The program has a matching requirement that says the state must pay 21.3 percent of Vocational Rehabilitation Program costs with state funds. The Department also has a level-of-effort requirement that says the state must ensure non-federal expenditures for a particular fiscal year meet or exceed the non-federal expenditures from the two prior years. Each award also has a period of availability when the Department can make expenditures and request reimbursement from that particular grant.

The Department requests funds from the federal grantor twice a month on a reimbursement basis. As part of its reimbursement preparation process, the Department has combined other monitoring processes as well. The manager who prepares the draws ensures the Department meets matching and level-of-effort requirements and that expenditures being reimbursed are drawn properly from the grant with an open period of availability.

The Department established a secondary review of this monitoring to ensure all of these processes are performed properly. This review is performed by another manager and is supposed to happen before the funds are drawn.

Description of Condition

We found the Department did not ensure managers followed established procedures.

To test the Department's internal controls, we examined reimbursement request documents and support for evidence of secondary review. We used a non-statistical sampling method and randomly selected eight out of the 24 draws during the audit period. We found four of the eight draws did not have evidence showing that the secondary review was performed.

We consider these control deficiencies to be a significant deficiency.

This condition was not reported in the prior audit.

Cause of Condition

The Department had turnover in staff who oversaw the draw process, and management did not ensure the established processes continued.

Effect of Condition

By not establishing adequate internal controls, the Department cannot ensure that draw amounts they requested were accurate, they met the level-of-effort and matching requirements, or expenditures occurred within the allowed period of performance. This increases the Department's risk of failing to meet grant compliance requirements.

Recommendation

We recommend the Department ensure staff follow its established procedures over the federal reimbursement request process.

Agency's Response

The Department of Services for the Blind (DSB) agrees with the audit finding and recommendation. The Department developed an internal checklist for steps in processing federal draws. The checklist requires interaction from two managers to ensure internal controls over the submission of federal draws.

During 2017 DSB incurred staff turnover in the fiscal unit. Beginning with the 2018 year, DSB established a new position and hired a Deputy Financial Officer. To ensure internal controls over federal draws, the Accounting Manager develops the draw and receives approval for the Deputy Financial Officer so that a secondary review is conducted prior to finalizing the draw.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls, states in part.

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

Section 200.516 Audit findings, state in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

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

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

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

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

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

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

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

2017-009 The Department of Services for the Blind did not have adequate controls over, and was not compliant with, federal requirements for charging costs to the Vocational Rehabilitation program.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Rehabilitation Services – Vocational Rehabilitation Grants to States
Federal Award Number:	H126A170072
Applicable Compliance Component:	Allowable Costs / Cost Principles
Questioned Cost Amount:	$2,479,527

Background

The Department of Services for the Blind's Vocational Rehabilitation program provides services for people who are blind, are going blind or have low vision so that they may prepare for and engage in gainful employment. These services are primarily funded by the Vocational Rehabilitation Grant.

When managing federal programs, the Department incurs some costs that benefit multiple programs. Some examples are salaries and benefits for staff who work on multiple programs, rent, utilities and IT services. The Department may charge these costs using either an indirect costs rate plan or a cost-allocation plan. Whichever plan is used must be submitted to and approved by the federal grantor before the may be used to charge a grant.

Description of Condition

We found the Department charged indirect costs during the audit period without an approved indirect cost rate plan. After the end of the audit period, the Department decided to stop using an indirect cost rate. Instead, it chose to implement a cost-allocation plan, and reversed the previously charged indirect expenditures.

After implementing the cost-allocation plan, the Department charged $2,479,527 in costs based on a cost-allocation plan that had not been submitted to the grantor.

We consider these internal control deficiencies to be a material weakness. This condition was not reported in the prior audit.

Cause of Condition

The Department was aware it did not have an approved indirect cost rate for state fiscal year 2017, but decided to charge the grantor using the prior year's rate without approval. The Department later decided to charge cost-allocated expenditures without an approved plan because the federal grantor indicated it would approve a cost-allocation plan that would be retroactive for state fiscal year 2017. Because no cost-allocation plan was submitted, the charges were not allowable.

Effect of Condition and Questioned Costs

We identified $2,479,527 in cost-allocated expenditures charged to the federal grant during fiscal year 2017. Because the federal grantor had not approved any of the Department's allocation plans, we consider the entire amount as questioned costs.

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

Recommendations

We recommend the Department:

- Establish and follow internal controls to ensure costs are not charged using an indirect rate or cost-allocation method unless a plan has been approved by the grantor
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Agency's Response

The Department of Services for the Blind (DSB) disagrees with this finding.

During August 2017 DSB requested to switch to a Cost Allocation Plan (CAP) in lieu of an Indirect Cost Rate and requested the CAP be approved retroactively to July 1, 2016. The Department requested the following:

> *Although the Cost Allocation Plan is not yet submitted for your approval, the DSB is requesting a Cost Allocation Plan be approved retro-active to July 1, 2016 to coincide with our new structure.*

The Indirect Cost Group with the Department of Education agreed to DSB's plan. DSB charged indirect costs with the understanding the CAP would be approved retroactively.

Indirect costs charged during FY 2017 were appropriate and allowable under 34 CFR Part 361 and meets Administrative requirements of 2 CFR Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. The Agency believes indirect costs were charged to federal grants in the best interest of the people we serve and with no harm to the state or federal government. The Agency will work with the Department of Education, Rehabilitation Services Administration to resolve this audit finding.

To ensure internal controls over indirect charges, the Accounting Manager identifies the amount of indirect costs to charge against each grant and receives approval from the Deputy Financial Officer so that a secondary review is conducted.

Auditor's Concluding Remarks

In its response, the Department disagreed with the finding but acknowledged charging the grant while knowing it did not have an approved plan in place. While we agree that communication with the grantor indicated it might approve a plan retroactively, federal regulations state the Department cannot charge these costs until a plan has been approved. While the grantor may choose not to require repayment of the questioned costs, we are required to report them as such because they were spent in violation of federal regulations.

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.
(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.
(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.
(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.
(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.
(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

(a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
  (1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.
  (2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.
  (3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned

(likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

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

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

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

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

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

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

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

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

Federal Grant Award number H216A170072 states, in part:

TERMS AND CONDITIONS

(2) The negotiated indirect costs rate or the indirect cost allocation plan approved for the entity identified in Block 1 of this GAN applies to this grant award.

2017-010 The Department of Services for the Blind did not have adequate internal controls over, and was not compliant with, reporting requirements for the Vocational Rehabilitation Grant.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Rehabilitation Services – Vocational Rehabilitation Grants to States
Federal Award Number:	H126A1500072, H126A1600072, H126A170072
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The Department of Services for the Blind's Vocational Rehabilitation program provides services for people who are blind, are going blind or have low vision so that they may prepare for and engage in gainful employment. These services are primarily funded by the Vocational Rehabilitation Grant.

The Department is required to submit a federal financial report SF-425 to the federal grantor semiannually for each open grant award. Information contained on this report includes the federal grant number, the recipient organization, grant period, reporting period end date, basis of accounting and a summary of expenditures and program income related to the grant during the reporting period. During the audit period, the Department submitted four SF-425 reports.

Financial information contained on the SF-425 is obtained from the Department's accounting records.

Description of Condition

We found the Department did not have adequate internal controls to ensure its federal financial reports were prepared accurately and submitted promptly during the audit period.

We examined all four submitted SF-425 reports and found the federal fiscal year 2017 report, which covered the period from October 2016 through March 2017, contained an error totaling $869,402. The Department improperly included expenditures from May 2017 in the report.

We also found the federal fiscal year 2015 and 2016 semiannual reports due September 30, 2016, were filed late.

We consider these control deficiencies to be a material weakness. This condition was not reported in the prior audit.

Cause of Condition

The Department had no secondary review of the SF-425 reports or the accounting data used to create them. The Department had staff changes in the positions that create and review the reports. After the staffing changes, the Department no longer completed a secondary review.

Effect of Condition

By not establishing adequate internal controls, the Department over-reported expenditures by $869,402. Without a secondary review process, the Department risks further misreporting to the grantor.

Recommendation

We recommend the Department improve its internal controls, including requiring a secondary review of the SF-425 reports.

Agency's Response

The Department reported expenditure adjustments made in April on the March Report. The Department will submit a corrected FFY 16 SF-425 for the period through March 2017.

The Department of Services for the Blind (DSB) developed an internal checklist for steps in processing federal draws. The checklist requires interaction from two managers to ensure internal controls over the submission of federal draws.

During 2017 DSB incurred staff turnover in the fiscal unit. Beginning with the 2018 year, DSB established a new position and hired a Deputy Financial Officer. To ensure internal controls over federal draws, the Accounting Manager develops the draw and receives approval for the Deputy Financial Officer so that a secondary review is conducted prior to finalizing the draw.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the

Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, state in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

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

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

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

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

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

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

Title 2, Code of Federal Regulations

Section 200.327 Financial reporting

Unless otherwise approved by OMB, the Federal awarding agency may solicit only the standard, OMB-approved government wide data elements for collection of financial information (at time of publication the Federal Financial Report or such future collections as may be approved by OMB and listed on the OMB Web site). This information must be collected with the frequency required by the terms and conditions of the Federal award, but no less frequently than annually nor more frequently than quarterly except in unusual circumstances, for example where more frequent reporting is necessary for the effective monitoring of the Federal award or could significantly affect program outcomes, and preferably in coordination with performance reporting.

2017-011 The Department of Services for the Blind did not have adequate internal controls over, and was not compliant with, federal requirements to ensure only eligible expenditures were earmarked as pre-employment transition services.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Rehabilitation Services – Vocational Rehabilitation Grants to States
Federal Award Number:	H126A1600072
Applicable Compliance Component:	Earmarking
Questioned Cost Amount:	None

Background

The Department of Services for the Blind's Vocational Rehabilitation program provides services for people who are blind, are going blind or who have low vision so that they may prepare for and engage in gainful employment. These services are primarily funded by the Vocational Rehabilitation (VR) Grant.

The Department operates and administers the program in accordance with federal laws and regulations, as well as a state plan that is approved every fiscal year. The Department must earmark at least 15 percent of each VR award for pre-employment transition services to students with disabilities who are eligible, or potentially eligible, for VR services. To be eligible, students must be between the ages of 13 and 21.

Description of Condition

We found the Department did not establish adequate internal controls to detect and prevent unallowable payments from being paid with earmarked funds.

We determined the Department accurately identified the earmarked amount of $1,309,533 for the federal fiscal year 2016 award and was tracking the earmarking expenditures through the year. However, we found the Department only spent $440,131 on pre-employment services. It spent the remaining $869,402 on basic support services, which is unallowable.

We consider these internal control deficiencies to be a material weakness. This condition was not reported in the prior audit.

Cause of Condition

Internal controls were in place to track pre-employment expenditures, but not to ensure earmarked funds were not spent on basic support services.

Additionally, there is no secondary review of the pre-employment services tracking to verify the Department is properly spending earmarked funds.

Effect of Condition and Questioned Costs

The Department improperly spent $869,402 (66 percent) of its earmarked funds on non-pre-employment services. We are not reporting these as questioned costs only because the Department reimbursed the grant prior to the end of the year.

Recommendation

We recommend the Department establish adequate internal controls, including policies and procedures, to ensure only allowable services for eligible or potentially eligible students are paid with earmarked funds.

Agency's Response

The Department must set aside 85% of the Vocational Rehabilitation grant for adult employment services. For the period through March 2017 the Department over expended this portion of the 2016 grant by $869,402. The expenditures were allowable as 2017 expenditures but the expenditures were not moved to the 2017 grant until May. This May adjustment was reported on the March SF-425 Federal report in error.

In October the Department submitted a corrected FFY 16 SF-425 and reported only transactions through the reporting period of March 31, 2017.

To ensure internal controls are maintained and federal reports are accurate, two managers review and validate data prior to submitting reports to the Department of Education.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following requirements:

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in

"Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

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

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

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

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

29 U.S. Code. Chapter 16 – Vocational Rehabilitation and Other Rehabilitation Services

Section. 705. Definitions, states in part:

(1) Administrative costs

(C) providing information about the program to the public;

(37) Student with a disability

(A) In general

The term "student with a disability" means an individual with a disability who –

(i)(I)(aa) is not younger than the earliest age for the provision of transition services under section 614(d)(1)(A)(i)(VIII) of the Individuals with Disabilities Education Act (20 U.S.C. 1414(d)(1)(A)(i)(VIII)); or

(bb) if the State involved elects to use a lower minimum age for receipt of pre-employment transition services under this chapter, is not younger than that minimum age; and

(II)(aa) is not older than 21 years of age;

(bb) if the State law for the State provides for a higher maximum age for receipt of services under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), is not older than that maximum age; and

(ii)(I) is eligible for, and receiving, special education or related services under part B of the Individuals with Disabilities Education Act (20 U.S.C. 1411 et seq.); or

(II) is an individual with a disability, for purposes of section 794 of this title.

Section 730 State Allotments, states in part:

(d) Funds for pre-employment transition services

(1) From any State allotment under section (a) for a fiscal year, the State shall reserve not less than 15 percent of the allotted funds for the provision of pre-employment transition services

(2) Such reserved funds shall not be used to pay for administrative costs of providing pre-employment transition services.

Section 733 Provision of pre-employment transition services, states in part:

(a) In general

From the funds reserved under section 730(d) of this title, and any funds made available from State, local or private funding sources, each State shall ensure that the designated

State unit, in collaboration with the local educational agencies involved, shall provide, or arrange for the provision of, pre-employment transition services for all students with disabilities in need of such services who are eligible or potentially eligible for services under this subchapter.

2017-012 The Department of Social and Health Services did not have adequate internal controls over, and was not compliant with, federal requirements to establish timely individual plans of employment for Vocational Rehabilitation program clients.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Rehabilitation Services – Vocational Rehabilitation Grants to States
Federal Award Number:	H126A150071, H126A160071, H126A170071
Applicable Compliance Component:	Reporting and Special Tests and Provisions – Completion of Individual Plans for Employment
Known Questioned Cost Amount:	None

Background

The Division of Vocational Rehabilitation at the Department of Social and Health Services provides employment and counseling services to individuals with disabilities who want to work but experience barriers because of physical, sensory or mental disabilities. These services are primarily funded by the Vocational Rehabilitation Grant.

The Department operates and administers the program in accordance with federal laws and regulations, as well as with a State Plan that is approved every fiscal year by the federal grantor. It is responsible for ensuring that, once an individual is determined eligible, an Individual Plan for Employment (IPE) is created as soon as possible but no later than 90 days after their eligibility determination date. The IPE's creation can extend past 90 days only if the Department and the individual agree to an extension with a specific date by which it must be completed. When this happens, Department staff must document the extension in the Department's case management system.

The Department requires that counselors send a letter to the client informing them of the need for an extension and the date by which the counselors believe they can create an IPE. The client is then required to sign the letter and return it to the Department to indicate that they agree to the extension. The Department also requires that the counselor and the client sign and date the completed IPE to indicate that they agree to the plan that was developed. Without both signatures, the IPE is not binding.

During the audit period, the Department was required to submit IPE completion dates on an annual RSA-911 form to the federal grantor and the Rehabilitation Services Administration (RSA). The report captures demographic and other data for each individual whose service record is closed during the fiscal year. The detail captured includes, but is not limited to, date of application, date of eligibility determination and date of IPE. The Department uses information recorded in the case management system to gather the required data and submit it electronically to the federal grantor.

In the prior audit, we reported the Department failed to establish adequate internal controls over, and was not compliant with, federal requirements to establish timely individual plans of employment for program clients. The prior audit finding number was 2016-011.

Description of Condition

The Department did not have adequate internal controls to ensure IPE development was completed within 90 days as required.

The Department gave us reports from its case management system that indicated 2,335 of 5,899 applicants did not receive their IPE within 90 days. It also gave us a list of 916 clients who should have received an IPE, or an extension, during the audit period but whose IPE date was blank in the case management system.

We used a statistical sampling method to randomly sample and examine 58 of the 3,251 determinations that did not have an IPE completed within 90 days. In 24 cases (41 percent) we found clients did not receive a timely IPE because either there was no client agreement to extend the date or the IPE was not completed by an agreed upon extension date. We also found eight cases (14 percent) when the IPE completion date was entered inaccurately into the case management system. In seven of these cases, the Department entered an earlier date than the actual IPE completion date.

We also received a list of 3,564 clients who received an IPE within the 90-day limit, according to the case management system. We used a statistical sampling method to randomly sample and examine 32 of the cases. In eight (25 percent), we found that the supporting records in the case management system showed the Department did not comply with the 90-day requirement. Specifically:

- In seven cases, a valid IPE was not on file
- In one case, the IPE date in the system was not correct

We found two additional cases where the IPE was completed timely but the date of the IPE completion was entered inaccurately into the case management system. Both cases showed an earlier date than was supported, but they still met the 90-day limit.

The IPE completion date is a key line item for the RSA-911 report. Based on our testing, we determined the submitted report was inaccurate and misreported to the federal grantor.

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

Cause of Condition

The Department did not have an adequate review process to ensure counselors followed department policy and that documentation recorded in case files is accurate. Although the Department states supervisors review cases that are selected each month, the procedure manual does not state that the review process is required or contain any guidance on how the review process is supposed to be performed and documented.

The Department's customer service manual did not include all requirements needed to extend the 90-day timeline until May of 2017. This change was communicated to staff that month.

Effect of Condition

Because it has not established adequate internal controls, the Department does not always make timely IPE determinations in accordance with federal law. The Department faces increased risk of not providing services to eligible clients in a timely manner.

Based on our statistically valid, random samples, we estimate the Department did not establish a timely IPE for 2,234 of the 6,815 clients in our testing populations.

We also estimate the Department incorrectly recorded completion dates for 1,565 of the 6,815 cases in its case management system. By not ensuring the accuracy of the data within the case management system, the Department is reporting inaccurate figures to the federal grantor in required reports.

Recommendations

We recommend the Department:

- Improve internal controls to ensure IPEs are created in a timely manner and data entered into the case management system is accurate
- Communicate internal control updates to all field staff
- Ensure extensions are agreed upon by the client and are properly documented
- Ensure both counselors and clients are approving the completed IPEs

Agency's Response

The Department concurs with the finding.

The results of the FY16 audit were not provided until early Spring of 2017. The Department took several corrective action steps in May of 2017. Since these actions were late in this audit period, the corrections will appear in the next audit period.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls.

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, state in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

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

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29 U.S. Code 722 (b) Development of an individual plan for employment, states in part:

(3) Mandatory Procedures

(F) Timeframe for completing the individualized plan for employment

The individualized plan for employment shall be developed as soon as possible, but not later than a deadline of 90 days after the date of the determination of eligibility described in paragraph (1), unless the designated State unit and the eligible individual agree to an extension of that deadline to a specific date by which the individualized plan for employment shall be completed.

2017-013 The Department of Social and Health Services did not have adequate internal controls over, and was not compliant with, federal requirements to ensure client eligibility determinations were accurate and made within a reasonable period of time for the Vocational Rehabilitation program.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Rehabilitation Services – Vocational Rehabilitation Grants to States
Federal Award Number:	H126A150071, H126A160071, H126A170071
Applicable Compliance Component:	Eligibility and Reporting
Known Questioned Cost Amount:	None

Background

The Division of Vocational Rehabilitation at the Department of Social and Health Services provides employment and counseling services to individuals with disabilities who want to work but experience barriers because of physical, sensory or mental disabilities. These services are primarily funded by the Vocational Rehabilitation Grant.

The Department operates and administers the program in accordance with federal laws and regulations, as well as with a state plan that is approved every fiscal year. To be eligible for services, an individual must undergo an assessment to determine eligibility, which includes obtaining medical documentation to support the person's disability. The applicant must also have an employment goal and be able to work.

In most cases, clients must be determined eligible within a reasonable period of time, not to exceed 60 days. There are two exceptions to the 60-day requirement:

- An exceptional or unforeseen circumstance occurred beyond the control of the Department and the individual agreed to a specific extension of time.
- The Department is assessing the client's ability to perform in work situations through trial work experience.

When either of these exceptions is met, staff must document the determination in the Department's case management system. The Department's customer service manual requires staff to complete an extension agreement form and have the client sign, indicating approval.

During the audit period, the Department was required to submit the date of eligibility determination on an annual RSA-911 report to the federal grantor and the Rehabilitation Services Administration (RSA). The report captures demographic and other data for each individual whose service record is closed during the fiscal year. The detail captured includes, but is not limited to, dates of application, eligibility determination and individual plan for employment. The Department uses information recorded in the case management system to gather the required data and submit it electronically to the federal grantor.

In the prior audit, we reported the Department did not establish adequate internal controls over, and was not compliant with, federal requirements to determine client eligibility within a reasonable period of time. The finding number is 2016-012.

Description of Condition

The Department did not have adequate internal controls to ensure eligibility determinations made during the audit period were properly supported and made within 60 days as required.

The Department provided us reports from their case management system of 9,986 clients who were determined eligible during the audit period. We used a statistical sampling method to randomly select and examine 59 of these determinations. In two cases (3 percent), we found the Department's internal controls failed, resulting in determinations that were made but not adequately supported. We also found 13 cases (22 percent) in which the dates on the source documents did not match the dates in the service tracking and reporting system. Of these 13 cases, three (5 percent) determinations were reported as meeting the required timeline but were actually made after 60 days. There were also two cases (3 percent) that did not have information to support the dates in the system, resulting in the potential for them to be understated as well.

Of the 9,986 cases, 806 were identified in the system as having eligibility determinations that took longer than 60 days. We used a statistical sampling method to randomly sample and examine 57 of these determinations. In 51 cases (89 percent) the Department exceeded the 60-day limit without evidence the required criteria for an extension was met. In 20 cases (35 percent), none of the criteria was present and another 30 (52 percent) were missing all criteria except documentation of an exceptional circumstance. The other case (2 percent) had the required support, but not until after the 60-day limit.

The eligibility completion date is a key line item for the RSA-911 report. Based on our testing, we determined the submitted report was inaccurately reported to the federal grantor.

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

Cause of Condition

The Department did not have an adequate review process to ensure counselors followed Department policy and documentation was accurate. Although the Department states supervisors review selected cases each month, its procedure manual does not state the review process is required or contain any guidance on how the review process is supposed to be performed and documented.

The Department's customer service manual did not include all requirements needed to extend the 60-day timeline until May of 2017. This change was communicated to staff that month.

Effect of Condition

Because it has not established adequate internal controls, the Department is not always making timely eligibility decisions in accordance with federal law. The Department is at a higher risk of not providing

services to eligible clients promptly. There is also a risk that the federal grantor could withhold grant funds.

Based on our statistically valid, random samples, we estimate the Department did not establish eligibility promptly for 1,177 of the 9,986 clients in our testing population and did not have valid support for 339 clients that were determined eligible.

We also estimate the Department incorrectly recorded application and/or eligibility dates for 2,197 of the 9,986 cases in its case management system. By not ensuring the accuracy of data within the case management system, the Department risks reporting inaccurate figures to the federal grantor in required reports.

Recommendations

We recommend the Department:

- Improve internal controls to ensure eligibility determinations are made promptly and data entered into the case management system is accurate
- Communicate changes in procedures to all field staff
- Ensure extensions are agreed upon by the client and are properly supported
- Update procedures to include the process for supervisory review

Agency's Response

The Department concurs with the finding.

The results of the FY 16 audit were not provided until early Spring of 2017. The Department took several corrective action steps in May of 2017. Since these actions were late in this audit period, the corrections will appear in the next audit period.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the

Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, state in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

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

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

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

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

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

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

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

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

29 U.S. Code section 722. Eligibility and individual plan for employment, states in part:

(a) Eligibility

(1) Criterion for eligibility

An individual is eligible for assistance under this subchapter if the individual—

(A) has undergone an assessment for determining eligibility and vocational rehabilitation needs and as a result has been determined to be an individual with a disability under section 705(20)(A) of this title; and

(B) requires vocational rehabilitation services to prepare for, secure, retain, advance in, or regain employment that is consistent with the individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.

(3) Presumption of eligibility

(A) In general

For purposes of this section, an individual who has a disability or is blind as determined pursuant to title II or title XVI of the Social Security Act (42 U.S.C. 401 et seq. and 1381 et seq.) shall be—

(i) considered to be an individual with a significant disability under section 705(21)(A) of this title; and

(ii) presumed to be eligible for vocational rehabilitation services under this subchapter (provided that the individual intends to achieve an employment outcome consistent with the unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual) unless the designated State unit involved can demonstrate by clear and convincing evidence that such individual is incapable of benefiting in terms of an employment outcome due to the severity of the individual's disability (as of the date of the determination).

(6) Timeframe for making an eligibility determination

The designated State unit shall determine whether an individual is eligible for vocational rehabilitation services under this subchapter within a reasonable period of time, not to exceed 60 days, after the individual has submitted an application for the services unless—

(A) exceptional and unforeseen circumstances beyond the control of the designated State unit preclude making an eligibility determination within 60 days and the designated State unit and the individual agree to a specific extension of time; or

(B) the designated State unit is exploring an individual's abilities, capabilities, and capacity to perform in work situations under paragraph (2)(B).

2017-014 The Department of Social and Health Services did not have adequate internal controls over, and was not compliant with, federal requirements to ensure payments paid on behalf of clients for Vocational Rehabilitation were allowable.

Federal Awarding Agency:	U.S. Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Rehabilitation Services – Vocational Rehabilitation Grants to States
Federal Award Number:	H126A150071, H126A160071, H126A170071
Applicable Compliance Component:	Activities Allowed or Unallowed and Allowable Costs/Cost Principles
Known Questioned Cost Amount:	$87,357

Background

The Division of Vocational Rehabilitation at the Department of Social and Health Services provides employment and counseling services to people with disabilities who want to work but experience barriers because of physical, sensory or mental disabilities. These services are primarily funded by the Vocational Rehabilitation Grant.

The Department operates and administers the program in accordance with federal laws and regulations, as well as with a State Plan that is approved every fiscal year. The Department spends federal grant money for employment services that are included in a client's individual plan for employment (IPE). The IPE assists a person with a disability in preparing for, securing, retaining or regaining an employment outcome. To ensure that the client is informed and involved in their employment outcome, both the client and a counselor must sign and date the completed IPE after reviewing it. Most services are not considered allowable unless they are in an approved IPE.

The Department may also spend federal grant money for pre-employment services that allow the Department to determine eligibility or ability to work and are not required to be in the IPE. While these expenses are not contained in an IPE, they still must be approved and have proper support.

The Department spent $55.2 million in federal program funds in fiscal year 2017 with about $28.7 million paid for client services.

In the prior audit, we reported that the Department did not have adequate internal controls over and was not compliant with requirements to ensure payments paid on behalf of clients and staff time and effort were allowable. The finding number was 2016-013.

Description of Condition

We found the Department did not establish adequate internal controls to ensure payments for client employment services were in an approved IPE. We used a statistical sampling method to randomly select and examine 59 of the 38,595 total payments over $50 made for client services during fiscal year

2017. We examined each payment to determine if it was an allowable employment service included in a client's IPE or a pre-employment service.

In seven cases (12 percent), totaling $15,998, we found the employment service was not included in an approved IPE, or the item was purchased before the IPE was approved. All of the exceptions identified were required to be in an approved IPE because they were not pre-employment services. We also examined six payments identified as high-risk expenditures, totaling $287,728, and found that two, totaling $71,359, were not allowable: one because it exceed the amount in the approved IPE by $32,117 and the other because the IPE was never signed by the client.

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

Cause of Condition

Department staff did not follow established policies and procedures to ensure that payments for client services were contained in the client's approved IPE and services were not being paid for before approval. Managerial oversight was not sufficient to detect or prevent these issues.

Effect of Condition and Questioned Costs

The Department risks making improper payments for client services with federal funds by not ensuring that employment services were included in an approved IPE. The Department paid $87,357 in improper payments to participants. Because a statistical sampling method was used to select the payments examined, we estimate the number of improper payments to be 4,593, totaling $4,342,649.

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

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a very high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Recommendations

We recommend Vocational Rehabilitation staff ensure the program pays for client employment services only when those services are contained in an approved IPE and that these services are not paid for before approval. We also recommend that managers ensure payments are monitored to ensure federal requirements are met.

We also recommend the Department consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid.

Agency's Response

The Department concurs with the finding.

The results of the FY 16 audit were not provided until early Spring of 2017. The Department took several corrective action steps in May of 2017. Since these actions were late in this audit period, the corrections will appear in the next audit period.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).

(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

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

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

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

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

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

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

29 U. S. Code. section 722. Eligibility and individual plan for employment, states in part:

(a) Eligibility

(2) Presumption of benefit

(A) Applicants

For purposes of this section, an individual shall be presumed to be an individual that can benefit in terms of an employment outcome from vocational rehabilitation services under section 705(20)(A) of this title.

(B) Responsibilities

Prior to determining under this subsection that an applicant described in subparagraph (A) is unable to benefit due to the severity of the individual's disability or that the individual is ineligible for vocational rehabilitation services, the designated State unit shall explore the individual's abilities, capabilities, and capacity to perform in work situations, through the use of trial work experiences, as described in section 705(2)(D) of this title, with appropriate supports provided through the designated State unit. Such experiences shall be of sufficient variety and over a sufficient period of time to determine the eligibility of the individual. In providing the trial experiences, the designated State unit shall provide the individual with the opportunity to try different employment experiences, including supported employment, and the opportunity to become employed in competitive integrated employment.

(b) Development of an individual plan for employment

(3) Mandatory procedures

(C) Signatories

An individualized plan for employment shall be—

(i) agreed to, and signed by, such eligible individual or, as appropriate, the individual's representative; and

(ii) approved and signed by a qualified vocational rehabilitation counselor employed by the designated State unit.

2017-015 The Department of Social and Health Services did not have adequate internal controls over, and was not compliant with, federal requirements to ensure only eligible expenditures were earmarked as pre-employment transition services.

Federal Awarding Agency:	Department of Education
Pass-Through Entity:	None
CFDA Number and Title:	84.126 Rehabilitation Services – Vocational Rehabilitation Grants to States
Federal Award Number:	H126A150071
Applicable Compliance Component:	Earmarking
Known Questioned Cost Amount:	$10,512

Background

At the Department of Social and Health Services, the Division of Vocational Rehabilitation provides employment services and counseling to people with disabilities who want to work but experience barriers to work because of physical, sensory or mental disabilities. These services are primarily funded by the Vocational Rehabilitation (VR) Grant.

The Department operates and administers the program in accordance with federal laws and regulations, as well as a State Plan that is approved every fiscal year. The Department must earmark at least 15 percent of each VR award each year for pre-employment transition services to students with disabilities who are eligible, or potentially eligible, for VR services. To be eligible, students must be between the ages of 13 and 21. The Department is not allowed to spend these earmarked funds on administrative costs such as providing information about the program to the public.

Of the $6.1 million that the Department earmarked from the federal fiscal year 2015 award, it reported spending $1.2 million.

Description of Condition

We found the Department did not establish adequate internal controls to detect and prevent unallowable payments from being funded by the earmarked amount.

The federal grant award that closed during state fiscal year 2017 was the federal fiscal year 2015 award. This is the award we tested. Using a non-statistical sampling method, we randomly selected 18 of 147 payments paid with funds earmarked for pre-employment transition services. We also examined three payments, totaling $857,816, separately because of their large amounts. We examined each payment to determine if it was allowable under the earmarking requirements.

We found four payments (22 percent), totaling $10,512, that were not allowable pre-employment transition services. Of these, three payments were for unallowable administrative costs, two of which also didn't serve students between the ages of 13 and 21. The fourth payment was for services for a client who was 45 years of age and therefore not eligible to be served with these funds.

We consider these internal control deficiencies to be a material weakness. This condition was not reported in the prior audit.

Cause of Condition

The Department did not have policies in place to guide how payments are initially determined as allowable to be paid with earmarked funds. It also did not establish an adequate monitoring process to ensure payments identified as allowable actually were.

Effect of Condition and Questioned Costs

By not establishing adequate internal controls, the Department made payments with earmarked funds that were not allowable. Some of these payments may have been allowable using basic vocational rehabilitation funds, but the Department fully expended those funds for the applicable fiscal year.

The improper payments also resulted in the Department reporting an inaccurate amount to the federal grantor, and there is a risk that the federal grantor could withhold grant funds.

We used a non-statistical, random sampling method and, therefore, estimate the amount of improper payments to be $85,850. We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to supports its expenditures.

Recommendations

We recommend the Department:

- Establish adequate internal controls, including policies and procedures, to ensure only allowable services for eligible or potentially eligible students are paid with earmarked funds
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Agency's Response

The Department concurs with the finding.

The case management system was updated to ensure payments from the earmarked amount only go to students between the ages of 13 and 21.

The Department will be developing standard operating procedures to guide how payments are initially determined as allowable to be paid with the earmarked funds.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

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(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

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

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

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

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

29 U. S. Code chapter 16 – Vocational Rehabilitation and Other Rehabilitation Services states in part:

Section. 705. Definitions

(1) Administrative costs

(c) providing information about the program to the public;

(37) Student with a disability

(A) In general The term "student with a disability" means an individual with a disability who –

(i)(I)(aa) is not younger than the earliest age for the provision of transition services under section 614(d)(1)(A)(i)(VIII) of the Individuals with Disabilities Education Act (20 U.S.C. 1414(d)(1)(A)(i)(VIII)); or

(bb) if the State involved elects to use a lower minimum age for receipt of pre-employment transition services under this chapter, is not younger than that minimum age; and

(II)(aa) is not older than 21 years of age;

(bb) if the State law for the State provides for a higher maximum age for receipt of services under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), is not older than that maximum age; and

(ii)(I) is eligible for, and receiving, special education or related services under part B of the Individuals with Disabilities Education Act (20 U.S.C. 1411 et seq.); or

(II) is an individual with a disability, for purposes of section 794 of this title.

Section 730. State Allotments

(d) Funds for pre-employment transition services

(1) From any State allotment under section (a) for a fiscal year, the State shall reserve not less than 15 percent of the allotted funds for the provision of pre-employment transition services

(2) Such reserved funds shall not be used to pay for administrative costs of providing pre-employment transition services.

Section 733. Provision of pre-employment transition services, states in part:

(a) In general – From the funds reserved under section 730(d) of this title, and any funds made available from State, local or private funding sources, each State shall ensure that the designated State unit, in collaboration with the local educational agencies involved, shall provide, or arrange for the provision of, pre-employment transition services for all students with disabilities in need of such services who are eligible or potentially eligible for services under this subchapter.

2017-016 The Department of Social and Health Services did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of the Substance Abuse and Mental Health Services Projects of Regional and National Significance and Block Grants for Prevention and Treatment of Substance Abuse programs received required audits.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.243	Substance Abuse and Mental Health Services Projects of Regional and National Significance
	93.959	Block Grants for Prevention and Treatment of Substance Abuse
Federal Award Number:	2B08TI010056-15; 2B08TI010056-16; 5U79TI023477-05; 79SP020155-03; 5U79TI024265-03; 1H79TI025995-01; 5H79SM061705-02; 5H79TI025342-02; 1H79TI026138-01; 1H79TI025570-01; 1H79SP022135-01; 5U79SM061237-04	
Applicable Compliance Component:	Subrecipient Monitoring	
Known Questioned Cost Amount:	None	

Background

The Department of Social and Health Services, Division of Behavioral Health and Recovery (BHA), administers the Block Grants for Prevention and Treatment of Substance Abuse. The Department subawards some of the funds to counties, tribes, nonprofit organizations and other state agencies to develop prevention programs and provide treatment and support services. While BHA directly awards most of the funds, the Department's Office of Indian Policy (OIP) provides the funds to the tribal entities. OIP enters into the contracts and awarded program funds to 26 tribal entities during the audit period. The Department spent more than $36.9 million in grant funds during fiscal year 2017. Of this amount, the Department passed about $30.6 million to 75 subrecipients, including nearly $1 million to the 26 tribes.

The Department also administers the Substance Abuse and Mental Health Services Projects of Regional and National Significance. This program is designed to address priority substance abuse treatment, prevention and mental health needs of regional and national significance. The Department spent more than $10 million in grant funds during fiscal year 2017. Of this amount, the Department passed about $6.6 million to 40 subrecipients, including counties, school districts and nonprofit organizations.

Federal regulations require the Department to monitor the activities of award subrecipients. This includes ensuring its subrecipients that spend $750,000 or more in federal grant money during a fiscal year obtain a single audit. The Department also must follow up on any audit findings a subrecipient receives that might affect the federal program, and must issue a management decision within six months

of the audit report's acceptance by the Federal Audit Clearinghouse. These requirements help ensure grant money is used for authorized purposes and within the provisions of contracts or grant agreements.

In prior audits, we reported the Department did not have internal controls over and did not comply with requirements to ensure subrecipients received required audits. The prior finding numbers were 2016-014, 2015-016 and 2014-019.

Description of Condition

We found the Department did not have adequate internal controls in place to verify:

- Subrecipients received required audits
- Findings were followed up on and management decisions were issued promptly

BHA implemented a new process to obtain and monitor information related to required subrecipient audits beginning in April 2016. As part of this process, BHA sends audit verification forms to all subrecipients and contractors that receive federal funds, asking whether they required an audit and, if so, to provide a copy of the audit report. When the forms are returned, the results are tracked and monitored in a tracking spreadsheet.

We evaluated BHA's process and found, for the 49 non-tribal subrecipients that received Substance Abuse Block Grants Funds:

- Three were not sent audit verification forms by BHA
- Five were not included on the BHA tracking spreadsheet, including the three that weren't sent forms

We also found, for the 40 subrecipients that received Substance Abuse and Mental Health Services Projects of Regional and National Significance funds:

- Four were not sent audit verification forms by BHA
- Six were not included on the BHA tracking spreadsheet, including the four that weren't sent forms

OIP was responsible for ensuring the 26 tribal entities received required audits. We found OIP did not ensure the required audits were performed for any of the 26 tribal entities and therefore did not review these audits to see if follow up was required.

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

Cause of Condition

While BHA had established procedures to monitor and verify if subrecipients obtained required audits, it did not follow them. When preparing a list of all subrecipients that received federal grant funds, several were unintentionally omitted. Additionally, BHA monitored subrecipient audit results only for those entities that had returned the audit verification form.

OIP did not have an established process in place to ensure tribal entities receive the required audits or to review the audits that are performed to determine if they need to follow up and issue management decision on any findings. OIP stated they did not track these audits because the amounts awarded were not material to the grant.

Effect of Condition

Without establishing adequate internal controls, the Department cannot ensure all subrecipients that met the threshold for an audit complied with federal grant requirements, and thus that it has met federal monitoring requirements.

Recommendations

To improve its monitoring of subrecipients, we recommend:

- BHA verifies all required audits occurred
- BHA follows up on all subrecipient audit findings related to the program and issues a management decision promptly
- OIP implements and follows procedures that ensure the tribal entities receive audits, if required, and that they review and follow up on identified audit issues as needed

Agency's Response

The Department concurs with the finding.

The Department will ensure all required audits occur.

The Behavioral Health Administration will develop additional internal control procedures to supplement Management Bulletin BFD 16-09-002 to certify:

- *Subrecipients submit required audits*
- *Audits are reviewed for findings*
- *If findings are found which relate to Department program funds, corrective action plans will be put in place and tracked.*

The Office of Indian Policy will establish procedures to document in the Agency Contracts Database:

- *The yearly amount of federal spends spent by each tribal entity.*
- *When the tribal entity audits were completed.*

The Behavioral Health Administration will use the Federal Audit Clearinghouse to determine if any of the tribal audits contained findings. If an audit resulted in a finding with Department funds, the Behavioral Health Administration will contact the tribal entity to obtain a copy of the finding and develop a corrective action plan. If the administration needs assistance, they will contact the Office of Indian Policy for additional support.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

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

> .11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows: …
>
> **Deficiency in internal control over compliance.** A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.
>
> **Material weakness in internal control over compliance.** A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:
>
> **Reasonably possible**. The chance of the future event or events occurring is more than remote but less than likely.
>
> **Probable**. The future event or events are likely to occur.
>
> **Significant deficiency in internal control over compliance.** A deficiency, or a combination of deficiencies, in internal control over compliance that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.
>
> **Material noncompliance**. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Title 2 U.S. Code of Federal Regulations Part 200, Appendix XI, *Compliance Supplement 2017*, Part 3 – Compliance Requirements states in part:

> Section M. Subrecipient Monitoring
>
> Compliance Requirements
>
> A pass-through entity is responsible for:
>
> -*Subrecipient Audits* – (1) Ensuring that subrecipients expending $750,000 or more in Federal awards during the subrecipient's fiscal year for fiscal years beginning on or after December 26, 2014 have met the audit requirements of 2 CFR part 200, subpart F and that the required audits are completed within 9 months of the end of the subrecipient's audit period; (2) issuing a management decision on audit findings within 6 months after receipt of the subrecipient's audit report; and (3) ensuring that the subrecipient takes timely and appropriate corrective action on all audit

findings. In cases of continued inability or unwillingness of a subrecipient to have the required audits, the pass-through entity shall take appropriate action using sanctions.

2017-017 The Department of Social and Health Services did not have adequate internal controls over requirements to ensure payments to child care providers for the Temporary Assistance for Needy Families program were allowable.

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:	1601WATANF; 1701WATANF
Applicable Compliance Component:	Activities Allowed or Unallowed and Allowable Costs/Cost Principles
Known Questioned Cost Amount:	$1,230

Background

The Department of Social and Health Services (DSHS), Community Services Division, administers the Temporary Assistance for Needy Families (TANF) grant that provides temporary cash assistance for families in need. To receive TANF benefits, participants must be engaged in activities listed in the Individual Responsibility Plan (IRP) through the WorkFirst program, unless the TANF benefits are received only on behalf of a child. TANF funds may be used to pay participants' childcare costs to meet one of the program's primary purposes of helping clients obtain employment. If a client obtains employment and is no longer eligible for the program, TANF funds may still be used to pay childcare costs to help the client maintain employment.

Working Connections Child Care program

Washington has established the Working Connections Child Care (WCCC) program to help eligible working families pay for childcare. Both the Department of Early Learning (DEL) and DSHS administer the program. DEL is responsible for establishing policies and procedures for the program and for licensing childcare providers. DSHS determines client eligibility and pays childcare providers under an agreement with DEL.

Federal grant funding

Some payments made to WCCC providers for childcare are paid for by both the Child Care and Development Fund (CCDF) grant and the TANF grant. While the two federal programs are separate, the requirements and policies in Washington for childcare payments are consolidated under the WCCC program.

In fiscal year 2017, DSHS made an estimated 659,003 monthly childcare subsidy payments to childcare providers from both the CCDF and TANF grant as well as state funding. These payments totaled almost $230 million in federal funds, about $39 million of which came from the TANF grant.

Childcare providers

There are three provider types in the WCCC program:

- Licensed centers
- Licensed family homes
- Family, friends and neighbors (FFN)

According to state rules, childcare providers must maintain attendance records to support their billing. At a minimum, the records must include: the children's names; date(s) childcare was provided; and authorized signatures, typically of a parent or guardian, documenting the times the child arrived and left care.

Prior audit results

In the prior audit, we reported DSHS failed to establish adequate internal controls over and did not comply with federal requirements to ensure payments to childcare providers, paid for by TANF funds, were allowable. The prior audit finding number was 2016-019. We have also been reporting on the same condition for the CCDF program since 2005. The most recent audit finding numbers were 2016-021, 2015-023, 2014-023, 2013-016, 12-28, 11-23, 10-31, 9-12 and 8-13.

Description of Condition

We found the internal control deficiencies identified during our audit of the CCDF program directly affect DSHS's use of TANF funds, because the federal grants are commingled when paying WCCC providers.

We found DSHS did not have adequate internal controls to ensure payments to childcare providers, paid for by TANF funds, were allowable. Although DEL and DSHS perform some oversight activities, these were not sufficient to ensure payments were allowable.

We randomly selected and examined 133 WCCC payments for childcare, totaling $61,937 in federal funds, to determine if they were allowable. We chose payments from each of the three provider types: licensed centers, licensed family homes and FFN's. Of the 133 payments, 20 included a total of $11,782 in TANF federal funding. With assistance from DEL, we requested attendance records from providers to support the payments. We reviewed the providers' records to determine if the payments were allowed by federal and state regulations, as well as by DEL's policies.

We found three of the 20 (15 percent) payments with TANF federal funding were partially or fully unallowable. Of these payments, two were fully paid for by TANF funds and one was partially paid for by TANF funds. In total, we questioned $1,230 paid by federal TANF funds.

The reasons the overpayments occurred were:

- Providers did not submit attendance records or submitted attendance records that were inadequate to support payments
- Providers overbilled for services not performed or were not supported by attendance records
- Providers billed for overtime, field trip fees or registration fees when they did not have a written policy in place to also charge private paying parents

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

Cause of Condition

Adequate internal controls did not exist to ensure payments were allowable. Although the authorizations establish a maximum for what providers may bill without further approval, they do not prevent providers from billing for unallowable days, hours or services. The claim and payment system is not linked to authorizations or attendance. Childcare providers must maintain attendance records and submit this supporting documentation only when it is requested.

Effect of Condition and Questioned Costs

By not having adequate internal controls in place, DSHS increases its risk of making improper payments for childcare services.

A statistical sampling method was used to randomly select the payments examined in the audit. We estimate the total amount of likely improper payments with federal TANF funds to be $6,095,629. Many of the improper payments were partially funded by state TANF funds. Specifically, we found 32 improper payments were partially funded with a total of $392 of state funds, which projects to a likely improper payment amount of $1,940,896. This amount is not included in the federal questioned costs.

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

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a very high level of assurance, with a 99 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Recommendations

We recommend the Department:

- Implement preventive internal controls over payments to providers to reduce the rate of unallowable payments
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Agency's Response

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

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

As noted in our response to 2016-034 TANF Activities Allowed, because we were already three quarters of the way through SFY17, we acknowledged that we were likely to see similar findings in this audit period.

The Department will continue to develop and implement internal controls including third-party reviews through the establishment of the Process Review Panel (PRP), and pre-authorization reviews on high-risk and/or high cost cases based on trend analysis discovered during the PRP. These initiatives will help ensure staff make correct eligibility and authorization determinations which will minimize the risk for providers to overbill or incorrectly bill for payments.

To appropriately and effectively initiate and implement these substantial changes, while minimizing impact to our clients, the Department will seek 25 additional full-time employees and necessary resources to staff the business-process redesign and support the information technology initiatives necessary to improve our internal controls.

***SAO Description of Weakness:** Providers overbilled for services not performed or supported by required documentation. Adequate internal controls did not exist to ensure payments were allowable. Although the authorizations establish a maximum for what providers may bill without further approval, they do not prevent providers from billing for unallowable days, hours or services.*

DSHS acknowledges that adequate attendance records are necessary in the reconciliation process to determine allowable payments. DELs policy requires providers receiving subsidy payments to maintain attendance records and provide them upon request. However, because attendance records are paper-based, it is not feasible for staff to request, review and reconcile all records before subsidy payments are made. As referenced in the agency response for the 2016-021 Activities Allowed finding, DEL is implementing an electronic attendance system and intends to require all providers to use it effective July 1, 2018. However, we are likely to see repeat findings because the implementation won't occur until halfway through SFY18.

DSHS will continue to conduct post-payment reviews where it appears likely that an improper payment may have occurred. Factors suggesting improper payment include, for example, providers that bill the maximum authorization each month. Staff will continue to review the case specifics and verification by requesting attendance records to determine whether an overpayment occurred, whether it was a provider or a client that was overpaid, and the amount of the improper payment and establish an overpayment if appropriate.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.
(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.
(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.
(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.
(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.
(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

(a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
  (1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.
  (2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.
  (3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned

(likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

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

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

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

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

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

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

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

45 Code of Federal Regulations Subpart A, 260.20, What is the purpose of the TANF program? States:

The TANF program has the following four purposes:

(a) Provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;
(b) End the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
(c) Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and
(d) Encourage the formation and maintenance of two-parent families.

Washington Administrative Code 170-290-0002 Scope of agency responsibilities.

DEL is designated as the lead agency for child care and development funds (CCDF) and oversees expenditure of CCDF funds.

(1) The responsibilities of the department of early learning (DEL) include, but are not limited to:
   (a) Determining child care subsidy policy for the WCCC and SCC programs;
   (b) Determining thresholds for eligibility and copayment amounts and establishing rights and responsibilities; and
   (c) Serving as the designated representative for the state to implement the collective bargaining agreement under RCW 41.56.028 for in-home/relative providers as defined in WAC 170-290-0003(13), and for all licensed family homes.
(2) The responsibilities of the department of social and health services (DSHS) include, but are not limited to:
   (a) Service delivery for the WCCC and SCC programs, including determining who is eligible for WCCC and SCC benefits; and
   (b) Authorizing payments for these programs, and managing payments made to providers that receive WCCC and SCC subsidies.
(3) This allocation between DEL and DSHS is pursuant to section 501(2), chapter 265, Laws of 2006 (2SHB 2964), in which the legislature transferred all of the powers, duties, and functions relating to the WCCC program from DSHS to DEL, except for eligibility staffing and eligibility payment functions, which remain in DSHS.

Washington Administrative Code 170-290-0268, Payment discrepancies—Provider overpayments, states:

(1) An overpayment occurs when a provider receives payment that is more than the provider is eligible to receive. Provider overpayments are established when that provider:
   (a) Bills and receives payment for services not provided;
   (b) Bills without attendance records that support their billing;
   (c) Bills and receives payment for more than they are eligible to bill;
   (d) With respect to license-exempt providers, bills the state for more than six children at one time during the same hours of care; or
   (e) With respect to licensed or certified providers:
      (i) Bills the state for more than the number of children they have in their licensed capacity; or
      (ii) Is caring for a WCCC child outside their licensed allowable age range without a DEL-approved exception; or
   (f) With respect to certified providers caring for children in a state bordering Washington:
      (i) Is determined not to be in compliance with their state's licensing regulations; or
      (ii) Fails to notify DSHS within ten days of any suspension, revocation, or change to their license.
(2) DEL or DSHS may request documentation from a provider when preparing to establish an overpayment. The provider has fourteen consecutive calendar days to supply any requested documentation.
(3) Providers are required to repay any payments that they were not eligible to receive.

(4) If an overpayment was made through departmental error, the provider is still required to repay that amount.

Washington Administrative Code 170-290-0271 Payment discrepancies—Consumer overpayments, states :

(1) DSHS establishes overpayments for past or current consumers when the consumer:
   (a) Received benefits when the consumer was not eligible;
   (b) Was determined eligible at application or reapplication based on the consumer's participation in an approved activity and used benefits while never participating in said activity;
   (c) Failed to report changes under the requirements of WAC 170-290-0031 to DSHS resulting in an error in determining eligibility, amount of care authorized, or copayment;
   (d) Used a provider that was not eligible per WAC 170-290-0125;
   (e) Received benefits for a child who was not eligible per WAC 170-290-0005, 170-290-0015 or 170-290-0020;
   (f) Failed to enter their approved activity at the end of the fourteen-day wait period;
   (g) Failed to have TANF approved and enter an approved WorkFirst activity; or
   (h) Failed to return, by the sixtieth day, the requested income verification of new employment as provided in WAC 170-290-0012.
(2) DEL or DSHS may request documentation from a consumer when preparing to establish an overpayment. The consumer has fourteen consecutive calendar days to supply any requested documentation.
(3) Consumers are required to repay any benefits paid by DSHS that they were not eligible to receive.
(4) If an overpayment was made through departmental error, the consumer is still required to repay that amount.
(5) If a consumer is not eligible under WAC 170-290-0030 through 170-290-0032 and the provider has billed correctly, the consumer is responsible for the entire overpayment, including any absent days.

Washington Administrative Code 170-290-0030 Consumers' responsibilities, states in part:

When a person applies for or receives WCCC benefits, the applicant or consumer must, as a condition of receiving those benefits:
(12) Document their child's attendance in child care by having the consumer or other person authorized by the consumer to take the child to or from the child care:
   (a) If the provider uses a paper attendance record, sign the child in on arrival and sign the child out at departure, using their full signature and writing the time of arrival and departure; or
   (b) Record the child's attendance using an electronic system if used by the provider;

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

Child care providers who accept child care subsidies must do the following:
(1) Comply with:

(a) All of the DEL child care licensing or certification requirements as provided in chapter 170-295, 170-296A, or 170-297 WAC, for child care providers who are licensed or certified; or

(b) All of the requirements in WAC 170-290-0130 through 170-290-0167, 170-290-0250, and 170-290-0268, for child care providers who provide in-home/relative care;

(2) Report pending charges or convictions to DSHS as provided in:

(a) Chapter 170-295, 170-296A, or 170-297 WAC, for child care providers who are licensed or certified; or

(b) WAC 170-290-0138 (2) and (3), for child care providers who provide in-home/relative care;

(3) Keep complete and accurate daily attendance records for children in their care, and allow access to DEL to inspect attendance records during all hours in which authorized child care is provided as follows:

(a) Current attendance records (including records from the previous twelve months) must be available immediately for review upon request by DEL.

(b) Attendance records older than twelve months to five years must be provided to DSHS or DEL within two weeks of the date of a written request from either department.

(c) Failure to make available attendance records as provided in this subsection may:

(i) Result in the immediate suspension of the provider's subsidy payments; and

(ii) Establish a provider overpayment as provided in WAC 170-290-0268;

(4) Keep receipts for billed field trip/quality enhancement fees as follows:

(a) Receipts from the previous twelve months must be available immediately for review upon request by DEL;

(b) Receipts from one to five years old must be provided to DSHS or DEL within two weeks of the date of a written request from either department;

(5) Allow consumers access to their child at all times while the child is in care;

(6) Collect copayments directly from the consumer or the consumer's third-party payor, and report to DSHS if the consumer has not paid a copayment to the provider within the previous sixty days;

(7) Follow billing procedures:

(a) As described in the most current version of "*Child Care Subsidies: A Guide for Licensed and Certified Family Home Child Care Providers*,"; or

(b) As described in the most current version of "*Child Care Subsidies: A Guide for Family, Friends and Neighbors Child Care Providers*"; or

(c) As described in the most current version of "*Child Care Subsidies: A Guide for Licensed and Certified Child Care Centers*."

(8) Not claim a payment in any month a child has not attended at least one day within the authorization period in that month.

(9) Invoice the state no later than one calendar year after the actual date of service;

(10) For both licensed and certified providers and in-home/relative providers, not charge subsidized families the difference between the provider's customary rate and the maximum allowed state rate; and

(11) For licensed and certified providers, not charge subsidized families for:

(a) Registration fees in excess of what is paid by subsidy program rules;

(b) Absent days on days in which the child is scheduled to attend and authorized for care;
(c) Handling fees to process consumer copayments, child care services payments, or paperwork;
(d) Fees for materials, supplies, or equipment required to meet licensing rules and regulations; or
(e) Child care or fees related to subsidy billing invoices that are in dispute between the provider and the state.

Washington Administrative Code 170-290-0138 In-home/relative providers—Responsibilities, states in part

An in-home/relative provider must:
(6) Bill only for actual hours of care provided. Those hours:
(a) Must be authorized by DSHS;
(b) Must be used by the consumer; and
(c) Can be claimed whether or not the consumer is present during the hours of care.
(7) Bill for no more than six children at one time during the same hours of care;
(8) Track attendance documenting the days and hours of care provided and keep records for five years:
(a) If paper attendance records are used, the provider must have the consumer sign and date the attendance records at least weekly, verifying the accuracy of the dates and times.
(b) Providers may use an electronic attendance system as provided in WAC 170-290-0139 to record attendance in lieu of a paper sign-in record;
(9) Repay any overpayments under WAC 170-290-0268; and

Washington Administrative Code 170-290-0190 WCCC authorized and additional payments—Determining units of care, states:

(1) DSHS may authorize and pay for the following:
(a) Full-day child care to licensed or certified facilities and DEL contracted seasonal day camps when a consumer's children need care between five and ten hours per day;
(b) Half-day child care to licensed or certified facilities and DEL contracted seasonal day camps when a consumer's children need care for less than five hours per day;
(c) Hourly child care for in-home/relative child care;
(d) Full-time care when the consumer participates in one hundred ten hours or more of approved activities per calendar month based on the consumer's approved activity schedule. Full-time care means the following:
(i) For licensed care or certified facilities, twenty-three full-day units if the child needs five or more hours of care per day, or thirty half-day units if the child needs fewer than five hours of care per day; and
(ii) Two hundred thirty hours for in-home/relative child care;
(e) A registration fee (under WAC 170-290-0245);
(f) A field trip fee (under WAC 170-290-0247);

(g) Special needs care when the child has a documented need for a higher level of care (under WAC 170-290-0220, 170-290-0225, 170-290-0230, and 170-290-0235); and
(h) A nonstandard hours bonus under WAC 170-290-0249.

(2) Beginning September 1, 2016, and applicable to school-age children, DSHS will authorize and pay for child care as follows:
(a) DSHS will automatically increase half-day authorizations to full-day authorizations beginning the month of June when the child needs full-day care; and
(b) DSHS will automatically decrease full-day authorizations to half-day authorizations beginning the month of September unless the child continues to need full-day care during the school year until the following June. If the consumer's schedule has changed and more care is needed, the consumer must request an increase, and DSHS will verify the need for increased care. DSHS will send the consumer notification of the decrease as stated in WAC 170-290-0025;

(3) DSHS may authorize up to the provider's private pay rate if:
(a) The parent is a WorkFirst participant; and
(b) Appropriate child care, at the state rate, is not available within a reasonable distance from the approved activity site.
"Appropriate" means licensed or certified child care under WAC 170-290-0125, or an approved in-home/relative provider under WAC 170-290-0130.
"Reasonable distance" is determined by comparing what other local families must travel to access appropriate child care.

(4) DSHS authorizes overtime care if:
(a) More than ten hours of care is provided per day (up to a maximum of sixteen hours a day); and
(b) The provider's written policy is to charge all families for these hours of care in excess of ten hours per day.

(5) In-home/relative providers who are paid child care subsidies to care for children receiving WCCC benefits cannot receive those benefits for their own children during the hours in which they provide subsidized child care.

Washington Administrative Code 170-290-0245 Registration fees, states:

(1) DSHS may pay licensed or certified child care providers and DEL contracted seasonal day camps a registration fee when:
(a) A child is first enrolled by the consumer for child care with a provider;
(b) A consumer enrolls their child with a new child care provider during their eligibility period; or
(c) A child has more than a sixty-day break in child care services with the same provider, and it is the provider's policy to charge all parents this fee when there is a break in service.

(2) A registration fee will be paid only once per calendar year for children who are cared for by the same provider, even if the provider receives subsidy payments under different subsidy programs during this time period for the enrolled children, unless there is a break of sixty days or more as provided in subsection (1)(c) of this section.

Washington Administrative Code 170-290-0247 Field trip/quality enhancement fees, states:

(1) DSHS pays licensed or certified family home child care providers a monthly field trip/quality enhancement fee up to thirty dollars per child or the provider's actual cost for the field trip, whichever is less, only if the fee is required of all parents whose children are in the provider's care. DEL-licensed or certified child care centers and school-age centers are not eligible to receive the field trip/quality enhancement fee.

(2) The field trip/quality enhancement fee is to cover the provider's actual expenses for:
   (a) Admission;
   (b) Enrichment programs and/or ongoing lessons;
   (c) Public transportation or mileage reimbursement at the state office of financial management rate for the use of a private vehicle;
   (d) The cost of hiring a nonemployee to provide an activity at the child care site in-house field trip activity; and
   (e) The purchase or development of a prekindergarten curriculum.

(3) The field trip/quality enhancement fee shall not cover fees or admission costs for adults on field trips, or food purchased on field trips.

2017-018 The Department of Social and Health Services did not establish adequate internal controls over and did not comply with federal requirements to sanction Temporary Assistance for Needy Families program participants who were not cooperative with the Department regarding child support issues.

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:	1601WATANF; 1701WATANF
Applicable Compliance Component:	Special Tests and Provisions - Child Support Non-Cooperation
Known Questioned Cost Amount:	$2,314

Background

The Department of Social and Health Services (Department), Community Services Division, administers the Temporary Assistance for Needy Families (TANF) grant that provides temporary cash assistance for families in need. The Department spent over $309 million in grant funds during fiscal year 2017.

The Department's Division of Child Support (DCS) provides child support services, including paternity establishment, child-support-order establishment and child support collection services. TANF clients are required to cooperate with DCS to help establish paternity and/or modify or enforce child support payments. The DCS is responsible for determining when a client is non-cooperative and notifying the Community Services Division of that determination. Federal regulations require the Department to reduce benefits if a client does not cooperate with DCS.

In our last two audits, we reported the Department did not have adequate internal controls over and did not comply with requirements to sanction TANF clients who did not cooperate with DCS child support services. The prior finding numbers were 2016-015 and 2015-018.

Description of Condition

During the audit period, the Department did not establish adequate internal controls to ensure it complied with child support noncooperation requirements. After child support noncooperation was determined, the Department did not sufficiently monitor to ensure benefits were reduced.

As a result of prior audit findings, the Department implemented the following procedures:

- Increased the priority of noncooperation cases so a staff member examines them within ten working days of being referred
- Implemented an automated process to identify currently closed cases that involve noncooperation, in the event the case is reopened

- Monitors to ensure all notifications of noncooperation received from prosecuting attorneys are entered into the case management system

However, we found that these procedures were not fully implemented until the last quarter of the audit period.

We randomly selected and examined two separate populations of TANF recipients who should have received a noncooperation notice. One population included cases closed during the audit year and the second population included open cases. For the population of closed cases, we examined 17 recipients of a total population of 280. We found no exceptions. For the population of open cases, we examined 59 recipients of a total population of 3,738. For the 59 recipients, we found:

- A record of noncooperation was not documented in three client files
- A record of noncooperation was documented three months late in one client file, as a result of a known computer failure period
- A record of noncooperation was not documented within 10 days of receipt in seven additional client files
- Of these 11 clients, benefits were not properly reduced for eight

None of these exceptions occurred after the Department fully implemented its new procedures in March 2017.

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

Cause of Condition

While the Department implemented new procedures, they were not in place and operating effectively for a majority of the audit period.

Effect of Condition and Questioned Costs

By not monitoring to ensure non-cooperative clients had their benefits reduced or denied, the Department issued $2,314 in improper payments to clients. We used a statistical sampling method to select the payments we examined, and estimate the amount of improper payments to be $146,621.

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

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining whether or not expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions were above our materiality threshold. This conclusion is reflected in our audit report and finding. However, the estimated improper payments are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3).

Recommendations

We recommend the Department continue to follow its newly established procedures to ensure participants who do not cooperate with DCS have their TANF benefits reduced or denied as required by federal law.

We also recommend the Department consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid.

Agency's Response

The Department partially concurs with the audit finding.

As a result of the previous year's audit findings, the Department fully implemented new procedures in March 2017 (note: the FY2017 audit period spans July 2016 – June 2017). The SAO did not find exceptions after the Department implemented the new procedures, validating that these new procedures are effective. The Department will continue to follow the new procedures to ensure TANF benefits are reduced or denied timely and accurately for participants who do not cooperate with child support requirements.

The Department recognizes that it did not properly apply sanctions for 11 clients who did not cooperate with child support requirements.

The Department concurs that seven of those 11 clients received more benefits than they were eligible to receive. The Department will carefully review these seven cases and will establish overpayments as appropriate.

For the remaining four clients in question, the Department (appropriately) did not reduce benefits because:

- *For one client, the noncooperation was not worked timely, however, the sanction was imposed and the overpayment was already appropriately established for prior months.*
- *For two clients, a procedural error occurred that did not result in any overpayments to the clients.*
- *For the remaining client, the Department concurs that a procedural error occurred, but does not concur with the associated question cost of $623. The Department did not properly apply the sanction, but subsequently received a back-dated cooperation notice during the audit period that cancelled out the sanction. Therefore, the client received the correct benefit amount. The Department believes the known question cost of this finding should be adjusted to $1,691.*

Auditor's Concluding Remarks

Regarding the Department's disagreement – we deemed the $623 as a questioned cost because, at the time of payment, the client was in non-cooperative status. The client's benefit amount should have been reduced until the Department ultimately determined the client was cooperative.

Since the Department disagrees an overpayment was made to the client, we reaffirm our recommendation that it consult with the grantor to determine what, if any, of the questioned costs should be repaid.

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.
(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.
(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

(a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.
(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.
(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

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

> .11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows: …
>
> **Deficiency in internal control over compliance.** A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.
>
> **Material weakness in internal control over compliance.** A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:
>
> **Reasonably possible**. The chance of the future event or events occurring is more than remote but less than likely.
>
> **Probable**. The future event or events are likely to occur.
>
> **Significant deficiency in internal control over compliance.** A deficiency, or a combination of deficiencies, in internal control over compliance that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.
>
> **Material noncompliance**. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Title 45, Code of Federal Regulations, Section 264.30 and 264.31-Other Accountability Provisions:

> §264.30 What procedures exist to ensure cooperation with the child support enforcement requirements?
>
> (a) (1) The State agency must refer all appropriate individuals in the family of a child, for whom paternity has not been established or for whom a child support order needs to be established, modified or enforced, to the child support enforcement agency (i.e., the IV-D agency).
>
> (2) Referred individuals must cooperate in establishing paternity and in establishing, modifying, or enforcing a support order with respect to the child.
>
> (b) If the IV-D agency determines that an individual is not cooperating, and the individual does not qualify for a good cause or other exception established by the State agency responsible for making good cause determinations in accordance with section 454(29)

of the Act or for a good cause domestic violence waiver granted in accordance with §260.52 of this chapter, then the IV-D agency must notify the IV-A agency promptly.

(c) The IV-A agency must then take appropriate action by:

(1) Deducting from the assistance that would otherwise be provided to the family of the individual an amount equal to not less than 25 percent of the amount of such assistance; or

(2) Denying the family any assistance under the program.

§264.31 "What happens if a State does not comply with the IV-D sanction requirement?" states in part,

(a) (1) If we find that, for a fiscal year, the State IV-A agency did not enforce the penalties against recipients required under §264.30(c), we will reduce the SFAG payable for the next fiscal year by one percent of the adjusted SFAG.

2017-019 The Department of Social and Health Services did not have adequate internal controls in place over maintenance of effort requirements for the Temporary Assistance for Needy Families grant.

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:	1601WATANF;1701WATANF
Applicable Compliance Component:	Level of Effort
Known Questioned Cost Amount:	None

Background

The Department of Social and Health Services (Department), Community Services Division, administers the Temporary Assistance for Needy Families (TANF) grant that provides temporary cash assistance for families in need. The Department spent more than $309 million in federal grant funds during fiscal year 2017.

Federal regulations require the Department to maintain state spending at certain levels to meet federal grant requirements, referred to as maintenance of effort (MOE). The state must:

- Maintain state expenditures for eligible families at a level that is at least 80 percent of historic state expenditures.
- Maintain state expenditures at a level that is more than 100 percent of its historic state expenditures for fiscal year 1994 to keep any of the federal contingency funding it received.
- Maintain supporting documentation to show the state is complying with MOE requirements.

Although the Department administers the grant, it can count certain expenditures made by other state agencies and nonprofit organizations toward its MOE requirements. The Department must ensure these expenditures of other agencies and organizations were for TANF-eligible clients.

During state fiscal year 2017, the Department claimed about $159 million of its own spending within eight programs toward its MOE requirements. In addition, the Department claimed about $442 million of expenditures from another 15 programs, including seven other state agencies and two nonprofit organizations. These expenditures were not part of the state's TANF program.

In our last two audits, we reported the Department did not have adequate internal controls to ensure it complied with the MOE requirements. This was reported as finding numbers 2016-017 and 2015-020.

Description of Condition

The Department did not have adequate internal controls in place to ensure it complied with the MOE requirements.

The Department uses information from large databases to produce a list of TANF-eligible clients, a complex process that requires changes in the way the information is coded. Other agencies use this list to identify state funds paid for benefits provided to the same clients. The Department performed reviews to ensure necessary coding changes were applied to the data properly. However, we found the Department did not use program change control software. Without the use of such a tool to document what code was modified, added or deleted, there is an increased risk that changes to code could be made and not reviewed.

We found the review and testing of coding changes was not adequately documented to evaluate if the Department's internal controls over MOE claims were in place and effective. We randomly selected and examined 86 clients on the Department's list of TANF clients and found that five (6 percent) were not eligible.

We also found the Department did not:

- Adequately monitor expenditures throughout the year to ensure it would meet the MOE expenditure level requirements
- Review final expenditure data from outside agencies to determine whether the expenditures were allowable and adequately supported

We consider these internal control weaknesses to be a significant deficiency. We were able to examine other supporting data not used by the report preparers to gain reasonable assurance the amounts reported by the Department were materially accurate.

Cause of Condition

The Department did not have adequate written policies or procedures in place to ensure it complied with MOE requirements. Additionally, although the Department indicated it had program change control software, the software was not in use during the audit period. Management did not adequately monitor to ensure the Department complied with federal requirements because it believed informal review and testing of the coding were sufficient to ensure accuracy and completeness.

The Department did not have ongoing fiscal monitoring to ensure it met the MOE requirements. The Department believed using budget data for the corresponding fiscal year would ensure it met MOE requirements. However, having sufficient budget does not give assurance that all budget will be expended.

The Department also believed it could rely on the other agencies' processes to ensure additional MOE expenditures are allowable, supported, and correct, through the use of attestations that accompany emails stating amounts expended.

Effect of Condition

By not performing adequate reviews of coding and expenditure data, the Department cannot be sure the expenditures claimed to meet the MOE requirements were accurate.

The Department did not know if it would be compliant with MOE requirements until after the year had ended because it did not perform ongoing monitoring. In addition, the Department did not review adequate supporting documentation before reporting the MOE amount to the grantor; therefore, the report preparer and approver did not know whether the amounts reported were allowable.

Although we determined the Department was materially compliant with the MOE requirements, we found the following:

- The Department included amounts totaling $1,516 that were not allowable MOE expenditures. Our examination was performed using a statistically valid sampling method. We estimate the Department claimed a total of $851,322 in unallowable expenditures.
- The Department included MOE amounts that were outside the current federal fiscal year.
- The errors on the Department's eligible client list led to an estimated $2.1 million in unallowable MOE expenditures being claimed.

If it does not ensure the data is allowable and accurate, the Department could unknowingly become noncompliant, and the grantor could reduce future grant funds in the amount of the shortage.

Recommendations

We recommend the Department:

- Establish adequate written policies and procedures for this complex process to ensure it collects and reviews adequate documentation to support all MOE expenditures
- Use a program change tool, or alternative method, along with a secondary review, to ensure all coding changes are appropriate, accurate and complete
- Monitor throughout the fiscal year to ensure MOE expenditure level requirements are being met

Agency's Response

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

The Department concurs with the State Auditor's Office's recommendation to establish written policies and procedures to ensure it collects and reviews adequate documentation to support all MOE expenditures.

In response to the 2016-017 finding, the Department took steps to address its lack of written policies and procedures regarding the preparation of its reports. As of February 1, 2017, the Department developed manuals that outline collaborative procedures between the Community Services Division, the Research and Data Analysis Division (RDA), and the Division of Finance and Financial Recovery in report preparation. However, because these changes were not implemented until half-way through SFY 17, the Department understands that the SAO could not consider the improvements in internal controls and anticipated seeing a repeat finding in this audit area.

RDA will address the recommendation to utilize a change tool and secondary review to ensure all coding changes are appropriate, accurate and complete, in the agency response to 2017-020 TANF Reporting 199 & 209.

Lastly, the Department supports the recommendation to monitor throughout the fiscal year to ensure MOE expenditure level requirements are being met.

In addition to improving the Department's internal controls and documentation processes, the Department proposed additional steps to address the recommendations provided by the State Auditor's Office. The Department intends to implement Memorandums of Understanding (MOUs) with all partnering sources at the outset of the federal fiscal year. These MOUs will give the Department an opportunity to discuss current program operations, allowable activities and expenditures, and develop a projection of expenditures with the partnering source. During presentation of the MOU, the Department will also review partners' methodologies and record management protocols, and offer training and assistance, if needed.

During the federal fiscal year, the Department will implement a quarterly monitoring/reporting schedule for all MOE sources, to ensure reported expenditures are allowable and accurate in a timelier manner. The Department believes its use of MOUs during the first quarter of the corresponding federal fiscal year, and the improved review/reporting schedule, will allow the Department to forecast and monitor its ability to meet both its TANF MOE and TANF Contingency Fund requirements throughout the year.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

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

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

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

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

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

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

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

45 Code of Federal Regulation section 263 Expenditures of State and Federal TANF Funds, states in part

Section 263.1 – How much State money must a State expend annually to meet the basic MOE requirement, states in part:

(a) (1) The minimum basic MOE for a fiscal year is 80 percent of a State's historic State expenditures.

Section 263.2 – What kinds of State expenditures count toward meeting a State's basic MOE expenditure requirement, states in part:

(e) Expenditures for benefits or services listed under paragraph (a) of this section may include allowable costs borne by others in the State (e.g., local government), including cash donations from non-Federal third parties (e.g., a non-profit organization) and the value of third party in-kind contributions if:
  (1) The expenditure is verifiable and meets all applicable requirements in 45 CFR 92.3 and 92.24;
  (2) There is an agreement between the State and the other party allowing the State to count the expenditure toward its MOE requirement; and,
  (3) The State counts a cash donation only when it is actually spent.

Section 263.8 - What happens if a State fails to meet the basic MOE requirement?

(a) If any State fails to meet its basic MOE requirement for any fiscal year, then we will reduce dollar-for-dollar the amount of the SFAG payable to the State for the following fiscal year.
(b) If a State fails to meet its basic MOE requirement for any fiscal year, and the State received a WtW formula grant under section 403(a)(5)(A) of the Act for the same fiscal year, we will also reduce the amount of the SFAG payable to the State for the following fiscal year by the amount of the WtW formula grant paid to the State.

Section 263.9 May a State avoid a penalty for failing to meet the basic MOE requirement through reasonable cause or corrective compliance?

No. The reasonable cause and corrective compliance provisions at §§ 262.4, 262.5, and 262.6 of this chapter do not apply to the penalties in § 263.8.

Section 264.72 What requirements are imposed on a State if it receives contingency funds, states in part:

(a) (1) A State must meet a Contingency Fund MOE level of 100 percent of historic State expenditures for FY 1994.
  (2) A State must exceed the Contingency Fund MOE level to keep any of the contingency funds that it received. It may be able to retain a portion of the amount of contingency funds that match countable State expenditures, as defined in § 264.0, that are in excess of the State's Contingency Fund MOE level, after the overall adjustment required by section 403(b)(6)(C) of the Act.

2017-020 The Department of Social and Health Services did not have adequate internal controls in place for ensuring the accuracy of submitted quarterly reports for the Temporary Assistance for Needy Families Grant.

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:	1601WATANF; 1701WATANF
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The Department of Social and Health Services, Community Services Division, administers the Temporary Assistance for Needy Families (TANF) grant that provides temporary cash assistance for families in need. To receive TANF benefits, participants must be engaged in entering the work force through the Work First program, with limited exceptions. State agencies must meet or exceed minimum annual work participation rates of 50 percent overall and 90 percent for two parents. The Department spent more than $309 million in grant funds during fiscal year 2017.

Federal regulations require the Department to file quarterly reports that include work participation data at summary and individual levels. The Department must file separate reports for their federal TANF program and state programs. The proper reporting of work participation data is critical because it serves as the basis for the federal government's determination of whether states have met the required work participation rates. A penalty may apply for failure to meet the required rates.

In our prior audit, we reported the Department did not have adequate internal controls in place for submitting accurate quarterly reports. The prior finding number was 2016-016.

Description of Condition

During the audit period, the Department did not have adequate internal controls in place to ensure it complied with grant reporting requirements. Data is extracted from large databases and is transformed with customized code to produce reports. The Department performed informal, manual reviews in an attempt to ensure necessary coding changes were applied properly. However, we found these reviews were not adequate to ensure all changes were properly identified and reviewed. Additionally, the reviews were not sufficiently documented. For these reasons, we were unable to evaluate if internal controls were in place and effective.

Additionally, a program change tool was not used to facilitate an adequate review. Without the use of such a tool or an alternative method to identify what code was modified, added or deleted, there is an increased risk that code could be changed, either intentionally or unintentionally.

We consider these internal control weaknesses to constitute a significant deficiency. We were able to examine other supporting data not used by the report preparers to verify the amounts reported by the Department were materially accurate.

Cause of Condition

The Department did not establish adequate written policies or procedures to ensure it complied with reporting requirements. The Department has researched program change tools, but none was used during the audit period. Management did not adequately monitor to ensure the Department complied with federal requirements because it believed informal review and testing of the coding were sufficient to ensure accuracy and completeness.

Effect of Condition

Because it did not perform adequate reviews, the Department cannot be sure data used for reporting purposes was accurate and complete. Without assurance the data is accurate, the Department could unknowingly become noncompliant and could be penalized.

Grant terms would allow the grantor to penalize the Department 4 percent of the grant for each quarter if the state failed to submit accurate, complete and timely reports, and up to 21 percent for not meeting minimum participation rates.

Recommendations

We recommend the Department:

- Establish adequate written policies and procedures that describe how the Department ensures the reported data is accurate and complete
- Improve internal controls to ensure accurate and complete reporting
- Use a program change tool, or an alternate method, along with a secondary review, to ensure changes are appropriate, accurate and complete

Department's Response

The Department partially agrees with the audit finding.

The Department concurs written policies and procedures that describe how the Department ensures grant reporting data is accurate and complete needs to be sufficient. We also concur internal controls are needed to ensure accuracy and completeness.

- *The Department believes controls for change requests, coding updates and the approval processes are adequate. The Department has extensive documentation on algorithms for deriving the items in the federal transmission, including specifications on tables and codes in the Automated Client Eligibility System and the Social Service Payment System and how Statistical Analysis System (SAS) processes use these data to comply with reporting*

requirements. Staff also run a quality assurance process for each report that identifies potential fatal and warning edits; these results are reviewed by the Supervisor.

- *While the Department may benefit from a more formal process, the review of both code and results is extensive and the process includes monthly dissemination of summary data to multiple partners for review and double checking. The quarterly reports required for meeting participation rates were accurate, complete and submitted timely.*
- *During FY17 the Department documented the 199 and 209 processes in detail and submitted this documentation to SAO for review. The Department continues to extend and update these written policies and procedures for this complex reporting process.*
- *The Department implemented a quarterly internal control/quality assurance process beginning in January 2017. In this process, a random sample of 199 and 209 reported cases are checked against the source data systems for correctness, and a summary of the QA results are reviewed by a supervisor. Documentation on this process was also submitted to the SAO for review.*

The Department does not concur a program change tool is needed.

- *Manual monitoring, reviewing, and testing of coding changes were performed by Department staff to ensure they were applied correctly. While no version control software was used by the Department, staff kept systematic copies of all old code versions using filename conventions, duplicating most of the functionality of version control software. The Department is not aware of any audit standards that require version control software to be used by entities audited under the Single Federal Audit.*

Going forward, the Department will ensure:

- *Quarterly quality assurance testing using statistical sampling continues to be performed in order to ensure that "data used for reporting purposes was accurate and complete."*
- *Written policies and procedures will continue to be updated that describe "how the Department ensures the reported data is accurate and complete."*
- *Supervisor review of quality assurance sampling results will be documented.*
- *Version control software packages and alternative methods will continue to be researched to determine if they will be used. Current source code archiving processes are documented.*

Auditor's Concluding Remarks

Without the use of a program change tool, or alternative method, to identify what code was modified, added or deleted, there is an increased risk that changes to code could be made, either intentionally or unintentionally, and not reviewed.

During our testing of maintenance of effort requirements for the TANF program we examined a random sample of 86 clients and found that five (six percent) were not eligible clients. These clients were improperly determined TANF eligible because an error was made in the coding that was not detected upon review. This condition is being reported in finding 2017-019. The retention of old versions of code does not help detect improper coding changes unless the two version are compared to each other line by line. This is further evidenced by the fact it took a significant amount of time for the Department to find and correct the undetected error in the code.

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

> Section 200.303 Internal controls, states in part:
>
> The non-Federal entity must:
>
> (a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

> Section 200.516 Audit findings, states in part:
>
> (a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
>
> (1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

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

> .11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows: …
>
> **Deficiency in internal control over compliance.** A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.
>
> **Material weakness in internal control over compliance.** A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility

that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

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

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

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

Title 45, Code of Federal Regulations

Section 265.3 – What reports must the State file on a quarterly basis, states in part:

(a) Quarterly reports

(1) Each State must collect on a monthly basis, and file on a quarterly basis, the data specified in the TANF Data Report and the TANF Financial Report

(2) Each State that claims MOE expenditures for a separate State program(s) must collect on a monthly basis, and file on a quarterly basis, the data specified in the SSP-MOE Data Report.

(b) *TANF Data Report.* The TANF Data Report consists of four sections. Two sections contain disaggregated data elements and two sections contain aggregated data elements.

(1) *Disaggregated Data on Families Receiving TANF Assistance – Section one.* Each State must file disaggregated information on families receiving TANF assistance. This section specifies identifying and demographic data such as the individual's Social Security Number and information such as the amount of assistance received, educational level, employment status, work participation activities, citizenship status, and earned and unearned income. The data must be provided by both adults and children.

(2) *Disaggregated Data on Families No Longer Receiving TANF Assistance - Section two.* Each State must file disaggregated information on families no longer receiving TANF assistance. This section specifies the reasons for case closure and data similar to the data required in section one.

(3) *Aggregated Data - Section three.* Each State must file aggregated information on families receiving, applying for, and no longer receiving TANF assistance. This section of the TANF Data Report requires aggregate figures in such areas as: The number of applications received and their disposition; the number of recipient families, adult recipients, and child recipients; the number of births and out-of-wedlock births for families receiving TANF assistance; the number of noncustodial parents participating in work activities; and the number of closed cases.

(4) *Aggregated Caseload Data by Stratum-Section four.* Each State that opts to use a stratified sample to report the quarterly TANF disaggregated data must file the monthly caseload data by stratum for each month in the quarter.

(d) *SSP-MOE Data Report.* The SSP-MOE Data Report consists of four sections. Two sections contain disaggregated data elements and two sections contain aggregated data elements.

(1) *Disaggregated Data on Families Receiving SSP-MOE Assistance - Section one.* Each State that claims MOE expenditures for a separate State program(s) must file disaggregated information on families receiving SSP-MOE assistance. This section specifies identifying and demographic data such as the individual's Social Security Number, the amount of assistance received, educational level, employment status, work participation activities, citizenship status, and earned and unearned income. The data must be provided for both adults and children.

(2) *Disaggregated Data on Families No Longer Receiving SSP-MOE Assistance - Section two.* Each State that claims MOE expenditures for a separate State program(s) must file disaggregated information on families no longer receiving SSP-MOE assistance. This section specifies the reasons for case closure and data similar to the data required in section one.

(3) *Aggregated Data - Section three.* Each State that claims MOE expenditures for a separate State program(s) must file aggregated information on families receiving and no longer receiving SSP-MOE assistance. This section of the SSP-MOE Data Report requires aggregate figures in such areas as: The number of recipient families, adult recipients, and child recipients; the total amount of assistance for families receiving SSP-MOE assistance; the number of non-custodial parents participating in work activities; and the number of closed cases.

(4) *Aggregated Caseload Data by Stratum - Section four.* Each State that claims MOE expenditures for a separate State program(s) and that opts to use a stratified sample to report the SSP-MOE quarterly disaggregated data must file the monthly caseload by stratum for each month in the quarter.

(e) *Optional data elements.* A State has the option not to report on some data elements for some individuals in the TANF Data Report and the SSP-MOE Data Report, as specified in the instructions to these reports.

(f) *Non-custodial parents.* A State must report information on a non-custodial parent (as defined in § 260.30 of this chapter) if the non-custodial parent:

(1) Is receiving assistance as defined in § 260.31 of this chapter;

(2) Is participating in work activities as defined in section 407(d) of the Act; or

(3) Has been designated by the State as a member of a family receiving assistance.

Title 45, Code of Federal Regulations

Section 262.1 What penalties apply to States [states in part]?

(a) We will assess fiscal penalties against States under circumstances defined in parts 261 through 265 of this chapter. The penalties are:

(1) A penalty of the amount by which a State misused its TANF funds;

(2) An additional penalty of five percent of the adjusted SFAG if such misuse was intentional;

(3) A penalty of four percent of the adjusted SFAG for each quarter a State fails to submit an accurate, complete and timely required report;

(4) A penalty of up to 21 percent of the adjusted SFAG for failure to satisfy the minimum participation rates;

2017-021 The Department of Social and Health Services did not have adequate internal controls in place for submitting quarterly and annual reports for the Temporary Assistance for Needy Families grant.

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:	1601WATANF; 1701WATANF
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The Department of Social and Health Services (Department), Community Services Division, administers the Temporary Assistance for Needy Families (TANF) grant that provides temporary cash assistance for families in need. To receive TANF benefits, participants must be engaged in entering the work force through the Work First program, with limited exceptions.

The Department spent about $309 million in federal grant funds during state fiscal year 2017. In addition, the Department reported it spent over $601 million in state funds toward meeting a maintenance of effort (MOE) requirement for the federal fiscal year 2016 grant. This amount includes over $400 million in expenditures made by other state agencies. When reporting the expenditures of other agencies, the Department must ensure the amounts reported are accurate and complete or enter into a written agreement with the other agencies specifying that they will do so.

Quarterly financial reports

Federal regulations require the Department to file quarterly financial reports that include details on how both federal and state TANF funds are spent. The Department collects information on a monthly basis and files the federal reports on a quarterly basis. A quarterly report must be filed for each federal grant that is open. At the end of each federal year, the report must include federal and state MOE expenditures.

Annual report

The Department must also file an annual report that contains detailed information on the state's MOE spending for that year. The total MOE expenditures reported on the quarterly financial report at federal fiscal year end must match the expenditures reported on the separate annual report. The Department must keep records that show all costs are allowable and verifiable.

In our last two audits, we reported findings that the Department did not have adequate internal controls over submitting quarterly and annual reports for the TANF program. This was reported in finding numbers 2016-018 and 2015-021.

Description of Condition

The Department did not have adequate internal controls in place to ensure it complied with grant reporting requirements for quarterly financial reports or its annual report.

Quarterly financial reports

The Department reported $601,121,012 in state spending for federal fiscal year 2016 but did not maintain adequate documentation needed to support the expenditures. The Department submitted seven quarterly reports, and we examined four of them. The final quarterly report for federal fiscal year 2016, which we examined, included MOE totaling over $400 million in spending by other state agencies. Each of these agencies attested to the Department how much it spent. However, the Department staff who prepared and submitted the reports to the federal government did not independently verify the amounts were accurate and adequately supported.

Annual report

We identified errors in the underlying data from other agencies that totaled about $2.1 million. These errors were partially identified through statistically valid sampling methods. We estimate an additional $850,000 was likely reported in error.

We consider these internal control weaknesses to constitute a significant deficiency for the quarterly financial reports and the annual report.

Cause of Condition

During the audit period, the Department spent significant time and effort on updating policies and procedures to address the previously identified weaknesses. However, these were not completed by the end of the audit period and therefore the Department did not have adequate written policies or procedures in place to ensure it complied with reporting requirements. In last year's finding, we recommended the Department ensure the amounts reported by other agencies were accurate. However, the staff who prepared the reports during fiscal year 2017 again relied on attestations from other state agencies and believed this was sufficient to ensure the reported amounts were correct.

Additionally, management did not adequately monitor to ensure the Department complied with the federal requirements.

Effect of Condition

Not ensuring the accuracy of the required quarterly and annual reports diminishes the federal government's ability to monitor grant funds. Additionally, grant terms allow the grantor to penalize the Department for noncompliance, including suspending or terminating the award.

We were able to examine other supporting data not used by the report preparers to verify the amounts reported by the Department were materially accurate.

Recommendations

We recommend the Department:

- Establish sufficient written policies and procedures for preparing the reports
- Verify expenditures reported by other state agencies to ensure they are allowable and adequately supported
- Maintain adequate documentation to support reports filed with its federal grantor

Agency's Response

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

The Department concurs with the State Auditor's Office's recommendation to establish written policies and procedures for preparing reports and to maintain adequate documentation to support reports filed with the federal grantor.

In response to the 2016-018 TANF Reporting finding, the Department took steps to address its lack of written policies and procedures regarding the preparation of its reports. As of February 1, 2017, the Department developed manuals that outline collaborative procedures between the Community Services Division (CSD), the Division of Research and Data Analysis (RDA), and the Division of Finance and Financial Recovery (DFFR) in report preparation. However, because these changes were not implemented until halfway through SFY 17, the Department understands that the SAO could not consider the improvements in internal controls and anticipated seeing a repeat finding in this audit area.

The Department will take additional steps to determine, to the best of its ability, all expenditures are accurate and adequately supported. The Department will develop a quarterly reporting schedule, use Memorandums of Understanding with all partnering sources at the outset of the federal fiscal year to outline allowable activities and expenditures, and approach partnering sources to offer training and guidance on TANF MOE and report preparation. The Department will also require attestations with submitted expenditure reports. All documentation will be stored locally and electronically for review. Representatives of CSD, DFFR, and RDA will review all sources' activities and expenditures on a quarterly basis in addition to participating in weekly meetings.

The Department understands the SAOs perspective on the requirement to verify expenditures reported by other state agencies. The Department will initiate discussions and seek guidance from the Office of Financial Management on establishing internal controls for this recommendation.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

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

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

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

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

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

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

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

Title 45, Code of Federal Regulations

Section 265.3 – What reports must the State file on a quarterly basis, states in part:

(a) Quarterly reports

(1) Each State must collect on a monthly basis, and file on a quarterly basis, the data specified in the TANF Data Report and the TANF Financial Report

Section 263.2 – What kinds of State expenditures count toward meeting a State's basic MOE expenditure requirement, states in part:

(e) Expenditures for benefits or services listed under paragraph (a) of this section may include allowable costs borne by others in the State (e.g., local government), including cash donations from non-Federal third parties (e.g., a non-profit organization) and the value of third party in-kind contributions if:

(1) The expenditure is verifiable and meets all applicable requirements in 45 CFR 75.2 and 75.306;

(2) There is an agreement between the State and the other party allowing the State to count the expenditure toward its MOE requirement; and,

(3) The State counts a cash donation only when it is actually spent.

Section 265.9 What information must the State file annually, states in part:

(a) Each State must file an annual report containing information on the TANF program and the State's MOE program(s) for that year. The report may be filed as:

(1) An addendum to the fourth quarter TANF Data Report; or

(2) A separate annual report.

(c) Each State must provide the following information on the State's program(s) for which the State claims MOE expenditures:

(1) The name of each program and a description of the major activities provided to eligible families under each such program;

(2) Each program's statement of purpose;

(3) If applicable, a description of the work activities in each separate State MOE program in which eligible families are participating;

(4) For each program, both the total annual State expenditures and the total annual State expenditures claimed as MOE;

(5) For each program, the average monthly total number or the total number of eligible families served for which the State claims MOE expenditures as of the end of the fiscal year;

(6) The eligibility criteria for the families served under each program/activity;

(7) A statement whether the program/activity had been previously authorized and allowable as of August 21, 1996, under section 403 of prior law;
(8) The FY 1995 State expenditures for each program/activity not authorized and allowable as of August 21, 1996, under section 403 of prior law (see § 263.5(b) of this chapter); and
(9) A certification that those families for which the State is claiming MOE expenditures met the State's criteria for "eligible families."

(d) If the State has submitted the information required in paragraphs (b) and (c) of this section in the State Plan, it may meet the annual reporting requirements by reference in lieu of re-submission. If the information in the annual report has not changed since the previous annual report, the State may reference this information in lieu of re-submission.

Section 265.10 When is the annual report due?

The annual report required by § 265.9 is due at the same time as the fourth quarter TANF Data Report.

Section 265.4 When are quarterly reports due?

(a) Each State must file the TANF Data Report and the TANF Financial Report (or, as applicable, the Territorial Financial Report) within 45 days following the end of the quarter or be subject to a penalty.
(b) Each State that claims MOE expenditures for a separate State program(s) must file the SSP-MOE Data Report within 45 days following the end of the quarter or be subject to a penalty.
(c) A State that fails to submit the reports within 45 days will be subject to a penalty unless the State files complete and accurate reports before the end of the fiscal quarter that immediately succeeds the quarter for which the reports were required to be submitted.

2017-022 The Department of Social and Health Services did not report fraud affecting multiple federal programs to grantors.

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
	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:	1701WATANF; 1601WATANF; G1701WACCDF; G1601WACCDF; G1501WACCDF	
Applicable Compliance Component:	Other-Fraud Reporting	
Known Questioned Cost Amount:	None	

Background

The Department of Social and Health Services (Department) administers the Temporary Assistance for Needy Families (TANF) grant that provides temporary cash assistance for families in need. The Department of Early Learning administers the federal Child Care and Development Fund (CCDF) grant to help eligible working families pay for childcare. DEL is the lead agency for the CCDF program; however, the Department's Office of Fraud and Accountability conducts investigations related to allegations of fraud for both agencies. During the audit period, the Department forwarded 77 cases involving TANF and/or CCDF funds to a prosecutor's office

The state spent about $309 million in federal TANF grant funds and $248 million in federal CCDF grant funds in fiscal year 2017.

Federal regulations require states to report in writing to federal grantors when fraud occurred that affected federal awards.

Description of Condition

During the audit period, prosecutor offices finalized 42 fraud cases that were identified by the Department over multiple years. These cases involved federal TANF funds, CCDF funds, or a combination of both. Federal funds from the TANF grant totaled $290,265. Federal funds from the CCDF grant totaled $243,249.

In addition, the Department identified one employee fraud for the TANF grant for a total of $8,523. These cases were not reported in writing to the respective federal grantors as required by federal regulations.

This condition was not reported in the prior audit.

Cause of Condition

The Department was not aware of the requirement to disclose, in writing, instances of fraud affecting federal awards to its grantors.

Effect of Condition

The Department's noncompliance with reporting fraud affecting federal awards diminishes the federal government's ability to monitor grant funds.

If the auditor identifies known or likely fraud affecting a federal award that was not already reported to a grantor by the agency, a federal regulation requires the auditor to report the condition as a finding.

Recommendations

We recommend the Department:

- Establish sufficient procedures to ensure it reports in writing, instances of fraud affecting grant awards, as required by federal regulations
- Provide training to staff to ensure they are educated about the federal reporting requirement
- Review guidance published by the U.S. Department of Health and Human Services on self-disclosing instances of fraud affecting federal awards[1]

Department's Response

The Department concurs with the audit finding and will take swift action to correct the issue.

As an immediate fix, the Department will report, in writing, the 43 confirmed instances of fraud to the respective federal grantors.

The Department will also:

- *Convene a workgroup that will review guidance published by the U.S. Department of Health and Human Services regarding self-disclosing instances of fraud affecting federal awards to develop:*
    - *Sufficient procedures to ensure the Department reports, in writing, instances of fraud affecting grant awards*
    - *Training for staff to ensure they are educated about the federal reporting requirement.*

The Department's Economic Services Administration, Office of the Assistant Secretary leadership will ensure the procedures and training are implemented effectively and in a timely manner.

[1] https://oig.hhs.gov/compliance/self-disclosure-info/index.asp

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.113 – Mandatory disclosures, states in part:

> The non-Federal entity or applicant for a Federal award must disclose, in a timely manner, in writing to the Federal awarding agency or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award.

Section 200.516 Audit findings, states in part:

> (a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
>
> (6) Known or likely fraud affecting a Federal program award, unless such fraud is otherwise reported as an audit finding in the schedule of findings and questioned costs for Federal awards. This paragraph does not require the auditor to report publicly information which could compromise investigative or legal proceedings or to make an additional reporting when the auditor confirms that the fraud was reported outside the auditor's report under the direct reporting requirements of GAGAS.

2017-023 The Department of Social and Health Services improperly charged payroll costs to the Child Support Enforcement Grant.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.563 Child Support Enforcement
Federal Award Number:	1604WACEST, 1604WACSES, 1704WACEST, 1704WACSES
Applicable Compliance Component:	Activities Allowed or Unallowed and Allowable Costs/Cost Principles
Known Questioned Cost Amount:	$29,194

Background

The Department of Social and Health Services, Division of Child Support, (Department) administers the Child Support Enforcement grant. The grant provides financial support to families by locating noncustodial parents, establishing and enforcing child support orders, establishing and enforcing medical insurance coverage, establishing paternity, and collecting and paying child and spousal support payments.

The Department operates under federal regulations as well as a state plan that is approved every year. The Department is allowed to spend federal grant money on administrative costs to run the program. Staff bill 100 percent of their time to the Child Support Enforcement grant, and the Department uses a monthly certification process to ensure time billed is accurate. For any employee who did not work 100 percent of their time on the grant, a timesheet must be submitted. At the end of each month, the Department creates journal vouchers (JVs) to allocate the payroll costs from the Child Support Enforcement grant to other activities associated with work by these employees.

In fiscal year 2017, the Department spent over $110 million in federal funds on the program; about $61 million of this amount was for salaries and benefits.

Description of Condition

We found the Department used an incorrect methodology when it allocated payroll costs from the Child Support Enforcement grant to other activities. The Department overcharged the Child Support Enforcement grant by $29,194.

This condition was not reported in the prior audit.

Cause of Condition

In May 2015, the grantor issued an audit report informing the Department it was improperly charging salaries and benefits to the grant. In response, the Department changed its process to ensure payroll

costs were properly charged in the future. During our audit period, there was some confusion about the Department's process, and management directed staff to go back to the prior methodology.

Effect of Condition and Questioned Costs

We found $29,194 in direct payroll and benefits charged to the Child Support Enforcement grant that should have been allocated to other grants. By changing the allocation methodology during state fiscal year 2017 to include leave hours, the Department improperly charged the grant.

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

Recommendations

We recommend the Department:

- Ensure its allocation methodology is accurate and that it is properly charging the Child Support Enforcement grant
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Agency's Response

The Department concurs with the finding.

The Child Support Enforcement Grant was not properly charged in SFY 2017 for specific payroll and benefits. Employees within DCS that do not spend 100% of their time on a specific grant must complete time sheets for cost allocating the payroll and benefits cost proportionately to the proper funding sources, i.e. federal and/or state. In SFY 2017, the Department changed the allocation methodology resulting in an incorrect methodology. Upon discovery, the Department immediately corrected the methodology and updated procedures. The Department will correct accounting records to reflect charging the appropriate costs to the Child Support Enforcement grant.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and
(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.
(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.
(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.
(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.
(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.
(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.
(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:
(a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:

(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Section 200.430 Compensation—personal services, states in part:

(a) *General.* Compensation for personal services includes all remuneration, paid currently or accrued, for services of employees rendered during the period of performance under the Federal award, including but not necessarily limited to wages and salaries. Compensation for personal services may also include fringe benefits which are addressed in § 200.431 Compensation—fringe benefits. Costs of compensation are allowable to the extent that they satisfy the specific requirements of this part, and that the total compensation for individual employees:

(1) Is reasonable for the services rendered and conforms to the established written policy of the non-Federal entity consistently applied to both Federal and non-Federal activities;

(3) Is determined and supported as provided in paragraph (i) of this section, Standards for Documentation of Personnel Expenses, when applicable.

(i) Allowable activities. Charges to Federal awards may include reasonable amounts for activities contributing and directly related to work under an agreement, such as delivering special lectures about specific aspects of the ongoing activity, writing reports and articles, developing and maintaining protocols (human, animals, etc.), managing substances/chemicals, managing and securing project-specific data, coordinating research subjects, participating in appropriate seminars, consulting with colleagues and graduate students, and attending meetings and conferences.

2017-024 The Department of Early Learning did not have adequate internal controls over and was not compliant with requirements to ensure payments to child care providers for the Child Care and Development Fund program were allowable.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.575 Child Care and Development Block Grant 93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund
Federal Award Number:	G1701WACCDF; G1601WACCDF; G1501WACCDF
Applicable Compliance Component:	Activities Allowed or Unallowed and Allowable Costs/Cost Principles
Known Questioned Cost Amount:	$8,814

Background

The Department of Early Learning (DEL) administers the federal Child Care and Development Fund (CCDF) grant to help eligible working families2 pay for child care. The Department of Social and Health Services (DSHS) determines client eligibility and pays child care providers under an agreement with DEL. Providers are paid from both the CCDF grant and the Temporary Assistance for Needy Families grant, and a payment can include funding from both programs.

DEL is responsible for establishing policies and procedures to ensure payments are allowable. In fiscal year 2017, DEL made 659,003 monthly child care subsidy payments to child care providers from both the Child Care and Development Fund and the Temporary Assistance for Needy Families grant as well as state funding. These payments totaled almost $230 million in federal funds.

There are three child care provider types: licensed centers; licensed family homes; and family, friends and neighbor providers (FFN). Licensed centers typically operate as larger facilities, whereas licensed family homes are limited to no more than 12 children at a given time. Both centers and homes must adhere to strict licensing requirements established by DEL and are subject to annual monitoring visits.

FFN providers are exempt from many of the licensing requirements and are not subject to routine onsite monitoring visits. These providers are limited to receiving payment for a maximum of six children in their home at a time.

Authorizations for child care

To be authorized for child care services, parents must be determined to be eligible based on their income, residency and demonstrated need based on their work schedules. Once parents are determined to be eligible, DSHS authorizes service levels. For licensed providers, the service levels are generally either 23 full-day units (up to 10 hours a day) or 30 half-day units (up to five hours a day). FFN providers are paid by the hour, and authorizations are made for either part-time care (up to 110 hours) or full-time care (up to 230 hours).

Attendance records

According to State rules, child care providers must maintain attendance records to support their billing. At a minimum, the records must include: the children's names; date(s) child care was provided; and authorized signatures, typically of a parent or guardian, documenting the times the child arrived and left care.

DEL subsidy auditor reconciliations

Providers are not required to submit attendance records with their monthly requests for payment. DEL has established a subsidy audit unit that randomly selects prior payments for review. To determine if payments were allowable and properly supported, providers are required to submit attendance records and other supporting documentation, which are reconciled to paid invoices.

DEL subsidy auditors completed 2,928 reconciliations during the audit period and identified 1,820 instances (62 percent) of provider overpayments that totaled $1,116,891. The identified overpayments represented about 16 percent of the total amount of payments reviewed.

The most common reasons DEL's reconciliations determined overpayments occurred were:

- Providers overbilled because child care was not provided
- Providers did not submit required attendance records

Prior audit results

In the prior audit, we reported DEL failed to establish adequate internal controls over and was not compliant with federal requirements to ensure payments to child care providers were allowable. We have been reporting on this condition since 2005. The most recent audit finding numbers were 2016-021, 2015-023, 2014-023, 2013-016, 12-28, 11-23, 10-31, 9-12 and 8-13.

Description of Condition

We found DEL took steps to address the previous findings but continues to lack adequate internal controls to effectively prevent and detect unallowable payments to child care providers.

We randomly selected and examined 133 payments for child care, totaling $50,154 in federal CCDF funds, to determine if they were allowable. We chose child care payments by totals from each of the three provider types: licensed centers, licensed family homes and FFN's. With assistance from DEL, we requested attendance records from providers that supported the payments. We reviewed each provider's records to determine if the payments were allowed by federal and state regulations, as well as by DEL's policies.

We found 34 payments were partially or fully unallowable. In total, we questioned $8,814 paid by federal CCDF funds.

The reasons we found overpayments occurred were:

- Attendance records were not submitted by providers in response to our request or were inadequate to support payments
- Providers overbilled for services not performed or supported by attendance records
- Providers billed for overtime, field trip fees and registration fees when they did not have a written policy in place to also charge these same fees to private paying parents

We also found 34 instances, including 13 of the 34 identified above when provider attendance records did not match billing records. These did not comply with the DEL's subsidy billing guidelines.

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

Cause of Condition

Adequate internal controls did not exist to ensure payments were allowable. While the authorizations establish a maximum for what providers may bill without further approval, it does not prevent providers from billing for unallowable days, hours or services. The claim and payment system is not linked to authorizations or attendance. Child care providers must maintain attendance records and submit this supporting documentation only when it is requested.

DEL has said the identified internal control weaknesses are unlikely to be resolved without an electronic time and attendance reporting system. DEL has finalized the procurement of a system that will maintain electronic copies of attendance records and potentially reduce provider errors. This system is expected to begin operation in July 2018 and will enable DEL to perform data analysis and audit of all payments.

Effect of Condition and Questioned Costs

By not having adequate internal controls in place, DEL increases its risk of making improper payments for child care services.

A statistical sampling method was used to randomly select the payments examined in the audit. Based on the results of our testing, we estimate the total amount of likely improper payments with federal CCDF funds to be $43,670,241. Many of the improper payments were partially funded by state dollars. We found $3,036 of improper state payments, which projects to a likely improper payment amount of $15,042,101. This amount is not included in the federal questioned costs.

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

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a very high level of assurance, with a 99 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment

projections are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Recommendations

We recommend DEL:

- Implement preventative internal controls over payments to providers to reduce the rate of unallowable payments
- Continue to pursue electronic systems to more efficiently prevent and detect improper payments
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Agency's Response

The Department concurs with the finding, as to the Auditor's specific recommendations, DEL offers the following additional details:

- *Implement preventative internal controls over payments to providers to reduce the rate of unallowable payments*
- *Continue to pursue electronic systems to more efficiently prevent and detect improper payments*

Earlier this year, the Legislature directed the Department of Early Learning (DEL) to establish a progressive disqualification process for child care providers who intentionally violate Working Connections and Seasonal Child Care program rules repeatedly. DEL has adopted rules that outline the administrative process for determining program violations and potential fraud, as well as definitions associated with this process. This review process could result in program ineligibility for any provider who fails to comply with established provider requirements. DEL continues to explore ways to improve communication through a consultation process about attendance and billing practices. DEL has procured an electronic attendance system to be used by all child care providers who accept subsidy by July 1, 2018. This new system will track daily attendance, enable accurate, real-time recording of child care attendance and serve as data capture of subsidy child care usage.

On February 1, 2018, DEL launched the Electronic Attendance System for about 200 Early Adopters. This launch marks an on-time initial release of the system after months of development by DEL and software company Controltec. Based on feedback from the Early Adopters, DEL will refine the training materials and delivery methods prior to full rollout of the system in March of 2018. By July 1, 2018, all providers that accept subsidy must use the DEL electronic attendance system or another DEL-approved electronic attendance system.

The attendance data will allow DEL to develop algorithms to look at billing behaviors which are out of the norm, including over-billing or potential fraud. The electronic attendance system will allow us to automate major aspects of the quality assurance process, increase the number of audits, and also to focus on high-risk indicators afforded by the reporting mechanisms in the electronic attendance.

While the attendance system does not prevent the provider from over-billing, access to real-time data makes identification of trends related to billings easier. These trends will guide our quality assurance efforts resulting in consultation and progressive sanctions that will help to eliminate the frequent over-billing by providers To proactively address incorrect payments to providers, DEL will continue to explore options to increase the automation of this process which will include the procurement of a billing system that interacts with the attendance system and authorization system.

Justification for the proposed "billing system" will become more apparent once DEL is able to show the true extent of provider overbilling with the reports that will be available from the electronic attendance system, rather than showing extrapolated data from sample audits.

Effective July 1, 2018, DEL will take over the approval process for Family, Friend & Neighbor (FFN) providers, which had previously been conducted by DSHS. DEL will create the provider number and DSHS will create the authorizations. This separation of duties creates stronger internal controls and reduces the possibility of an ineligible provider receiving an authorization for payment.

- *Consult with the U.S. Department of Health and Human Services to discuss repaying the questioned costs, including interest*

DEL consults with the U.S. Department of Health and Human Services whenever the agency receives an audit finding from SAO. This includes conducting a case by case review and providing any additional documentation requested when the audit finding results in questioned costs of federal funds.

In addition to reviewing audit findings, DEL has worked collaboratively with the Office of Child Care (OCC) over the past year to review the child care rules and procedures to ensure we are supporting the expectations under the Child Care Development Fund (CCDF).

DEL rules related to WCCC are often more restrictive than the CCDF rules. This creates more internal control requirements, which can lead to increased errors identified by the SAO. To mitigate this issue, DEL has worked with federal partners to update our CCDF plan more frequently to reflect current practice.

DEL continues to work with Office of Child Care (OCC) to ensure grant spending in accordance with the CCDF federal guidelines related to removing barriers to families obtaining child care and providing continuity of care.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).

(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

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

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

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

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

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

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

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

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

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

Washington Administrative Code 170-290-0268, Payment discrepancies—Provider overpayments, states:

(1) An overpayment occurs when a provider receives payment that is more than the provider is eligible to receive. Provider overpayments are established when that provider:
   (a) Bills and receives payment for services not provided;
   (b) Bills without attendance records that support their billing;
   (c) Bills and receives payment for more than they are eligible to bill;
   (d) With respect to license-exempt providers, bills the state for more than six children at one time during the same hours of care; or
   (e) With respect to licensed or certified providers:
      (i) Bills the state for more than the number of children they have in their licensed capacity; or
      (ii) Is caring for a WCCC child outside their licensed allowable age range without a DEL-approved exception; or
   (f) With respect to certified providers caring for children in a state bordering Washington:
      (i) Is determined not to be in compliance with their state's licensing regulations; or
      (ii) Fails to notify DSHS within ten days of any suspension, revocation, or change to their license.
(2) DEL or DSHS may request documentation from a provider when preparing to establish an overpayment. The provider has fourteen consecutive calendar days to supply any requested documentation.
(3) Providers are required to repay any payments that they were not eligible to receive.

(4) If an overpayment was made through departmental error, the provider is still required to repay that amount.

Washington Administrative Code 170-290-0271 Payment discrepancies—Consumer overpayments, states :

(1) DSHS establishes overpayments for past or current consumers when the consumer:
   (a) Received benefits when the consumer was not eligible;
   (b) Was determined eligible at application or reapplication based on the consumer's participation in an approved activity and used benefits while never participating in said activity;
   (c) Failed to report changes under the requirements of WAC 170-290-0031 to DSHS resulting in an error in determining eligibility, amount of care authorized, or copayment;
   (d) Used a provider that was not eligible per WAC 170-290-0125;
   (e) Received benefits for a child who was not eligible per WAC 170-290-0005, 170-290-0015 or 170-290-0020;
   (f) Failed to enter their approved activity at the end of the fourteen-day wait period;
   (g) Failed to have TANF approved and enter an approved WorkFirst activity; or
   (h) Failed to return, by the sixtieth day, the requested income verification of new employment as provided in WAC 170-290-0012.
(2) DEL or DSHS may request documentation from a consumer when preparing to establish an overpayment. The consumer has fourteen consecutive calendar days to supply any requested documentation.
(3) Consumers are required to repay any benefits paid by DSHS that they were not eligible to receive.
(4) If an overpayment was made through departmental error, the consumer is still required to repay that amount.
(5) If a consumer is not eligible under WAC 170-290-0030 through 170-290-0032 and the provider has billed correctly, the consumer is responsible for the entire overpayment, including any absent days.

Washington Administrative Code 170-290-0030 Consumers' responsibilities, states in part:

When a person applies for or receives WCCC benefits, the applicant or consumer must, as a condition of receiving those benefits:
(12) Document their child's attendance in child care by having the consumer or other person authorized by the consumer to take the child to or from the child care:
   (a) If the provider uses a paper attendance record, sign the child in on arrival and sign the child out at departure, using their full signature and writing the time of arrival and departure; or
   (b) Record the child's attendance using an electronic system if used by the provider;

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

Child care providers who accept child care subsidies must do the following:
(1) Comply with:

(a) All of the DEL child care licensing or certification requirements as provided in chapter 170-295, 170-296A, or 170-297 WAC, for child care providers who are licensed or certified; or
(b) All of the requirements in WAC 170-290-0130 through 170-290-0167, 170-290-0250, and 170-290-0268, for child care providers who provide in-home/relative care;

(2) Report pending charges or convictions to DSHS as provided in:
(a) Chapter 170-295, 170-296A, or 170-297 WAC, for child care providers who are licensed or certified; or
(b) WAC 170-290-0138 (2) and (3), for child care providers who provide in-home/relative care;

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

(4) Keep receipts for billed field trip/quality enhancement fees as follows:
(a) Receipts from the previous twelve months must be available immediately for review upon request by DEL;
(b) Receipts from one to five years old must be provided to DSHS or DEL within two weeks of the date of a written request from either department;

(5) Allow consumers access to their child at all times while the child is in care;

(6) Collect copayments directly from the consumer or the consumer's third-party payor, and report to DSHS if the consumer has not paid a copayment to the provider within the previous sixty days;

(7) Follow billing procedures:
(a) As described in the most current version of "*Child Care Subsidies: A Guide for Licensed and Certified Family Home Child Care Providers*,"; or
(b) As described in the most current version of "*Child Care Subsidies: A Guide for Family, Friends and Neighbors Child Care Providers*"; or
(c) As described in the most current version of "*Child Care Subsidies: A Guide for Licensed and Certified Child Care Centers*."

(8) Not claim a payment in any month a child has not attended at least one day within the authorization period in that month.

(9) Invoice the state no later than one calendar year after the actual date of service;

(10) For both licensed and certified providers and in-home/relative providers, not charge subsidized families the difference between the provider's customary rate and the maximum allowed state rate; and

(11) For licensed and certified providers, not charge subsidized families for:
(a) Registration fees in excess of what is paid by subsidy program rules;

(b) Absent days on days in which the child is scheduled to attend and authorized for care;
(c) Handling fees to process consumer copayments, child care services payments, or paperwork;
(d) Fees for materials, supplies, or equipment required to meet licensing rules and regulations; or
(e) Child care or fees related to subsidy billing invoices that are in dispute between the provider and the state.

Washington Administrative Code 170-290-0138 In-home/relative providers—Responsibilities, states in part

An in-home/relative provider must:
(6) Bill only for actual hours of care provided. Those hours:
(a) Must be authorized by DSHS;
(b) Must be used by the consumer; and
(c) Can be claimed whether or not the consumer is present during the hours of care.
(7) Bill for no more than six children at one time during the same hours of care;
(8) Track attendance documenting the days and hours of care provided and keep records for five years:
(a) If paper attendance records are used, the provider must have the consumer sign and date the attendance records at least weekly, verifying the accuracy of the dates and times.
(b) Providers may use an electronic attendance system as provided in WAC 170-290-0139 to record attendance in lieu of a paper sign-in record;
(9) Repay any overpayments under WAC 170-290-0268; and

Washington Administrative Code 170-290-0190 WCCC authorized and additional payments—Determining units of care, states:

(1) DSHS may authorize and pay for the following:
(a) Full-day child care to licensed or certified facilities and DEL contracted seasonal day camps when a consumer's children need care between five and ten hours per day;
(b) Half-day child care to licensed or certified facilities and DEL contracted seasonal day camps when a consumer's children need care for less than five hours per day;
(c) Hourly child care for in-home/relative child care;
(d) Full-time care when the consumer participates in one hundred ten hours or more of approved activities per calendar month based on the consumer's approved activity schedule. Full-time care means the following:
(i) For licensed care or certified facilities, twenty-three full-day units if the child needs five or more hours of care per day, or thirty half-day units if the child needs fewer than five hours of care per day; and
(ii) Two hundred thirty hours for in-home/relative child care;
(e) A registration fee (under WAC 170-290-0245);
(f) A field trip fee (under WAC 170-290-0247);

(g) Special needs care when the child has a documented need for a higher level of care (under WAC 170-290-0220, 170-290-0225, 170-290-0230, and 170-290-0235); and
(h) A nonstandard hours bonus under WAC 170-290-0249.

(2) Beginning September 1, 2016, and applicable to school-age children, DSHS will authorize and pay for child care as follows:
(a) DSHS will automatically increase half-day authorizations to full-day authorizations beginning the month of June when the child needs full-day care; and
(b) DSHS will automatically decrease full-day authorizations to half-day authorizations beginning the month of September unless the child continues to need full-day care during the school year until the following June. If the consumer's schedule has changed and more care is needed, the consumer must request an increase, and DSHS will verify the need for increased care. DSHS will send the consumer notification of the decrease as stated in WAC 170-290-0025;

(3) DSHS may authorize up to the provider's private pay rate if:
(a) The parent is a WorkFirst participant; and
(b) Appropriate child care, at the state rate, is not available within a reasonable distance from the approved activity site.
"Appropriate" means licensed or certified child care under WAC 170-290-0125, or an approved in-home/relative provider under WAC 170-290-0130.
"Reasonable distance" is determined by comparing what other local families must travel to access appropriate child care.

(4) DSHS authorizes overtime care if:
(a) More than ten hours of care is provided per day (up to a maximum of sixteen hours a day); and
(b) The provider's written policy is to charge all families for these hours of care in excess of ten hours per day.

(5) In-home/relative providers who are paid child care subsidies to care for children receiving WCCC benefits cannot receive those benefits for their own children during the hours in which they provide subsidized child care.

Washington Administrative Code 170-290-0245 Registration fees, states:

(1) DSHS may pay licensed or certified child care providers and DEL contracted seasonal day camps a registration fee when:
(a) A child is first enrolled by the consumer for child care with a provider;
(b) A consumer enrolls their child with a new child care provider during their eligibility period; or
(c) A child has more than a sixty-day break in child care services with the same provider, and it is the provider's policy to charge all parents this fee when there is a break in service.

(2) A registration fee will be paid only once per calendar year for children who are cared for by the same provider, even if the provider receives subsidy payments under different subsidy programs during this time period for the enrolled children, unless there is a break of sixty days or more as provided in subsection (1)(c) of this section.

Washington Administrative Code 170-290-0247 Field trip/quality enhancement fees, states:

(1) DSHS pays licensed or certified family home child care providers a monthly field trip/quality enhancement fee up to thirty dollars per child or the provider's actual cost for the field trip, whichever is less, only if the fee is required of all parents whose children are in the provider's care. DEL-licensed or certified child care centers and school-age centers are not eligible to receive the field trip/quality enhancement fee.
(2) The field trip/quality enhancement fee is to cover the provider's actual expenses for:
    (a) Admission;
    (b) Enrichment programs and/or ongoing lessons;
    (c) Public transportation or mileage reimbursement at the state office of financial management rate for the use of a private vehicle;
    (d) The cost of hiring a nonemployee to provide an activity at the child care site in-house field trip activity; and
    (e) The purchase or development of a prekindergarten curriculum.
(3) The field trip/quality enhancement fee shall not cover fees or admission costs for adults on field trips, or food purchased on field trips.

2017-025 The Department of Early Learning did not have adequate internal controls over and did not comply with health and safety requirements for the Child Care and Development Fund program.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.575	Child Care and Development Block Grant
	93.596	Child Care Mandatory and Matching Funds of the Child Care and Development Fund
Federal Award Number:	G1701WACCDF; G1601WACCDF; G1501WACCDF	
Applicable Compliance Component:	Special Tests and Provisions – Health and Safety Requirements	
Known Questioned Cost Amount:	$1,855	

Background

The Department of Early Learning (DEL) administers the federal Child Care and Development Fund (CCDF) grant to assist eligible working families in paying for childcare. In fiscal year 2017, the Department paid about $190 million in federal funding to childcare providers. DEL is responsible for ensuring providers meet licensing standards, which includes ensuring background checks are performed for all staff with direct access to children.

The Department conducts unannounced, annual onsite inspections of licensed providers to verify if required health and safety standards are being met and requires providers to address any identified issues. Department licensors document inspections using a monitoring checklist. If a provider has no recent complaints or identified noncompliance, and has received a full checklist review in the past three years, an abbreviated checklist may be used. Otherwise, the licensor must use a full review checklist. When health and safety infractions are identified, licensors document them on a Facility Licensing Compliance Agreement (FLCA). The FLCA identifies the areas of provider non-compliance and establishes deadlines for correcting them. Providers must submit a corrective action plan or resolution activity to their licensor.

If an inspection was attempted but the provider was not present, the licensor must follow up and conduct the inspection within 30 days of the due date. If a follow-up inspection is not conducted, the licensor consults with their supervisor for a decision on conducting any further inspection attempts.

Common examples of noncompliance identified by licensors are:

- Providers that exceed the required staff-to-child ratios
- Providers that did not maintain accurate or complete attendance logs
- Providers missing training or certification requirements
- Health and safety hazards

When serious health and safety violations are identified, licensors must conduct an unannounced re-check of the facility within 10 business days. Less serious non-compliance issues must be addressed within 30 days. If the provider does not resolve a noncompliance issue, the Department may impose sanctions, issue fines, or suspend or revoke the provider's license.

The Department also must ensure that Family, Friends & Neighbors (FFNs) providers, which are exempt from licensing requirements, passed background checks upon becoming providers, and at least every two years or when there is a 30-day break in service in providing care.

In June 2017, the Department replaced its current system with a new electronic system (WA Compass) to allow licensing staff to make more timely updates and streamline their process for performing monitoring visits.

In prior audits, we reported the Department did not have adequate internal controls over and did not comply with health and safety requirements. This was reported as finding numbers 2016-022 and 2015-024.

Description of Condition

We found the Department did not have adequate internal controls to ensure providers met health and safety requirements.

In state fiscal year 2017, the Department regulated 4,771 licensed providers. Department staff informed us that 581 (12 percent) of all licensed providers were overdue on their yearly inspections (licensors had attempted visits at 156 of those providers).

We used a statistical sampling method and randomly selected and reviewed records for 59 licensed providers who received federal CCDF payments during state fiscal year 2017 to determine if inspections were conducted as required. We found:

- Three (5 percent) inspections were overdue and not conducted by June 30, 2017
- Nine (15 percent) inspections were performed late by up to 35 months

We reviewed the provider's prior visit history to determine if the licensor used the appropriate monitoring checklist. We found three instances (5 percent) when licensors did not use the full inspection checklist as required.

We examined the Department's response to serious violations documented during inspections and found in 20 instances (34 percent) there was not sufficient documentation to show follow-up was performed adequately or promptly for violations of health, safety or well-being of children. Some examples of these serious violations were:

- General health and safety hazards to the children
- Lack of background check documentation
- Inadequate supervision of children
- Exceeding the staff-to-child ratio

We also found circumstances that required a follow-up visit but for which licensors accepted and relied on provider attestations in their FLCA in place of the onsite inspections to resolve issues.

Additionally, during our testing of childcare subsidy payments to childcare providers, we randomly selected and examined 133 payments to determine if they were allowable. We reviewed attendance records to determine if they complied with health and safety requirements. We found:

- Thirty-six of 133 attendance records did not fully document absent days and parent/guardians' full signatures for sign in/out as applicable.
- Eighteen of 60 licensed homes' and FFN providers' attendance records (or lack thereof) did not support that the provider was at or under capacity (fewer than 12 children at one time for homes and six children for FFN's).

We used a statistical sampling method to randomly select 59 FFN providers to examine whether the Department performed background checks as required. We found two background checks were not performed before the provider became eligible and received payments.

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

Cause of Condition

The Department said it was unable to complete all licensing visits promptly for the following reasons:

- Transition to a new licensing management system
- Turnover of licensing staff
- New policies and procedures for licensing have been written but not implemented. This has caused inconsistent application and enforcement of policies
- Some providers refused the licensor access

Management did not effectively monitor to ensure licensors completed required monitoring and follow-up visits promptly.

Effect of Condition and Questioned Costs

When inspections are not conducted, or are conducted late, health and safety violations are less likely to be detected by the Department promptly, if at all.

Further, we found that two inspection records (3 percent) we reviewed identified noncompliance with a health or safety issue that had also been identified as noncompliant in the prior inspection. By not following up on violations promptly, the Department cannot be sure these issues have been corrected. Health and safety, supervision, background check and over-capacity/over-ratio violations might put children in jeopardy for harm, neglect, and unhealthy emotional and cognitive development environments.

The two providers who were determined to be eligible and received payments before their background checks were approved received $1,855 in improper payments with federal funds. Because a statistical

sampling method was used to select the providers examined, we estimate the amount of likely federal improper payments to be $256,349. Additionally, the providers were improperly paid $722 in state funds, and we estimate likely state funded improper payments of $99,691.

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a very high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3).

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

Recommendations

We recommend the Department:

- Ensure management follows policy and procedures to ensure all visits are performed on time and in compliance with regulations
- Ensure required policy changes are implemented promptly and that staff follow them
- Ensure staff sufficiently document the results of follow-up visits when serious violations are identified
- Ensure providers are not approved to provide care until all required background checks have been completed
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid.

Agency's Response

The Department of Early Learning (DEL) concurs with this finding, and is strongly committed to ensuring the health, safety and well-being of all children in licensed care.

As to the Auditor's specific recommendations, DEL concurs and offers the following detail:

- *In response to last year's audit, DEL continues to implement new monitoring and compliance agreement policies and procedures to clarify language for the use of a full checklist every three years and to clarify when a site visit is needed and what methods of compliance can be used. The Department will continue to train Licensing staff on these new policies and procedures.*
- *DEL has been working on revising all of our licensing policies, procedures, and tasks to ensure that they align with current state and federal rules and regulations. These policies, procedures and tasks will temporarily take the place of our current policies and procedures as we transition into the alignment of the new rules. DEL continues to work on the aligning Family Home and Child Care Center licensing rules in Washington Administrative Code (WAC). This alignment*

process is in response to the demands of the legislature and to the needs of the provider community.

- *DEL will also be weighting all licensing standards. This will create an objective enforcement system that connects licensing infractions with the level of risk to children. DEL will ensure that enforcement of these rules is both timely and consistent. DEL will also provide more information and clarity about the risk level of each standard and the consequences for violations.*
- *DEL will provide training to staff on both the new IT system and new weighted rules. Additionally, DEL will work to create a continuous training plan for licensing staff.*
- *DEL has implemented plans for blended caseloads statewide. The purpose of establishing a blended caseload approach is to maintain equitable caseloads at the state, regional and unit levels in order to ensure full compliance with federal and state requirements for monitoring and other licensing activities of child care providers and facilities. Our transition to the blended caseload is based on two expectations:*
    - *All licensors will be trained to monitor and license three childcare settings – family home, center, and school age*
    - *All licensors will be able to monitor and license three childcare settings – family home, center, and school age*
    -

  Caseloads may be blended as well as specialized and consist of Family Home providers, Centers/School-age providers and Combination of all three. Caseloads must be assigned to ensure equity by considering:
    - *National Association for Regulatory Administration's (NARA) recommended licensor to childcare provider ratios*
    - *Provider's capacity*
    - *Provider's diversity*
    - *Complaints' activities*
    - *Administrative and legal activities*
    - *Outreach activities*
    - *Training activities*
    - *Catchment area geography*
    -

  Training activities have been completed statewide and have focused on the following areas:
    - *Unit caseload profile*
    - *Core health & safety for all settings*
    - *Monitoring protocols for all settings*
    - *Field practice - shadowing*
    - *File Reviews*
    - *New standards - justifications*
    - *Admin and legal actions*

- *In April 2017, DEL replaced the current paper driven monitoring system with a new electronic system (WA COMPASS, built on the Salesforce platform). Currently, licensing staff have been trained with the new system and are currently transiting to WA Compass. In order to provide a more consistent sequential support to the licensors in their transition to WA COMPASS and be transparent about DEL expectations we establish Operational Milestones based on the IT*

Functionality Milestones, and include operational expectations to the weekly WA COMPASS update and other WA COMPASS communication venues. This has allowed Licensing staff to make timely updates, improve data integrity, streamline staff work processes, and provide electronic reminders to licensing staff and supervisors. The new system will result in time savings we will reinvest in the higher caseload and additional state and federal licensing requirements.

- *WA COMPASS will provide electronic tools for tracking the 10 day health and safety rechecks currently required by policy and for automatically converting from an abbreviated checklist to a full checklist when criteria is met.*

As to the Auditor's specific recommendation regarding consulting with the U.S. Department of Health and Human Services:

- *DEL consults with the U.S. Department of Health and Human Services whenever the agency receives an audit finding from SAO. This includes conducting a case by case review and providing any additional documentation requested when the audit finding results in questioned costs of federal funds.*
- *In addition to reviewing audit findings, DEL has worked collaboratively with the Office of Child Care (OCC) over the past year to review the child care rules and procedures to ensure we are supporting the expectations under the Child Care Development Fund (CCDF).*

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).

(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

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

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

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

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

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

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

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

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

45 Code of Federal Regulation section 98.40 Compliance with applicable State and local regulatory requirements, states:

(a) Lead Agencies shall:
  (1) Certify that they have in effect licensing requirements applicable to child care services provided within the area served by the Lead Agency;
  (2) Provide a detailed description of the requirements under paragraph (a)(1) of this section and of how they are effectively enforced.

(b) (1) This section does not prohibit a Lead Agency from imposing more stringent standards and licensing or regulatory requirements on child care providers of services for which assistance is provided under the CCDF than the standards or requirements imposed on other child care providers.
  (2) Any such additional requirements shall be consistent with the safeguards for parental choice in § 98.30(f).

45 Code of Federal Regulation section 98.41 Health and safety requirements, states:

(a) Although the Act specifically states it does not require the establishment of any new or additional requirements if existing requirements comply with the requirements of the statute, each Lead Agency shall certify that there are in effect, within the State (or other area served by the Lead Agency), under State, local or tribal law, requirements designed to protect the health and safety of children that are applicable to child care providers of services for which assistance is provided under this part. Such requirements shall include:
  (1) The prevention and control of infectious diseases (including immunizations). With respect to immunizations, the following provisions apply:
    (i) As part of their health and safety provisions in this area, States and Territories shall assure that children receiving services under the CCDF are age-appropriately immunized. Those health and safety provisions shall incorporate (by reference or otherwise) the latest recommendation for childhood immunizations of the respective State or territorial public health agency.
    (ii) Notwithstanding paragraph (a)(1)(i) of this section, Lead Agencies may exempt:
      (A) Children who are cared for by relatives (defined as grandparents, great grandparents, siblings (if living in a separate residence), aunts, and uncles);

(B) Children who receive care in their own homes;
(C) Children whose parents object to immunization on religious grounds; and
(D) Children whose medical condition contraindicates immunization;
(iii) Lead Agencies shall establish a grace period in which children can receive services while families are taking the necessary actions to comply with the immunization requirements; (2) Building and physical premises safety; and

(3) Minimum health and safety training appropriate to the provider setting.

(b) Lead Agencies may not set health and safety standards and requirements under paragraph (a) of this section that are inconsistent with the parental choice safeguards in § 98.30(f).

(c) The requirements in paragraph (a) of this section shall apply to all providers of child care services for which assistance is provided under this part, within the area served by the Lead Agency, except the relatives specified in paragraph (e) of this section.

(d) Each Lead Agency shall certify that procedures are in effect to ensure that child care providers of services for which assistance is provided under this part, within the area served by the Lead Agency, comply with all applicable State, local, or tribal health and safety requirements described in paragraph (a) of this section.

(e) For the purposes of this section, the term "child care providers" does not include grandparents, great grandparents, siblings (if such providers live in a separate residence), aunts, or uncles, pursuant to § 98.2.

Washington Administrative Code 170-290-0143 In-home/relative providers—Background checks—Required persons, states:

(1) A background check must be completed for:
(a) All in-home/relative providers who apply to care for a WCCC consumer's child; and
(b) Any individual sixteen years of age or older who is residing with a provider when the provider cares for the child in the provider's own home where the child does not reside.

(2) A background check must be completed for individuals listed in subsection (1)(a) and (b) of this section at least every two years.

(3) Additional background checks must be completed for individuals listed in subsection (1)(a) and (b) of this section when:
(a) Any individual sixteen years of age or older is newly residing with a provider when the provider cares for the child in the provider's own home where the child does not reside;
(b) DSHS has a valid reason to check more frequently;
(c) An in-home/relative provider applies to provide care for a family, such as when:
(i) A thirty day break in service occurs to the current consumer;
(ii) There is a thirty day break in consumer eligibility; or
(iii) A provider is currently providing care and there are no prior background results for this provider.

(4) DSHS does not need to request a new background check for an individual in subsection (1)(a) or (b) if:
(a) DSHS has results that were received no more than ninety days prior to the current requested start date of care; and
(b) The results indicate there is no record.

Washington Administrative Code 170-295-0030 Eligibility to receive state child care subsidies, states:

> To be eligible to receive state child care subsidies for children in their care, individuals, entities and agencies must:
> (1) Be licensed or certified;
> (2) Be a seasonal camp that has a contract with DEL and is certified by the American Camping Association;
> (3) Follow billing policies and procedure in *Child Care Subsidies: A Booklet for Licensed and Certified Child Care Providers*, revised 2012;
> (4) Bill at the individual's, entity's, or agency's customary rate or the state rate, whichever is less; and
> (5) Keep attendance records as described in WAC 170-295-7030 and invoices for state-paid children on-site for at least five years as provided in WAC 170-295-7031.

Washington Administrative Code 170-295-7030 Attendance records, states:

> Licensees must keep daily attendance records.
> (1) The parent or other person authorized by the parent to take the child to or from the center must:
> (a) Sign in the child on arrival and sign out the child at departure, using their full signature and writing the time of arrival and departure; or
> (b) Record the child's attendance using an electronic system if used by the licensee under WAC 170-295-7032;
> (2) When the child leaves the center to attend school or participate in offsite activities as authorized by the parent, the licensee or staff must sign out the child, and sign in the child on return to the center; and
> (3) Paper and electronic attendance records and invoices for state subsidized children must be kept on the premises for at least five years after the child leaves the licensee's care as provided in WAC 170-295-7031.

Washington Administrative Code 170-296A-1050 The licensee, states in part:

> (1) The licensee is the individual or individuals:
> (c) Licensed by the department to provide child care and early learning services for not more than twelve children in the licensee's home in the family living quarters;

Washington Administrative Code 170-296A-1075 Child care subsidy, states:

> A licensee who receives child care subsidy payments must follow the requirements of the applicable subsidy program. A licensee who receives subsidy payments under the working connections child care or seasonal child care programs must follow the requirements of chapter 170-290 WAC.

Washington Administrative Code 170-296A-1410, Department inspection, states:

(1) Prior to the department issuing a license, a department licensor must inspect the proposed indoor and outdoor spaces to be used for child care to verify compliance with the requirements of this chapter.
(2) The licensee must grant reasonable access to the department licensor during the licensee's hours of operation for the purpose of announced or unannounced monitoring visits to inspect the indoor or outdoor licensed space to verify compliance with the requirements of this chapter.

Washington Administrative Code 170-296A-8000 Facility licensing compliance agreements, states:

At the department's discretion, when a licensee is in violation of this chapter or chapter 43.215 RCW, a facility licensing compliance agreement may be issued in lieu of the department taking enforcement action.
(1) The facility licensing compliance agreement contains:
  (a) A description of the violation and the rule or law that was violated;
  (b) A statement from the licensee regarding the proposed plan to comply with the rule or law;
  (c) The date the violation must be corrected;
  (d) Information regarding other licensing action that may be imposed if compliance does not occur by the required date; and
  (e) Signature of the licensor and licensee.
(2) The licensee must return a copy of the completed facility license compliance agreement to the department by the date indicated when corrective action has been completed.
(3) The licensee may request a supervisory review regarding the violation of rules or laws identified on the facility license compliance agreement.
(4) A facility license compliance agreement is not subject to appeal under chapter 170-03 WAC.

Washington Administrative Code 170-296A-8025, Time period for correcting a violation, states:

The length of time the licensee has to make the corrections depends on:
(1) The seriousness of the violation;
(2) The potential threat to the health, safety and well-being of the children in care; and
(3) The number of times the licensee has violated rules in this chapter or requirements under chapter 43.215 RCW.

Washington Administrative Code 170-296A-8175 Violations—Enforcement action, states:

The department may deny, suspend, revoke, or not continue a license when:
(1) The licensee is unable to provide the required care for the children in a way that promotes their health, safety and well-being;
(2) The licensee is disqualified under chapter 170-06 WAC (DEL background check rules);
(3) The licensee or household member has been found to have committed child abuse or child neglect;

(4) The licensee has been found to allow staff or household members to commit child abuse or child neglect;
(5) The licensee has a current charge or conviction for a disqualifying crime under WAC 170-06-0120;
(6) There is an allegation of child abuse or neglect against the licensee, staff, or household member;
(7) The licensee fails to report to DSHS children's administration intake or law enforcement any instances of alleged child abuse or child neglect;
(8) The licensee tries to obtain or keep a license by deceitful means, such as making false statements or leaving out important information on the application;
(9) The licensee commits, permits or assists in an illegal act at the child care premises;
(10) The licensee uses illegal drugs or alcohol in excess, or abuses prescription drugs;
(11) The licensee knowingly allowed a staff or household member to make false statements on employment or background check application related to their suitability or competence to provide care;
(12) The licensee fails to provide the required level of supervision for the children in care;
(13) The licensee cares for more children than the maximum number stated on the license;
(14) The licensee refuses to allow department authorized staff access during child care operating hours to:
(a) Requested information;
(b) The licensed space;
(c) Child, staff, or program files; or
(d) Staff or children in care.
(15) The licensee is unable to manage the property, fiscal responsibilities or staff in the facility;
(16) The licensee cares for children outside the ages stated on the license;
(17) A staff person or a household member residing in the licensed home is disqualified under chapter 170-06 WAC (DEL background check rules);
(18) The licensee, staff person, or household member residing in the licensed home has a current charge or conviction for a crime described in WAC 170-06-0120;
(19) A household member residing in the licensed home had a license to care for children or vulnerable adults denied or revoked;
(20) The licensee does not provide the required number of qualified staff to care for the children in attendance; or
(21) The department is in receipt of information that the licensee has failed to comply with any requirement described in WAC 170-296A-1420.

Washington Administrative Code 170-297-1410, Department inspection, states:

(1) Prior to the department issuing a license, a department licensor must inspect the proposed indoor and outdoor spaces to be used for child care to verify compliance with the requirements of this chapter.
(2) Access must be granted to the department licensor during the child care hours of operation for the purpose of announced or unannounced monitoring visits to inspect the indoor or outdoor licensed space to verify compliance with the requirements of this chapter.

Washington Administrative Code 170-297-8000 Facility licensing compliance agreements, states:

At the department's discretion, when a licensee is in violation of this chapter or chapter 43.215 RCW, a facility licensing compliance agreement may be issued in lieu of the department taking enforcement action.

(1) The facility licensing compliance agreement contains:
   (a) A description of the violation and the rule or law that was violated;
   (b) A statement from the licensee regarding the proposed plan to comply with the rule or law;
   (c) The date the violation must be corrected;
   (d) Information regarding other licensing action that may be imposed if compliance does not occur by the required date; and
   (e) Signature of the licensor and licensee.
(2) The licensee must return a copy of the completed facility license compliance agreement to the department by the date indicated when corrective action has been completed.
(3) The licensee may request a supervisory review regarding the violation of rules or laws identified on the facility license compliance agreement.
(4) A facility license compliance agreement is not subject to appeal under chapter 170-03 WAC.

Washington Administrative Code 170-297-8025, Time period for correcting a violation, states:

The length of time the program has to make the corrections depends on:

(1) The seriousness of the violation;
(2) The potential threat to the health, safety and well-being of the children in care; and
(3) The number of times the program has violated rules in this chapter or requirements under chapter 43.215 RCW.

Washington Administrative Code 170-297-8175 Violations—Enforcement action, states:

The department may deny, suspend, revoke, or not continue a license when:

(1) The licensee or program staff are unable to provide the required care for the children in a way that promotes their health, safety and well-being;
(2) The licensee or program staff person is disqualified under chapter 170-06 WAC (DEL background check rules);
(3) The licensee or program staff person has been found to have committed child abuse or child neglect;
(4) The licensee has been found to allow program staff or volunteers to commit child abuse or child neglect;
(5) The licensee or program staff person has a current charge or conviction for a disqualifying crime under WAC 170-06-0120;
(6) There is an allegation of child abuse or neglect against the licensee, staff, or volunteer;
(7) The licensee or program staff person fails to report to DSHS children's administration intake or law enforcement any instances of alleged child abuse or child neglect;
(8) The licensee tries to obtain or keep a license by deceitful means, such as making false statements or leaving out important information on the application;

(9) The licensee or a program staff person commits, permits or assists in an illegal act at the child care premises;
(10) The licensee or a program staff person uses illegal drugs or alcohol in excess, or abuses prescription drugs;
(11) The licensee knowingly allowed a program staff person or volunteer to make false statements on employment or background check application related to their suitability or competence to provide care;
(12) The licensee does not provide the required number of qualified program staff to care for the children in attendance;
(13) The licensee or program staff fails to provide the required level of supervision for the children in care;
(14) When there are more children than the maximum number stated on the license at any one time;
(15) The licensee or program staff refuses to allow department authorized staff access during child care operating hours to:
(a) Requested information;
(b) The licensed space;
(c) Child, staff, or program files; or
(d) Staff or children in care;
(16) The licensee is unable to manage the property, fiscal responsibilities or staff in the facility; or
(17) The licensee or program staff cares for children outside the ages stated on the license.

The Department of Early Learning Child Care Licensing Policies and Procedures, 10.1.8 Monitoring Visits Procedure, states in part:

2. A full checklist (10.9.3.5 Family Home Checklist, 10.9.4.6 Child Care Center Checklist, or 10.9.4.11 SA Checklist) must be used at least once every 3 years effective January 1, 2016. When the file is up for the three year review this must be verified and/or completed.
5. Monitoring visits must be unannounced, unless approved by a supervisor. If children are not in care, the monitoring visit can be conducted with the expectation that the licensor will return within 30 days to observe the program with children present. If children are not in care during the follow-up visit, the licensor must consult with their supervisor for a decision on conducting further visits.
6. If the licensee is temporarily closed a visit must not be conducted. This visit must be documented as "Attempted" in the provider notes.
7. Attempted visits must be followed up and conducted within 30 calendar days. If a follow-up visit cannot be conducted, the licensor must consult with their supervisor for a decision on conducting any further visits.
8. A family home child care, child care center and school age program monitor visit must occur every 12 months – within 90 days prior to the yearly due date. The Monitoring Visit is considered late if it occurs after the yearly due dates. For example, if the last visit occurred on January 1, 2008, the next monitoring visit must occur within 90 days of January 1, 2009.
11. The licensor and licensee or child care staff will complete a compliance agreement to address any violation of WAC or RCW. See "10.1.3 Compliance Agreement" procedure.

The Department of Early Learning Child Care Licensing Policies and Procedures, 10.1.3 Compliance Agreement Procedure, states in part:

Completing the Facility Licensing Compliance Agreement

1. The licensor must use 10.9.1.1 Compliance Agreement form in ELF to record noncompliance issues. If the technology equipment is not working, then the licensor will use the hardcopy 10.9.1.1 Compliance Agreement form.
8. If there is an immediate health and safety issue, the noncompliance issue will be corrected immediately or as soon as possible. Verification of compliance should be completed within 10 business days and follow the process under Compliance Agreement Follow-up section below.

Compliance Agreement Follow-up

1. The licensor must monitor the completion of the compliance agreement.
2. The licensor must verify within 10 business days the correction of licensing noncompliance issues that could impact the health, safety and well-being of children in care. The verification must be documented in FamLink using the health and safety recheck code. Allowable verification is as follows:
    a. Health and Safety recheck – An on-site visit is required if the noncompliance issue is a serious health and safety violation which may include but is not limited to:
        i. Health and safety hazards
        ii. Behavior management
        iii. Supervision
        iv. Staff/child interaction
        v. Group size/capacity
        vi. Medication management
        vii. Safe Sleep
        viii. Window blind cords that form a loop
    b. Acceptable use of photographic or email verification may include but is not limited to:
        i. Environmental changes
        ii. Indoor/outdoor equipment
3. The licensor must request supervisor approval if they are unable to meet the 10 business day requirement. The supervisor must approve or deny the request and document the decision in FamLink provider notes.
4. If the noncompliance issues do not immediately impact the health, safety, and well-being of children in care, written verification in lieu of a site visit may be used to verify correction of noncompliance. Examples may include but are not limited to:
    a. Menu posting
    b. Documentation of activity program
    c. Supplies verified with receipt
    d. Changes to parent communication
    e. Staff development and training records
    f. Attendance logs
    g. Health Care Plan
    h. Fire Drill record

2017-026 The Department of Social and Health Services did not have adequate internal controls over and did not comply with client eligibility requirements for the Child Care Development Fund.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.575	Child Care and Development Block Grant
	93.596	Child Care Mandatory and Matching Funds of the Child Care and Development Fund
Federal Award Number:	G1701WACCDF; G1601WACCDF; G1501WACCDF	
Applicable Compliance Component:	Eligibility	
Known Questioned Cost Amount:	$7,386	

Background

The Department of Early Learning (DEL) administers the federal Child Care and Development grant (CCDF) to assist eligible working families in paying for childcare. The Department of Social and Health Services (DSHS) determines client eligibility and pays childcare providers under an agreement with DEL. In fiscal year 2017, the Departments paid childcare providers about $190 million in federal grant funds.

For a family to be eligible for childcare assistance, state and federal rules require that children:

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

State rules also describe the information that clients must provide to DSHS to verify their eligibility. DSHS must complete client eligibility determinations within 30 days or the application process must start over. The information must be accurate, complete, consistent and from a reliable source. This information includes, but is not limited to, employer and hourly wage information, wage data and family household size and composition.

Once determined to be eligible for the program, a client is eligible for one year unless a change in income causes the client to exceed 85 percent of the state's median income. The Department requires that clients self-report such income changes. If the client's new income exceeds this cutoff level, DSHS must determine if the client exceeded the threshold only temporarily or should be denied services.

DSHS has direct access to systems that contain wage and household benefit and composition data for some, but not all, childcare recipients. DSHS uses this information in part to determine program eligibility, benefit level including client copayment and the amount of child care the family is eligible

to receive. If an ineligible client receives assistance, the payment made to the childcare provider is not allowable by federal regulations.

In the past five annual single audits for Washington, we reported in findings that DSHS did not establish adequate internal controls over the eligibility process for childcare subsidy recipients. The two most recent also reported they were materially non-compliant with federal requirements. These were reported as finding numbers 2016-023, 2015-026, 2014-026, 2013-017 and 12-30.

Description of Condition

DSHS did not establish adequate internal controls to ensure it correctly determined and documented that clients were eligible before paying childcare providers.

Improper eligibility determinations

During the audit period, 39,161 clients younger than 13 were determined to be eligible for childcare. We used a statistical sampling method to randomly select and examine 59 of these determinations. In 17 instances, we found DSHS made eligibility determinations improperly, did not obtain required documentation or did not verify information before authorizing services.

Specifically, we found:

- 12 cases (20 percent) where benefit levels were improperly calculated
- Two cases (3 percent) that did not meet initial eligibility requirements, including age, citizenship, employment and income
- Three cases (5 percent) that did not meet initial eligibility requirements and benefits were improperly calculated

Inadequate supervisory reviews

In most of the cases, a DSHS caseworker processes client eligibility information and authorizes services without a secondary review or approval. For authorizations requiring more than standard full-time care, DSHS policy requires staff to use a special authorization code. The code does not become active until a supervisor has reviewed and approved the request. We found one authorization that was reviewed by a supervisor, but the total benefit level was approved for more than the maximum allowable daily amount.

Verification of state median income level

The Department did not monitor to identify if a family exceeded 85 percent of the state's median income level during its year of eligibility. DSHS instead relied solely on clients to self-report if their income exceeded the maximum allowable amount. Because DSHS did not monitor this requirement, it did not collect any wage information from any clients during the twelve-month eligibility period beyond what was collected at initial application.

To determine if any clients exceeded the limit, we reviewed wage information DSHS had access to. For seven of the 59 clients (12 percent), data was not available for us to make this determination. The other clients appeared to have stayed under the maximum income limit. However, because the data we reviewed was not comprehensive, we cannot ensure no client exceeded the limit.

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

Cause of Condition

DSHS staff made eligibility determinations without requiring sufficient supporting documentation to ensure the client was eligible, such as three months of wage information. While DSHS had policies and procedures, they are not detailed enough to ensure staff document in a consistent manner. Additionally, management did not ensure staff consistently followed the procedures that were in place.

Further, DSHS's eligibility system alerts staff when an issue is outstanding and needs to be addressed, but the alerts can be dismissed without confirming the issues were addressed.

In addition, DSHS' review of eligibility determinations was not effective to prevent clients from being improperly approved.

Effect of Condition and Questioned Costs

Because it does not have adequate internal controls in place, DSHS is at a higher risk of paying providers for childcare services when clients are ineligible.

The 17 client eligibility determinations with errors resulted in $7,386 of federal overpayments to providers. Of this amount, $1,697 was paid to clients who had an inaccurate co-pay assessed, $590 was paid for a client who was authorized for more than the daily amount, and the remaining $5,099 was paid to clients from whom DSHS did not collect the required documentation to determine their eligibility. We used a statistical sampling method to randomly select the payments examined in the audit. We estimate the amount of likely federal improper payments to be $4,902,586.

Further, many of the improper payments were partially funded by state dollars. Specifically, we found $2,544 of improper state payments, which projects to a likely improper payment amount of $1,688,675. This amount is not included in the federal questioned costs.

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

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures were in compliance with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. This conclusion is reflected in our audit report and finding. However, the likely

questioned costs projections are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3).

Recommendations

We recommend DSHS improve its internal controls over determining eligibility to ensure:

- Authorizations for childcare are adequately supported with verified documentation
- Eligibility determinations are reviewed sufficiently to detect improper eligibility determinations
- Employees review client eligibility documents and compare those documents with source data available to DSHS staff

We also recommend the Department consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid.

Agency's Response

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

The Department partially concurs with the overall finding of the State Auditor's Office.

In response to DSHS 2016-028 CCDF Eligibility Finding, the Department enacted or is in the process of enacting major changes to improve our internal controls over determining eligibility. However, as noted in our response to the 2016 finding, because we were already three quarters of the way through SFY17 when we received the finding, we acknowledged that we were likely to see similar (repeat) findings in this audit period. We likely won't see the full benefit of our corrective actions until the SFY18 audit (which will span the period of July 1, 2017 – June 30, 2018).

To appropriately and effectively initiate and implement these substantial changes, while minimizing impact to our clients, the Department will seek 25 additional full-time employees and necessary resources to staff the business-process redesign and support the information technology initiatives necessary to improve our internal controls.

***SAO Description of Weakness: Improper Eligibility Determinations** – DSHS made improper eligibility determinations, did not obtain required documentation or did not verify information before authorizing services.*

Of the 17 exceptions cited, the Department concurs that we did not fully comply with eligibility requirements. Within these 17 exceptions, our further review indicates:

- *Eight exceptions were the result of minor procedural errors that had no effect on the eligibility of the cases and the associated payments.*

- *Seven exceptions were the result of benefit calculation errors that had no effect on eligibility – ,either the copayment or the amount of care authorized was incorrect, resulting in a partial payment error.*
- *Two exceptions were the result of clients fraudulently (inaccurately) reporting household composition at the time of application. DSHS appropriately requested that fraud investigators verify household composition. Investigators determined the client reported their household composition fraudulently – stating the father was NOT in the home when he actually was. The Department closed the cases and established overpayments.*

For the nine exceptions (seven due to benefit calculation errors, two due to clients fraudulently reporting their household composition) that we agree resulted in a payment error, we will establish the overpayment where appropriate and refer it to the Office of Financial Recovery for collection.

The Department is collaborating with the Department of Early Learning (DEL) to update policies and procedures, and make system enhancements to correct weaknesses in the following areas, which account for 15 of the 17 exceptions cited:

Wage Verification

In ten cases, the SAO found that DSHS staff made eligibility determinations without requiring sufficient supporting documentation to ensure the client was eligible - specifically, requiring the client to provide three months of wage information.

Jointly, DEL and DSHS analyzed the CCDF state plan and program rules to ensure they were aligned with federal guidance, and made changes where needed. Effective December 12, 2017, DSHS and DEL revised the associated WAC 170-290-0012, 170-290-0050, 170-290-0065 to allow more flexibility when calculating and verifying household income by removing the requirement that clients provide three months of wage information.

WAC 170-290-0190 was also revised to standardize authorization amounts for all families, including those with parents participating in approved activities full-time and part-time, for traditional, non-traditional, and variable working schedules, and for school-age and non-school-age children, across all provider types.

Single Parent Household Composition Verification

In five cases, the SAO found the client's household composition questionable, which possibly resulted in incorrect eligibility determinations, and in some instances, client overpayments.

As part of the Fiscal Year 2016 Statewide Single Audit Corrective Action Plan, DSHS made IT changes that allow eligibility staff to identify discrepancies between the household composition a family reports when applying for CCSP and the household composition they report to other programs within DSHS.

Effective March 1, 2018, new rules will require a consumer to attest under penalty of perjury their single parent status. Additionally, as a condition of eligibility, clients will be required to supply third party verification when household composition cannot be verified by reviewing DSHS records and systems.

SAO Description of Weakness: Verification of State Median Income (SMI) Level *- The Department did not monitor to identify if a family exceeded 85 percent of the state's median income level during its year of eligibility.*

The Department does not concur with this finding. DEL is planning to adopt rules regarding temporary increases that will be in alignment with Federal rule. Federal rule regarding irregular fluctuations in earnings (see page 10-11 of 45 CFR Part 98, RIN 0970-AC6 Child Care and Development Fund), states that temporary increases in income should not affect eligibility or family co-payments, including monthly income fluctuations that show temporary increases, which if considered in isolation, may incorrectly indicate that a family is above the federal threshold of 85 percent of SMI, when in actuality their annual income remains at or below 85 percent of SMI. To account for irregular fluctuations in earnings, monitoring activities would need to be a look-back at a full year of client income data. However, federal rule discourages this. Page 129 of 45 CFR Part 98 reads in part:

"Some Lead Agencies currently use "look back" and recoupment policies as part of eligibility re-determinations. These review a family's eligibility for the prior eligibility period to see if the family was ineligible during any portion of that time and recoup benefits for any period where the family had been ineligible. However, there is no Federal requirement for Lead Agencies to recoup CCDF overpayments, except in instances of fraud. We strongly discourage such policies as they may impose a financial burden on low-income families that is counter to CCDF's long-term goal of promoting family economic stability. The Act affirmatively states an eligible child will be considered to meet all eligibility requirements for a minimum of 12 months regardless of increases in income (as long as income remains at or below 85 percent of SMI) or temporary changes in parental employment or participation in education and training. Therefore, there are very limited circumstances in which a child would not be considered eligible after an initial eligibility determination. We encourage Lead Agencies instead to focus program integrity efforts on the largest areas of risk to the program, which tend to be intentional violations and fraud involving multiple parties."

SAO Description of Weakness: Inadequate Supervisory Review *– In most cases, a DSHS caseworker processes client eligibility information and authorizes services without secondary review or approval. For authorizations requiring more than standard full-time care, DSHS policy requires staff to use a special authorization code. The code does not become active until a supervisor has reviewed and approves the request. We found one authorization that was reviewed but approved for more than the allowable daily amount.*

The Department partially concurs with this finding. Child care program policy, as established and maintained by DEL, does not require secondary review or approval when determining eligibility and authorizing benefits and payment. However, DSHS continues to employ the following internal controls to ensure child care subsidy payment authorizations are made correctly:

- *A supervisory review is required for payment requests that exceed certain parameters. The supervisor reviews the need for the additional payment and either approves the payment by submitting the authorization to the Social Service Payment System (SSPS) or denies the payment if the consumer is not eligible. In July 2017, DSHS added a monthly report to check for any situations where it appeared that an authorization may have been approved without the required approval; while this report has been helpful in quality management efforts it has*

confirmed that most cases are being handled appropriately. Additionally, CSD auditing staff audit the exceptional payments approved by supervisors to ensure proper payment.

- *For authorizations for high cost special needs rates, a panel of DSHS and DEL staff review the request and supporting documentation, in addition to supervisory review before payment is made.*
- *New employees have 100 percent of their work audited by lead workers until they achieve proficiency; these reviews may be conducted either pre or post-authorization.*

In response to the DSHS 2016-028 CCDF Eligibility finding, the Department:

- *Has implemented actions to ensure authorizations for child care are adequately supported with verified documentation based on DEL policy and procedures and the CCDF State Plan.*
- *Has delivered systems navigation training for child care staff on the use of ACES, SEMS, and eJAS to confirm household composition and other eligibility criteria.*
- *Will implement, in spring of 2018, a lead (and where appropriate, supervisory) review of eligibility decisions and authorizations made from cases that were not randomly assigned.*
- *Will implement, in February 2018, a child care process review panel (PRP), based on the highly-successful and established model that produces an average 99% federal SNAP accuracy rate, that will introduce the same rigor and attention to eligibility determinations for child care subsidies. The Division of Program Integrity child care quality team will review cases selected based on statistically valid methodology, verify case circumstances and arrive at quality control determinations about whether each sampled case has been correctly determined in accordance with state policy and procedure. The results of this case-error review system will be used to inform programmatic, process, systems and policy-level continuous improvement prioritization and implementation. It will also clarify where there are types of cases where the risk of error is high and inform decisions about pre-authorization reviews.*

Auditor's Concluding Remarks

We thank the Department for its cooperation and assistance throughout the audit. We are pleased that the Department concurred with the majority of the finding and committed to enacting major changes over internal controls.

We would, however, like to address two areas of concern within the Department's response. The first is related to wage verification. The Department stated "*In ten cases, the SAO found that DSHS staff made eligibility determinations without requiring sufficient supporting documentation to ensure the client was eligible - specifically, requiring the client to provide three months of wage information."* One of the Department's proposed actions was to remove the requirement for workers to obtain three months wage information from the client. In this finding, we did not question any costs solely because the Department did not collect enough support for the wage verifications. We only questioned costs if the Department determined a client eligible for an improper amount because the information they gathered was insufficient and incorrect when compared to actual wage data. Of the ten cases cited, six led to improper payments totaling $5,117 in federal dollars, which projects to $3.4 million. By reducing the need for documented support when determining eligibility, the Department may decrease the likelihood it will detect improper payments.

Our second concern is regarding the Department not monitoring to identify if a family exceeded 85 percent of the State's median income level during its year of eligibility. The Department asserts this is not required and cites federal regulations as support. We conveyed to the Department that we agree detecting irregular fluctuations in earnings is not the requirement. It is, however, required that they have internal controls to detect more permanent changes in income level. Within the quote of federal regulation the Department included in its response, the federal grantor specifically references this requirement. "*The Act affirmatively states an eligible child will be considered to meet all eligibility requirements for a minimum of 12 months regardless of increases in income* ***(as long as income remains at or below 85 percent of SMI)*** *or temporary changes in parental employment or participation in education and training."* The Department has not implemented sufficient internal controls over, and did not monitor compliance for, this requirement. We reaffirm our finding.

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).

(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

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

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

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

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

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

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

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

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

45 Code of Federal Regulation 98.20 A child's eligibility for child care services, states:

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

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

(e) The Lead Agency shall specify in the Plan any requirements for parents to notify the Lead Agency of changes in circumstances during the minimum 12-month eligibility period, and describe efforts to ensure such requirements do not place an undue burden on eligible families that could impact continued eligibility between redeterminations.
  (1) The Lead Agency must require families to report a change at any point during the minimum 12-month period, limited to:
    (i) If the family's income exceeds 85% of SMI, taking into account irregular income fluctuations; or
    (ii) At the option of the Lead Agency, the family has experienced a non-temporary cessation of work, training, or education.
  (2) Any additional requirements the Lead Agency chooses, at its option, to impose on parents to provide notification of changes in circumstances to the Lead Agency or entities designated to perform eligibility functions shall not constitute an undue burden on families. Any such requirements shall:
    (i) Limit notification requirements to items that impact a family's eligibility (e.g., only if income exceeds 85 percent of SMI, or there is a non-temporary change in the status of the child's parent as working or attending a job training or educational

program) or those that enable the Lead Agency to contact the family or pay providers;

(ii) Not require an office visit in order to fulfill notification requirements; and

(iii)Offer a range of notification options (e.g., phone, email, online forms, extended submission hours) to accommodate the needs of parents;

(3) During a period of graduated phase-out, the Lead Agency may require additional reporting on changes in family income in order to gradually adjust family co-payments, if desired, as described in paragraph (b)(3) of this section.

(4) Lead Agencies must allow families the option to voluntarily report changes on an ongoing basis.

(i) Lead Agencies are required to act on this information provided by the family if it would reduce the family's co-payment or increase the family's subsidy.

(ii) Lead Agencies are prohibited from acting on information that would reduce the family's subsidy unless the information provided indicates the family's income exceeds 85 percent of SMI for a family of the same size, taking into account irregular income fluctuations, or, at the option of the Lead Agency, the family has experienced a non-temporary change in the work, training, or educational status.

Washington Administrative Code 170-290-0005 Eligibility, states:

(1) At application and reapplication, to be eligible for WCCC, the applicant or reapplicant must:

(a) Have parental control of one or more eligible children;

(b) Live in the state of Washington;

(c) Be the child's:

(i) Parent, either biological or adopted;

(ii) Stepparent;

(iii) Legal guardian verified by a legal or court document;

(iv) Adult sibling or step-sibling;

(v) Nephew or niece;

(vi) Aunt;

(vii) Uncle;

(viii) Grandparent;

(ix) Any of the relatives in (c)(vi), (vii), or (viii) of this subsection with the prefix "great," such as great-aunt; or

(x) An approved in loco parentis custodian responsible for exercising day-to-day care and control of the child and who is not related to the child as described above;

(d) Participate in an approved activity under WAC 170-290-0040, 170-290-0045, 170-290-0050, or have been approved per WAC 170-290-0055;

(e) Comply with any special circumstances that might affect WCCC eligibility under WAC 170-290-0020;

(f) Have countable income at or below two hundred percent of the federal poverty guidelines (FPG). The consumer's eligibility shall end if the consumer's countable income is greater than eighty-five percent of the state median income or if resources exceed one million dollars;

(g) Complete the WCCC application and DSHS verification process regardless of other program benefits or services received; and
(h) Meet eligibility requirements for WCCC described in Part II of this chapter.

(2) Children. To be eligible for WCCC, the child must:
(a) Belong to one of the following groups as defined in WAC 388-424-0001:
(i) A U.S. citizen;
(ii) A U.S. national;
(iii) A qualified alien; or
(iv) A nonqualified alien who meets the Washington state residency requirements as listed in WAC 388-468-0005;
(b) Live in Washington state, and be:
(i) Less than thirteen years of age; or
(ii) Less than nineteen years of age, and:
(A) Have a verified special need, according WAC 170-290-0220; or
(B) Be under court supervision.

Washington Administrative Code 170-290-0012 Verifying consumers' information, states in part:

(1) A consumer must provide all required information to DSHS to determine eligibility when the consumer initially applies or reapplies for benefits.
(2) All verification that is provided to DSHS must:
(a) Clearly relate to the information DSHS is requesting;
(b) Be from a reliable source; and
(c) Be accurate, complete, and consistent.
(3) If DSHS has reasonable cause to believe that the information is inconsistent, conflicting or outdated, DSHS may:
(a) Ask the consumer to provide DSHS with more verification or provide a collateral contact (a "collateral contact" is a statement from someone outside of the consumer's residence that knows the consumer's situation); or
(b) Send an investigator from the DSHS office of fraud and accountability (OFA) to make an unannounced visit to the consumer's home to verify the consumer's circumstances. See WAC 170-290-0025(9).
(4) The verification that the consumer gives to DSHS includes, but is not limited to, the following:
(a) A current WorkFirst individual responsibility plan (IRP) for consumers receiving TANF;
(b) Employer name, address, and phone number;
(c) State business registration and license, if self- employed;
(d) Hourly wage or salary;
(e) Either the:
(i) Gross income for the last three months;
(ii) Self-attestation of anticipated wages for new employment and third-party verification of the wages within sixty days of the date DSHS approved the consumer's application or reapplication for WCCC benefits;
(iii) Federal income tax return for the preceding calendar year; or
(iv) DSHS employment verification form;

(f) Monthly unearned income the household receives, such as supplemental security income (SSI) benefits or child support. Child support payment amounts are verified as follows:
  (i) For applicants or consumers who are not receiving DSHS division of child support services, the amount as shown on a current court or administrative order;
  (ii) For applicants or consumers who are receiving DSHS division of child support services, the amount as verified by the DSHS division of child support;
  (iii) For applicants or consumers who have an informal verbal or written child support agreement, the amount as verified by the written agreement signed by the noncustodial parent (NCP);
  (iv) For applicants or consumers who cannot provide a written agreement signed by the NCP, the amount received for child support verified by a written statement from the consumer that documents why they cannot provide the statement from the NCP.

(g) If the other parent is in the household, the same information for them;

(h) Proof that the child belongs to one of the following groups as defined in WAC 388-424-0001:
  (i) A U.S. citizen;
  (ii) A U.S. national;
  (iii) A qualified alien; or
  (iv) A nonqualified alien who meets the Washington state residency requirements as listed in WAC 388-468-0005.

(5) If DSHS requires verification from a consumer that costs money, DSHS must pay for the consumer's reasonable costs.

(6) DSHS does not pay for a self-employed consumer's state business registration or license, which is a cost of doing business.

(7) If a consumer does not provide all of the verification requested within thirty days from the application date, DSHS will determine if a consumer is eligible based on the information already available to DSHS.

2017-027 The Department of Social and Health Services did not have adequate internal controls over and was not compliant with requirements to identify and detect fraud in the Child Care and Development Fund program.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.575	Child Care and Development Block Grant
	93.596	Child Care Mandatory and Matching Funds of the Child Care and Development Fund
Federal Award Number:	G1701WACCDF; G1601WACDF; G1501WACCDF	
Applicable Compliance Component:	Special Tests and Provisions – Fraud Detection and Repayment	
Known Questioned Cost Amount:	None	

Background

The federal Child Care and Development Fund (CCDF) grant helps eligible working families pay for child care. In fiscal year 2017, Washington child care providers were paid about $190 million in federal grant funds. Although the Department of Early Learning (DEL) is the lead agency for the CCDF program, the Department of Social and Health Services' (DSHS) Office of Fraud and Accountability (OFA) has the statutory authority to conduct investigations related to allegations of fraud in the CCDF program. State law requires DEL to refer suspected incidents of child care subsidy fraud to OFA for appropriate investigation and action.

Both DEL and DSHS accept reports of suspected fraud online, or by mail, phone or fax. Staff from either agency can report suspected fraud through internal systems or to a hotline.

When DSHS receives a report of suspected fraud in a program it oversees, it runs the report through an automated process in its Barcode system to assess the level of potential fraud risk. he process considers which social service programs the client is receiving benefits from, the total benefits (dollars) being received by the client, whether the client has come up on prior reports and the client's overpayment history. The report is rated from 1 to 5, with 1 being the highest risk level. Once the report is rated, it is received by OFA, where it may be assigned to an investigator for review.

OFA supervisors attempt to assign reports rated as 1 or 2 then work their way down to lower rated reports. OFA management explained that some reports are not assigned to investigators because of workload capacity. No matter what priority level is assessed, if a report is not assigned to an investigator within the first 90 days, it is "aged out" and sent back to DSHS program staff. Program staff review the original reported information and decide whether to send the case back through the automated process to be reassessed, or dismiss the fraud report. In fiscal year 2017, OFA received 3,522 child care fraud reports. Of those, 1,542 reports (44 percent) aged out of the system.

If an OFA investigation concludes that potential fraud occurred, the results are sent to a local prosecuting attorney's office or United States attorney's office. If a court responds with the legal

determination of fraud, the case is forwarded to the Office of Financial Recovery at DSHS, so that an overpayment can be recovered from the client.

During the previous two audits, we reported that DEL and DSHS lacked adequate internal controls over the identification and detection of child care fraud. The prior finding numbers were 2016-020 and 2015-025.

Description of Condition

We found the automated process used by DSHS to prioritize fraud reports was not effectively designed. While the process incorporates the dollar value of some other program benefits, it does not include child care benefits that clients receive. The consideration of this dollar amount could increase the assigned risk level of fraud reports for the CCDF program.

We also found OFA did not review all of the highest risk fraud reports it received in state fiscal year 2017. Of the 3,522 reports received, 529 were rated as a 1 and 603 were rated as a 2. We found seven rated as a 1 (1 percent) and 31 rated as a 2 (5 percent) were not assigned to an investigator and aged out of the system after 90 days.

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

Cause of Condition

The automated process used to prioritize reports does not include the monetary value of child care benefits being received. The Department also does not have written policies or procedures specifying which priority levels of reports are required to be assigned to an investigator.

OFA staff said that the 1,542 fraud reports, including some that were rated at the highest levels of risk for fraud, were not reviewed because of insufficient staffing. Staff were reassigned to a special project in an attempt to catch up on overpayments, including for child care.

Effect of Condition

By not considering the amount of child care dollars at risk in its automated assessment process, the Department becomes less likely to give higher priority to reports involving CCDF funds.

By not reviewing all of the highest rated fraud referrals related to the CCDF program, the Department is at risk of not detecting fraudulent billing activities and not complying with the grant requirement to correctly identify and report fraud. Non-compliance with grant requirements could potentially disqualify the state from receiving future federal funding.

Recommendations

We recommend the Department:

- Include the child care dollars at risk as a factor when determining the priority of investigating a fraud referral
- Establish a written policy that describes which priority levels must be assigned to investigators. This policy should include all reports assessed at the highest risk of fraud (1 and 2).

Agency's Response

The Department concurs with the audit finding.

The Department's Office of Fraud and Accountability agrees the fraud priority system does not include the cost of child care benefits and a written policy did not exist outlining how to use the priority scoring system. We also agree a few of the highest risk of fraud cases involving childcare did not get worked during SFY17. We would like to note though, many of these cases were worked after the state fiscal year ended.

The fraud scoring system was first instituted in 2012 using lean techniques. The scoring system has been reviewed over the years and was examined by an SAO performance audit, Prioritizing Fraud Investigations at the Department of Social and Health Services' Office of Fraud and Accountability, during June 2015. None of these reviews revealed the current issue surrounding child care cases. The SAO performance audit stated the tool was working as designed, in 2015, to prioritize a workload that was not capable of being worked as a whole, due to lack of sufficient staffing.

The Department is currently working on incorporating the current SAO recommendation to include child care dollars as a risk factor in determining the priority of fraud referral investigations.

The Department has had a long standing practice of managers assigning cases based off the priority level, starting with the highest priority cases. The Department maintains a goal of completing as many of the highest risk of fraud cases as staffing and workload allows. The Office of Fraud and Accountability reports out on this performance measurement monthly and it is reviewed monthly with management. A written policy has been provided to management staff to memorialize existing processes.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

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

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

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to

prevent, or detect and correct, noncompliance on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

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

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

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

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

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

45 Code of Federal Regulation, section 98.60 Availability of funds, states in part:

(i) Lead Agencies shall recover child care payments that are the result of fraud. These payments shall be recovered from the party responsible for committing the fraud.

Revised Code of Washington 43.215.562 Child care subsidy fraud – Referral – Collection of overpayment, states in part:

(1) The department must refer all suspected incidents of child care subsidy fraud to the department of social and health services office of fraud and accountability for appropriate investigation and action.
(2) For the purposes of this section, "fraud" has the definition in RCW 74.04.004.
(3) This section does not limit or preclude the department or the department of social and health services from establishing and collecting overpayments consistent with federal regulation or seek other remedies that may be legally available, including but not limited to criminal investigation or prosecution.

2017-028 The Department of Social and Health Services improperly charged $1,544 to the federal foster care grant.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.658 Foster Care- Title IV-E
Federal Award Number:	G-1601WAFOST; G-1701WAFOST
Applicable Compliance Component:	Activities Allowed or Unallowed, Allowable Costs/Cost Principles
Known Questioned Cost Amount:	$1,544

Background

The federal Title IV-E Foster Care program helps states provide safe and stable out-of-home care for children under the jurisdiction of the State's child welfare agency until the children are returned home safely, placed with adoptive families or placed in other planned, permanent arrangements. The program provides funds to reduce the costs of foster care for eligible children, reduce administrative costs to manage the program, and provide training for adults in the Foster Care program, including state agency staff, foster parents and certain private agency staff. In Washington, the Department of Social and Health Services Children's Administration (Department) is responsible for overseeing and administering the Foster Care program.

The Department is responsible for ensuring grant money is used only for costs allowable under the grant and that payments are adequately supported. During fiscal year 2017, the Department spent about $119 million in federal grant funds, with more than $37 million paid to children in the program and their guardians.

Description of Condition

We used a statistical sampling method, randomly selecting for examination 60 social service payments of a total population of 32,440.

Twenty payments were to purchase goods and services for clients, and we identified no exceptions with these payments.

Forty payments were made to vendors for visitation services provided to multiple children, each of whom is listed separately on the support for the payment. These 40 payments covered services for up to 60 children each. We randomly sampled payments for 112 children from those invoices and examined the respective charges to determine if the Department had authorized them. We found six children for whom the Department could not provide evidence that they had authorized the services. This resulted in known questioned cost of $1,544.

This condition was not reported in the prior audit.

Cause of Condition

The Department did not review to ensure payments for visitation services provided to multiple children were authorized prior to making the payment. The Department did not have any policies or procedures in place to ensure a review was performed.

Effect of Condition and Questioned Costs

A statistical sampling method was used to randomly select the payments examined in the audit. We estimate the amount of likely improper federal payments to be $214,819. The payments were partially funded with state dollars and we found $1,544 of improper state payments, which we estimate to be $214,819. This amount is not included in the federal questioned costs.

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

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a very high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Recommendations

We recommend the Department:

- Ensure charges have been authorized before paying
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Agency's Response

The Department concurs with the finding.

The Department will work with field staff and fiduciaries to ensure proper documentation exists when making invoice payments to vendors.

The administration will work with the grantor to discuss any necessary repayment of the known questioned costs.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).

(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

2017-029 The Department of Social and Health Services did not have adequate internal controls over and did not comply with payment rate setting and application requirements for the Foster Care program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.658 Foster Care- Title IV-E
Federal Award Number:	G-1601WAFOST; G-1701WAFOST
Applicable Compliance Component:	Special Tests and Provisions – Payment Rate Setting and Application
Known Questioned Cost Amount:	$293

Background

The federal Title IV-E Foster Care program helps states provide safe and stable out-of-home care for children under the jurisdiction of the state's child welfare agency until the children are returned home safely, placed with adoptive families or placed in other planned, permanent arrangements. The program provides funds to assist with the costs of foster care for eligible children, administrative costs to manage the program, and training for adults in the Foster Care system, including state agency staff, foster parents and certain private agency staff. In Washington, the Department of Social and Health Services Children's Administration (Department) is responsible for the oversight and administration of the Foster Care program.

As the state Foster Care agency, the Department establishes basic rates for maintenance payments to foster parents or childcare institutions, or directly to children. The Department must submit a Title IV-E plan to the grantor that includes a periodic review of the payment rates at reasonable, specific and time-limited periods. The Department also must review Foster Care basic maintenance payment rates for continued appropriateness in accordance with its submitted plan, and must establish payment rates that provide only for costs necessary for the Foster Care program's proper and efficient administration.

During fiscal year 2017, the Department spent about $119 million in federal grant funds, with more than $37 million paid to eligible foster care recipients and their guardians.

For the previous three audits, we reported the Department did not have adequate internal controls to ensure it reviewed basic maintenance payment rates for their continued appropriateness in reasonable, specific, time-limited periods, as federal regulations require. The Department did not comply with foster care payment rate setting and application requirements for the Foster Care program. The prior finding numbers were 2016-024, 2015-028 and 2014-027.

Description of Condition

During the audit, we tested to determine if the Department reviewed its basic maintenance rates for their continued appropriateness and if it conducted the review in accordance with its Title IV-E

approved state plan. We found the Department's Title IV-E plan did not specifically address the methodology and frequency of the Department's periodic reviews of payment rates.

The Department conducted its most recent rate assessment in 2016, and increased the basic maintenance rates paid to foster care recipients effective July 1, 2015. We determined the Department accurately determined the payment rates currently in effect. The Department has agreed to conduct an economic analysis of current foster care rates every four years, as a result of a court settlement with the Foster Parents' Association of Washington State.

The Department was not able to provide any policies or procedures specifying the methodology and frequency for conducting its periodic review of payment rates. There are no provisions in state law or in Department rule that clarify how or when the reviews must be performed, and the Department did not include any such provisions in its current Title IV-E state plan.

We also examined payments made to 45 foster care recipients and found one instance when the payments exceeded the allowable monthly foster care rate by $585.

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

Cause of Condition

The grantor approved the Department's most recent Title IV-E state plan in January 2015. As such, the Department believed the plan was sufficient to ensure it met federal program requirements. However, this plan did not provide for periodic review of payment rates at reasonable, specific time-limited periods as required.

During the audit period, the Department created a draft policy that would address this issue, but the policy was not implemented and has not been added to the Title IV-E state plan.

Effect of Condition

Because its Title IV-E plan does not specify the methodology and frequency of its future reviews of foster care basic maintenance payment rates, the Department is not in compliance with the federal grant requirements. Additionally, the grant terms and conditions state that failure to comply may result in the loss of federal funds and may be considered grounds for suspension or termination of the grant.

The instance when the Department's payments exceeded the allowable monthly foster care rate by $585 included $293 in federal expenditures.

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

Recommendations

We recommend the Department:

- Revise its policies and procedures to specify the methodology and frequency of its reviews of basic maintenance payment rates for their continued appropriateness and include this process in its Title IV-E plan
- Ensure rates paid to foster care recipients comply with state and federal law
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid.

Agency's Response

The Department concurs with the finding.

The Department updated its policy regarding the methodology and frequency of its reviews of the basic maintenance payment rates. The reviews will occur every four years beginning in 2019. In addition, the Department amended the Title IV-E Plan and forwarded it to the Administration of Children and Families.

The Department will ensure when a child is placed with a family residing and licensed in another state, the payment rate from that state will be what the Department pays.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) established reporting requirements for audit findings.

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls.

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).

(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

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

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

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

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

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

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

Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requir4ements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

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

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

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

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

45 Code of Federal Regulation section 1356.21 (m) – Requirements Applicable to Title IV-E, states in part:

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

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

42 U.S. Code 671(a)(11) - State Plan for foster care and adoption assistance – Requisite features of State Plan states, in part:

In order for a State to be eligible for payments under this part, it shall have a plan approved by the Secretary which –

(11) Provides for periodic review of the standards referred to in the preceding paragraph and amounts paid as foster care maintenance payments and adoption assistance to assure their continuing appropriateness;

2017-030 The Department of Social and Health Services did not have adequate internal controls over and did not comply with federal level of effort requirements for the Adoption Assistance program.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.659 Adoption Assistance- Title IV-E
Federal Award Number:	G-1601WAADPT; G-1701WAADPT
Applicable Compliance Component:	Level of Effort
Known Questioned Cost Amount:	None

Background

The Department of Social and Health Services' (Department) Children's Administration operates the Adoption Assistance program to provide funding for parents who adopt eligible children with special needs. The program provides financial and medical benefits to qualified children. Adoptive parents can receive a monthly assistance payment from the Department to care for the children, in addition to expenses related to the initial placement of the child in the home such as court fees, payments for medical visits and transportation costs.

The Department spent more than $49 million on Adoption Assistance in fiscal year 2017, with more than $40 million paid to the adoptive parents of eligible children for adoption services.

Since federal fiscal year 2010, federal regulations have required states to apply less restrictive program eligibility requirements to children who meet specified criteria. This can result in an additional federal funding, and therefore a reduction in State costs. Federal regulations require the Department to calculate the amount saved, if any, and spend an equal amount on certain program services. Maintaining this state spending at the appropriate level is referred to as maintenance of effort (MOE). The Department is also required to spend no less than 30 percent of any such savings on post-adoption services, post-guardianship services, and services to support and sustain positive permanent outcomes for children who might otherwise enter the State foster care program. At least two-thirds of that amount must be spent on post-adoption and post-guardianship services. The Department must accurately report these amounts to the federal grantor.

In the previous audit, we reported the Department did not have adequate internal controls over and did not comply with federal MOE requirements for the Adoption Assistance program. The prior finding number was 2016-026.

Description of Condition

The Department did not have adequate internal controls in place to ensure it complied with the MOE requirements. The Department did not have a policy or procedure to establish a method for identifying the eligible expenditures to be reported.

The required MOE for the audit period was $780,280. The Department reported it spent $263,310, which was not supported by adequate documentation to determine if it was accurately calculated and used only for allowable purposes.

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

Cause of Condition

During the audit period, the Department had no means of identifying expenditures related to adoption savings in its accounting system. Although the Department was made aware of this deficiency by our finding from the previous year, the Department stated it did not have adequate time to make the required changes to its accounting system before the current audit period closed.

Effect of Condition

Without a system to accurately account and record expenditures related to adoption savings, the Department could not demonstrate it spent the amount reported.

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

Recommendations

We recommend the Department:

- Establish internal controls to track state-funded spending
- Establish written policies and procedures specifying how the Department will determine the amount of adoption assistance savings and subsequent expenditures of those savings to be reported to the grantor
- Review maintenance of effort reports to ensure the amount of expenditures reported to the grantor has been accurately determined and is adequately supported

Agency's Response

The Department concurs with the finding.

Children's Administration concurs internal controls; written policies and procedures; and supporting documentation were lacking for the annual Adoption Savings report.

The Department has:

- *Implemented internal controls to include establishing AFRS coding to track state-funded spending.*
- *Developed written procedures in the preparation of the annual Adoption Savings report.*

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls, states in part:

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

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

> .11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows: …
>
> **Deficiency in internal control over compliance.** A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.
>
> **Material weakness in internal control over compliance.** A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:
>
> **Reasonably possible**. The chance of the future event or events occurring is more than remote but less than likely.
>
> **Probable**. The future event or events are likely to occur.
>
> **Significant deficiency in internal control over compliance.** A deficiency, or a combination of deficiencies, in internal control over compliance that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.
>
> **Material noncompliance**. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requir4ements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

Grant Award; General Terms and Conditions; Mandatory Formula, Block and Entitlement Grant Programs:

> Except as noted otherwise, these Terms and Conditions apply to all mandatory grant programs administered by the Administration for Children and Families (see Appendix A). Please also review the separate program-specific Addendum to these Terms and Conditions applicable to each program.
>
> By acceptance of the individual awards, each grantee agrees to comply with these requirements. Failure to comply may result in the loss of Federal funds and may be considered grounds for the suspension or termination of the grant.

42 U.S. Code § 673 – Adoption and guardianship assistance program states, in part:

(a) Agreements with Adoptive Parents of Children with Special Needs; State Payments; Qualifying Children; Mount of Payments; Changes in Circumstances; Placement Period Prior to Adoption; Nonrecurring Adoption Expenses

(8)

(A) A State shall calculate the savings (if any) resulting from the application of paragraph (2)(A)(ii) to all applicable children for a fiscal year, using a methodology specified by the Secretary or an alternate methodology proposed by the State and approved by the Secretary.

(B) A State shall annually report to the Secretary—

(i) the methodology used to make the calculation described in subparagraph (A), without regard to whether any savings are found;

(ii) the amount of any savings referred to in subparagraph (A); and

(iii) how any such savings are spent, accounting for and reporting the spending separately from any other spending reported to the Secretary under part B or this part.

(C) The Secretary shall make all information reported pursuant to subparagraph (B) available on the website of the Department of Health and Human Services in a location easily accessible to the public.

(D)

(i) A State shall spend an amount equal to the amount of the savings (if any) in State expenditures under this part resulting from the application of paragraph (2)(A)(ii) to all applicable children for a fiscal year, to provide to children of families any service that may be provided under part B or this part. A State shall spend not less than 30 percent of any such savings on post-adoption services, post-guardianship services, and services to support and sustain positive permanent outcomes for children who otherwise might enter into foster care under the responsibility of the State, with at least ⅔ of the spending by the State to comply with such 30 percent requirement being spent on post-adoption and post-guardianship services.

(ii) Any State spending required under clause (i) shall be used to supplement, and not supplant, any Federal or non-Federal funds used to provide any service under part B or this part.

2017-031 The Health Care Authority did not perform semi-annual data sharing with health insurers as required by State law.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT
Applicable Compliance Component:	Allowable Costs/Cost Principles
Known Questioned Cost Amount:	None

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and State funds during fiscal year 2017.

It is common for Medicaid beneficiaries to have one or more additional sources of coverage for healthcare services. Third-party liability refers to the legal obligation of third parties, such as insurance companies, to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan. By law, Medicaid is the "payer of last resort," meaning all other available third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

The federal Deficit Reduction Act of 2005 (Act) requires health insurers to give states eligibility and coverage information that will enable Medicaid agencies to determine whether clients have third-party coverage. As a condition of receiving federal Medicaid funding, the Act directed states to enact laws requiring health insurers doing business in their state to provide the eligibility and coverage information necessary to determine whether Medicaid clients have third-party coverage.

To comply with this requirement, the Legislature passed Revised Code of Washington 74.09A in 2007, which requires the Health Care Authority to provide Medicaid client eligibility and coverage information to health insurers. As a condition of doing business with the State, the insurers must use that information to identify Medicaid clients with third-party coverage and provide those results to the Authority. The law requires the exchange of data to occur at least twice a year. The Authority must focus its implementation of the law on those health insurers with the highest probability of joint beneficiaries.

The U.S. Government Accountability Office (GAO) published an audit report in January 2015, report number GAO-15-208 titled *Additional Federal Action Needed to Further Improve Third-Party Liability Efforts* for the Medicaid program. The GAO also found states commonly face challenges with their third-party liability efforts, such as health insurers refusing the provider coverage information or denying liability for procedural reasons.

Since 2008, we have reported findings regarding lack of internal controls over and noncompliance with State law. Prior audit finding numbers were 2016-028, 2015-030, 2014-034, 2013-020, 12-49, 11-38, 10-40, 09-19 and 08-25.

Description of Condition

The Authority did not perform semi-annual data sharing with health insurers, as State law requires. The Centers for Medicare and Medicaid Services developed the Payer Initiated Eligibility/Benefits (PIE) Transaction, the format recommended by the federal government for data sharing. The Authority implemented this transaction format in July 2013. In October 2013, the Authority sent letters to 10 major insurance carriers with the most Medicaid clients, inviting them to begin data sharing. Two carriers have chosen to work with the Authority to implement the PIE Transaction and share data.

During fiscal year 2017, the Authority refined the logic for uploading PIE data files into its Medicaid Management Information System, ProviderOne, to ensure accurate automated loading of data. The two health insurance carriers submitted monthly PIE data files to the Authority. However, the Authority was unable to upload the PIE data files. The Authority continues to work on refining the data to ensure "Good Cause" clients, 18 years of age and younger who depend on their parents' medical insurance or Domestic violence victims, seeking confidential services are excluded. The Authority is working with its ProviderOne vendor to complete this enhancement.

Also, Revised Code of Washington 74.09A.020(1) states that the Authority is to provide client data to health insurers, and the insurers are to identify joint beneficiaries and transmit the information to the Authority. The law and the Authority's current practice do not align because this identification is not being done by the insurers. In practice, the data exchange is initiated by payers (insurers) and then the Authority attempts to identify joint beneficiaries.

Cause of Condition

The Authority asserts it has no legal influence to enforce or compel private insurance carriers to participate in the data exchange.

The Authority was unable to upload all client files because of system upload issues.

Effect of Condition

Without performing the data exchange and cross-matching insurance claims, the Authority is not able to promptly identify Medicaid clients who have third-party coverage. This increases the Authority's risk of paying claims that are not allowable.

Additionally, the Authority is not compliant with State law (Revised Code of Washington 74.09A.020), requiring the Authority and insurance carrier perform a data exchange. Because this finding reports non-compliance with State law, the Office of Financial Management is required by Revised Code of Washington 43.09.312 (1) to submit the agency's response and plan for remediation to the Governor, the Joint Legislative Audit and Review Committee and the relevant fiscal and policy committees of the Senate and House of Representatives.

Recommendations

We recommend the Authority:

- Work with the Legislature to bring Washington into compliance with State law
- Continue efforts to perform data matches with private insurers

Agency's Response

The SAO is correct in stating that not all health insurers participate in the specific semi-annual data sharing process with the Health Care Authority (HCA) as described in state law (RCW 74.09A.020(5)). The SAO is not correct in concluding that, because of this, HCA is not able to promptly identify Medicaid clients with third party insurance coverage.

Insurers do share data, and HCA has robust and effective processes for identifying and collecting from third parties, much of which happens on an on-going basis and in real time. These activities include data exchanges with insurers; data matching using information obtained from other governmental agencies; cross-matching of insurance claims; and regularly exchanging data with our Medicaid Managed Care Organizations (MCOs). Acting on behalf of HCA, MCOs perform data matches with insurance carriers in the State of Washington that includes the utilization of large national databases to identify third party coverage.

HCA has found these activities to be very effective in the timely identification of third party insurers. On average, HCA staff update over 7,000 third party liability records each month. During this audit period, cost recovery/cost avoidance activities resulted in savings of more than $72 million in federal funds. SAO has neither reviewed these cost recovery activities nor acknowledged the resulting significant savings.

SAO's finding is based on a specific data exchange method which most carriers have chosen not to participate in and which HCA has no legal authority to enforce. SAO management stated it believes HCA should seek and obtain that legal authority through legislation, and continues this audit finding in support of that opinion. The Office of the Insurance Commissioner is responsible for regulating insurers, not HCA. HCA does not intend to ask Legislature for such authority.

HCA will continue to engage in a variety of effective third party liability identification activities, including encouraging insurance carriers to share data, as we have been doing for many years.

Auditor's Concluding Remarks

Our finding is based on the fact that the Authority is not materially compliant with the specific requirements of a State law (Revised Code of Washington 74.09A). This law requires the Authority to use a specific method of data exchange to accomplish third-party payment verification. While the Authority does engage in other methods of third-party payment verification, it isn't required by State law.

The Authority will continue to be bound by the State law that requires this specific method of data exchange, and therefore will continue to risk a finding of non-compliance. That is why our Office suggested the Authority work with the Legislature.

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.303 Internal controls.

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

Section 200.516 Audit reporting, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

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

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

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

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

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

Title 42, United States Code, Part 1396a(a)(25) State plan for medical assistance, states in part:

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including-

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

Revised Code of Washington 74.09A.005 Findings, states:

The legislature finds that:

(1) Simplification in the administration of payment of health benefits is important for the state, providers, and health insurers;

(2) The state, providers, and health insurers should take advantage of all opportunities to streamline operations through automation and the use of common computer standards;

(3) It is in the best interests of the state, providers, and health insurers to identify all third parties that are obligated to cover the cost of health care coverage of joint beneficiaries; and

(4) Health insurers, as a condition of doing business in Washington, must increase their effort to share information with the authority and accept the authority's timely claims consistent with 42 U.S.C. 1396a(a)(25).

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

Revised Code of Washington 74.09A.020 Computerized information — Provision to health insurers, states:

1. The authority shall provide routine and periodic computerized information to health insurers regarding client eligibility and coverage information. Health insurers shall use this information to identify joint beneficiaries. Identification of joint beneficiaries shall be transmitted to the authority. The authority shall use this information to improve accuracy and currency of health insurance coverage and promote improved coordination of benefits.
2. To the maximum extent possible, necessary data elements and a compatible database shall be developed by affected health insurers and the authority. The authority shall establish a

representative group of health insurers and state agency representatives to develop necessary technical and file specifications to promote a standardized database. The database shall include elements essential to the authority and its population's health insurance coverage information.

3. If the state and health insurers enter into other agreements regarding the use of common computer standards, the database identified in this section shall be replaced by the new common computer standards.
4. The information provided will be of sufficient detail to promote reliable and accurate benefit coordination and identification of individuals who are also eligible for authority programs.
5. The frequency of updates will be mutually agreed to by each health insurer and the authority based on frequency of change and operational limitations. In no event shall the computerized data be provided less than semiannually.
6. The health insurers and the authority shall safeguard and properly use the information to protect records as provided by law, including but not limited to chapters 42.48, 74.09, 74.04, 70.02, and 42.56 RCW, and 42 U.S.C. Sec. 1396a and 42 C.F.R. Sec. 43 et seq. The purpose of this exchange of information is to improve coordination and administration of benefits and ensure that medical insurance benefits are properly utilized.
7. The authority shall target implementation of this section to those health insurers with the highest probability of joint beneficiaries.

2017-032 The Health Care Authority overpaid a tribe for Medicaid chemical dependency treatments.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Activities Allowed/Unallowed Allowable Costs/Cost Principles	
Known Questioned Cost Amount:	$3,909,517	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

Tribal health care facilities that deliver health care services to Medicaid-eligible clients can bill the Health Care Authority (Authority) for delivering those services. The Authority submits an annual state plan describing coverage benefits, prior authorization requirements, and reimbursement requirements and limitations, to the Centers for Medicare and Medicaid Services for approval. Chemical dependency treatment is a service covered by Medicaid. State billing policies require providers to retain supporting documentation as evidence of what, when and by whom services were provided.

As part of the state plan, tribal health care facilities are authorized to bill for services at an encounter rate. An encounter is a face-to-face contact between a health care professional and a Medicaid client for the provision of all services that are provided to that client within a 24-hour period, as documented in the client's records. To be eligible to bill at the encounter rate, the services must be provided by specific credentialed health care professionals. In calendar year 2016, the Medicaid encounter reimbursement rates were $368 for tribal clients and $184 for non-tribal clients.

In August 2017, our Office published a whistleblower investigation (report number 1019566) that reported the Authority overpaid a tribe almost $6 million for chemical dependency treatments.

Description of Condition

The Stillaguamish Tribe (Tribe) operates a chemical dependency facility that provides services to tribal and non-tribal clients. From January 2016 through December 2016, the Tribe was paid about $32 million for chemical dependency treatments billed at the encounter rate.

To determine if the Tribe was reimbursed properly, we reconciled almost $7 million in claims to supporting documentation obtained from the Tribe. We found more than $6 million was paid improperly because the service provider was ineligible to claim at the encounter rate because he or she was not a specifically credentialed health care professional as named in the state plan.

Cause of Condition

The Authority had no systematic edit in its Medicaid Management Information System (Provider One) to detect and prevent when the Tribe improperly billed at an encounter rate when a client received services from a non-qualified provider.

Without a systematic edit, the Authority relied on post-payment review, which did not occur for these claims until after we conducted the whistleblower investigation.

Effect of Condition and Questioned Costs

The scope of the whistleblower investigation covered payments made from January 1, 2016, to December 31, 2016. For the purposes of this finding, we are questioning $3,909,517, which is the federal share of the overpayments made during state fiscal year 2017 (from July 1, 2016 to December 31, 2016).

We also identified the Authority made overpayments totaling $2,115,465 in fiscal year 2016 (from January 1, 2016 to June 30, 2016). These payments occurred outside the audit period, but this additional information is included to provide proper perspective for judging the prevalence and consequences of the finding.

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

Recommendation

Consult with the U.S. Department of Health and Human Services regarding whether the questioned costs identified by the audit should be repaid

Agency's Response

On September 12, 2017, the Authority requested guidance from the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services on whether the payments described in SAO Whistleblower report number 1019566 are in fact overpayments. The language in the State Plan is not conclusive, and more than one tribe has challenged the State Auditor's Office's

conclusions in its report. On January 29, 2018, CMS directed the Authority to Section 4320 of the State Medicaid Manual issued by the Health Care Financing Administration (predecessor agency to CMS). In particular, CMS directed the Authority to paragraph C: "If a State elects to cover clinic services, it may choose the type of clinics or clinic services that are covered, provided that the services constitute medical or remedial care." In light of this CMS guidance, the authority is conducting a policy review to determine how to proceed in regard to appropriate reimbursement policy.

Auditor's Concluding Remarks

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

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.53 Improper Payments states:

(a) Improper payment means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) Improper payment includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.
(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

(a) Audit findings reported. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

42 United State Code 1396a - State plans for medical assistance; states in part:

(a) Contents

A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

Washington State Plan under TITLE XIX of the Social Security Act

Reimbursement for Indian Health Service and Tribal Health Facilities

Payment for Services

Services provided by facilities of the Indian Health Service (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization, and funded by Title I or III of the Indian Self Determination and Education Assistance Act (Public Law

93-638), are paid at the rates negotiated between the Health Care Financing Administration (HCFA) and the IHS and which are published in the Federal Register or Federal Register Notices.

The outpatient per visit rate is also known as the, IHS encounter rate. The definition of an encounter is, "A face-to-face contact between a health care professional and a Medicaid beneficiary, for the provision of Title XIX defined services through an IHS or Tribal 638 facility within a 24-hour period ending at midnight, as documented in the patient's record."

The services of the following providers are included in the encounter rate:

- Physicians
- Physician Assistants
- Nurse Midwives
- Advanced Nurse Practitioners
- Speech-Language Pathologists
- Audiologists
- Physical Therapists
- Occupational Therapists
- Podiatrists
- Optometrists

2017-033 The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure Medicaid medical providers were revalidated every five years and screening requirements were met.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Special Tests and Provisions – Provider Eligibility-Provider Revalidation	
Questioned Cost Amount:	None	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017. The state Medicaid agency for Washington is the Health Care Authority (Authority).

Provider enrollment

In March 2011, a new federal regulation required state Medicaid agencies to revalidate the enrollment of all Medicaid providers at least every five years. The Centers for Medicare and Medicaid Services (CMS) notified states through an informational bulletin that the revalidation of all providers, enrolled on or before March 25, 2011, must be completed by March 24, 2016.

In January 2016, CMS issued updated guidance to states that extended the deadline for provider revalidation to September 25, 2016. This new deadline applied to all providers enrolled on or before September 25, 2011. After this deadline, all providers must be revalidated every five years from their initial enrollment date. As part of this updated guidance, CMS required states to notify all affected providers of the revalidation requirement by the original March 24, 2016, deadline.

In revalidating a provider's enrollment, the state Medicaid agency must conduct a Fingerprint Based Criminal Background Check (FCBC) when the agency has designated a provider as high risk. On June 1, 2016, CMS required state Medicaid agencies to implement the FCBC process by December 31, 2016. On August 1, 2017, CMS extended the deadline to July 1, 2018.

Provider screening levels

The first step in revalidating a provider is to determine the provider's screening risk level. A provider can be designated as one of three risk levels: limited, moderate or high. Each risk level requires progressively greater scrutiny of the provider before it can be revalidated. CMS issued initial guidance on screening levels for specific provider types. For providers enrolled with both Medicare and Medicaid, state Medicaid agencies must assign providers to the same or higher risk category applicable under Medicare. In addition, certain provider behaviors require a provider to be moved to a higher screening risk level.

The following are the required screening procedures for each of the risk levels:

Limited risk

- Verify that provider meets applicable federal regulations or state requirements for provider type before making an enrollment determination
- Conduct license verifications, including for licenses in states other than where the provider is enrolling
- Conduct database checks to ensure providers continue to meet the enrollment criteria for their provider type

Moderate categorical risk

- Perform the "limited" screening requirements
- Conduct onsite visits

High risk

- Perform the "limited" and "moderate" screening requirements
- Conduct a Fingerprint Based Criminal Background Check

According to federal regulation, state Medicaid agencies must adjust the categorical risk level of a particular provider from "limited" or "moderate" to "high" when any of the following situations occur:

- A Medicaid agency imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse. The provider's risk remains "high" for 10 years beyond the date of the payment suspension.
- A provider that, upon applying for enrollment or revalidation, is found to have an existing state Medicaid Plan overpayment.
- The provider has been excluded by the Office of Inspector General or another state's Medicaid Program within the previous 10 years.
- A Medicaid agency or CMS, in the previous six months, lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

Over 98,000 Medicaid providers were active in Washington during fiscal year 2017. The Authority paid about $2.24 billion for fee-for-service claims billed by medical providers. In the prior audit, we reported the Authority did not notify all required Medicaid providers of the revalidation requirements by March 24, 2016. The prior finding number was 2016-035.

Description of Condition

The Authority did not have adequate internal controls to ensure it complied with federal requirements related to Medicaid medical provider enrollment and screening.

Provider enrollment

Despite multiple extensions and notifications issued to states by CMS that began in January 2016, the Authority did not revalidate all medical providers as required by federal regulations. The Authority has established a process to revalidate medical providers, but that process was not designed effectively to ensure all medical providers were revalidated timely.

Provider screening levels

During the audit period, the Authority revalidated 4,513 providers. We found the Authority did not establish a process to adjust provider screening risk levels.

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

Cause of Condition

The Authority said medical providers were not revalidated by their five-year deadline because of limited staff resources. The Authority's policies and procedures do not instruct staff on how to adjust a medical provider's risk-level in accordance with federal regulation.

The Authority decided not to adjust the risk-level of medical providers it revalidated during the audit period until the FCBC requirement goes into effect in July 2018.

Effect of Condition

The Authority did not revalidate 41,594 out of 54,144 medical providers required to be revalidated as of July 31, 2017, resulting in a noncompliance rate of almost 77 percent.

By not complying with federal provider revalidation and screening requirements, the Authority is at a higher risk of not detecting when medical providers are ineligible to provide services, or be paid with Medicaid funds.

Recommendation

We recommend the Authority:

- Implement internal controls designed to bring the Authority into material compliance with provider revalidation requirements
- Establish a written process that describes how staff are to adjust providers' screening risk levels

Agency's Response

The Health Care Authority is aware that provider revalidations have not been done timely, and has been closely monitoring the situation. In fact, the information SAO uses in this finding was obtained from the Authority's routine monitoring reports.

The revalidation process currently consists of manual searches of state and national databases to verify the existence, qualifications, and licensing of a provider. The requirement to revalidate providers every five years, rather than just at the time of application, greatly increased the revalidation workload. HCA's long-term solution for compliance with the revalidation requirement is to develop an automated process to conduct all the necessary data matches. When fully implemented, manual work will consist only of reviewing those providers that do not pass the automated screening, which will be significantly more efficient than the current one-at-a-time manual review. In the meantime, the Authority mitigates the risk of paying ineligible providers by:

- *Utilization of the Lexis Nexis Provider Scan product that conducts the required federal and state database searches for all HCA enrolled providers at a single point in time, allowing the agency to focus staff revalidation resources on providers that do not pass the database checks. This was conducted in April of 2017, and is planned to be run again in March of 2018.*
- *HCA ProviderOne has an interface with the Department of Health licensure database that automatically updates HCA provider licensure records based on changes to the licensure database. In addition, HCA has an automated process which checks for any providers without an active licensure in the ProviderOne, these providers are automatically placed in a nonpayable status until reviewed by state staff.*
- *HCA staff monitor Department of Health for provider sanction information and take action on a provider's enrollment status as needed.*

As described above, federal regulations require providers to be re-categorized as high risk under very specific, limited circumstances. SAO is correct in stating that the Authority has not formally changed the risk level of the approximately two dozen providers, out of 98,000, that meet the criteria. The significant result of re-classification to a high-risk category is that these providers must submit to a fingerprint based background check. However, the fingerprint requirement does not take effect until July 2018. When the requirement takes effect, HCA will formally change the risk level of those two dozen providers to high and require them to submit to a fingerprint based background check. Processes will be documented at that time.

SAO has not provided specific information about what internal controls are missing or lacking. Given the lack of specific recommendations about internal controls, the Authority will continue with the planned course of action of risk mitigation activities and pursuing the long-term solution of automating the revalidation process.

Auditor's Concluding Remarks

Although the fingerprint based background check requirement for high risk providers does not take effect until July 2018, the requirement for a provider to have an on-site monitoring visit is required for any provider's risk level that changes from low to high. Because the Authority is not reclassifying a provider from one risk level to another, they are not performing site visits as required.

Authority management is responsible for establishing and maintaining internal controls designed to ensure the agency materially complies with federal requirements. As stated in the Cause section of the finding, the Authority made decisions related to the number of staff assigned to provider revalidations and the timing of reclassifying providers based on risk, with the understanding that it would not result in material compliance with program requirements. We confirmed this result in our audit and finding.

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.303 Internal controls.

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The

auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

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

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

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

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

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

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

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

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

Title 42 U.S. Code of Federal Regulations section 455 Subpart E – Provider Screening and Enrollment, states in part:

Section 455.414 Revalidation of enrollment

The State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years.

Section 455.434 Criminal background checks

The State Medicaid agency -

(a) As a condition of enrollment, must require providers to consent to criminal background checks including fingerprinting when required to do so under State law or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider.

(b) Must establish categorical risk levels for providers and provider categories who pose an increased financial risk of fraud, waste or abuse to the Medicaid program.

(1) Upon the State Medicaid agency determining that a provider, or a person with a 5 percent or more direct or indirect ownership interest in the provider, meets the State Medicaid agency's criteria hereunder for criminal background checks as a "high" risk to the Medicaid program, the State Medicaid agency will require that each such provider or person submit fingerprints.

(2) The State Medicaid agency must require a provider, or any person with a 5 percent or more direct or indirect ownership interest in the provider, to submit a set of fingerprints, in a form and manner to be determined by the State Medicaid agency, within 30 days upon request from CMS or the State Medicaid agency.

Section 455.450 Screening levels for Medicaid providers.

A State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of "limited," "moderate," or "high." If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

(a) Screening for providers designated as limited categorical risk. When the State Medicaid agency designates a provider as a limited categorical risk, the State Medicaid agency must do all of the following:

(1) Verify that a provider meets any applicable Federal regulations, or State requirements for the provider type prior to making an enrollment determination.

(2) Conduct license verifications, including State licensure verifications in States other than where the provider is enrolling, in accordance with § 455.412.

(3) Conduct database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type, in accordance with § 455.436.

(b) Screening for providers designated as moderate categorical risk. When the State Medicaid agency designates a provider as a "moderate" categorical risk, a State Medicaid agency must do both of the following:

(1) Perform the "limited" screening requirements described in paragraph (a) of this section.

(2) Conduct on-site visits in accordance with § 455.432.

(c) Screening for providers designated as high categorical risk. When the State Medicaid agency designates a provider as a "high" categorical risk, a State Medicaid agency must do both of the following:
   (1) Perform the "limited" and "moderate" screening requirements described in paragraphs (a) and (b) of this section.
   (2) (i)Conduct a criminal background check; and (ii) Require the submission of a set of fingerprints in accordance with § 455.434.

(d) Denial or termination of enrollment. A provider, or any person with 5 percent or greater direct or indirect ownership in the provider, who is required by the State Medicaid agency or CMS to submit a set of fingerprints and fails to do so may have its -
   (1) Application denied under § 455.434; or
   (2) Enrollment terminated under § 455.416.

(e) Adjustment of risk level. The State agency must adjust the categorical risk level from "limited" or "moderate" to "high" when any of the following occurs:
   (1) The State Medicaid agency imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse, the provider has an existing Medicaid overpayment, or the provider has been excluded by the OIG or another State's Medicaid program within the previous 10 years.
   (2) The State Medicaid agency or CMS in the previous 6 months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within 6 months from the date the moratorium was lifted.

Centers for Medicare and Medicaid Services, Center for Medicaid and CHIP Services, CMCS Informational Bulletin, dated December 21, 2011, states in part:

> The Federal regulation at 42 CFR 455.414 requires States, beginning March 25, 2011, to complete revalidation of enrollment for all providers, regardless of provider type, at least every five years. Based upon this requirement, States must complete the revalidation process of all provider types by March 24, 2016.

Centers for Medicare and Medicaid Services (CMS) Sub Regulatory Guidance for State Medicaid Agencies (SMA): Revalidation (2016-001) states in part:

> The federal regulation at 42 CFR 455.414 requires that state Medicaid agencies revalidate the enrollment of all providers, regardless of provider types, at least every 5 years. The regulation was effective March 25, 2011. Based on this requirement, in a December 23, 2011 CMCS Informational Bulletin, we directed states to complete the revalidation process of all provider types by March 24, 2016.
>
> The purpose of this guidance is to revise previous guidance in order to align Medicare and Medicaid revalidation activities to the greatest extent possible. We are revising that previous guidance to now require a two-step deadline under which states must notify all affected

providers of the revalidation requirement by the original March 24, 2016 deadline, and must have completed the revalidation process by a new deadline of September 25, 2016.

…

(3) Deadline for SMA to revalidate providers enrolled on or before September 25, 2011. The Federal regulation at 42 CFR § 455.414 requires states, beginning March 25, 2011, to revalidate the enrollment of all Medicaid providers, regardless of provider type, at least every five years. Based upon this requirement, by March 24, 2016, states must notify providers that were enrolled on or before March 25, 2011 that they must revalidate their enrollment. On March 25, 2016, states that have notified all providers subject to the revalidation requirement will be considered compliant with the revalidation activities required as of that date.

2017-034 The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure Medicaid service verifications were performed for all eligible claims.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Special Tests and Provisions – Utilization Control and Program Integrity	
Known Questioned Cost Amount:	None	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

For states, such as Washington, that use an automated claims processing system (ProviderOne), federal regulations require a specific method be in place to verify with Medicaid clients that they received services billed by providers. The intent is to improve program integrity and identify potential fraud and abuse in the Medicaid program.

The specific verification method involves sending individual written notices, within 45 days of payment, to all or a sample group of Medicaid clients whose claims were processed through ProviderOne. Medical, nursing home and social service claims are subject to the Medicaid service verification process. The only allowable exclusion is claims for confidential services. In fiscal year 2017, the state Medicaid program paid about $5 billion for medical, nursing home and social service claims.

The Health Care Authority (Authority) processes medical claims, and the Department of Social and Health Services (Department) processes social service and nursing home claims. The Authority is ultimately responsible to ensure all eligible claims are included in the Medicaid service verification survey process.

In state fiscal year 2017 (from July 1, 2016 to June 30, 2017), the Authority mailed Medicaid medical service verification surveys to randomly selected clients every month and social service verification

surveys to randomly selected clients in May and June 2017. Clients who receive the survey are selected based on payments made through ProviderOne.

If the Authority identifies a credible suspicion of fraud or abuse, it must forward the information to the Attorney General's Office, Medicaid Fraud Control Unit, for investigation.

In prior audits, we reported the Authority did not ensure all eligible claims were included in the Medicaid service verification process. The prior finding numbers were 2016-029, 2015-032, 2014-039, 13-031, 12-54and 11-39
.

Description of Condition

We found the Authority's internal controls were not effectively designed to ensure material compliance with Medicaid service verification requirements.

Exclusion of nursing home and social service claims

Although the Authority established an adequate process to select medical claims processed through ProviderOne, it did not include nursing home claims in any monthly random sample or social service claims for 10 of the 12 months during the fiscal year.

Nursing home and social service claims account for about 50 percent of total fee for service claims paid through ProviderOne.

Follow-up on returned social service surveys

For the social service claim verifications sent in May and June 2017, the Authority did not have a policy to ensure returned social service surveys were reviewed and followed up if questions about the legitimacy of payments existed.

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

Cause of Condition

Exclusion of nursing home and social service claims

The Authority excluded nursing home claims because these facilities are paid a fixed monthly rate and the return on investment was low. It believed identifying potential fraud for this population could be accomplished through other means and by excluding this population, it could select higher risk providers to include in this process.

The Authority excluded social services claims from its monthly random sample survey process because it believed the Department was surveying the claims.

Follow-up on returned social service surveys

Because the Department authorized the services, Authority staff said it did not have the expertise to follow up on returned social service surveys.

The Authority and the Department had no written agreement that described each agency's responsibilities to ensure the State complied with federal regulations related to Medicaid service verifications.

Effect of Condition

By not effectively designing its service verification process, the Authority is at an increased risk of not detecting potential Medicaid fraud.

Recommendations

We recommend the Authority:

- Establish a written policy that requires all ProviderOne claims subject to the service verification requirements be included in the sample population
- Design its service verification survey process effectively by sampling from all ProviderOne claims subject to the service verification requirements
- Establish a written agreement with the Department describing each agency's roles and responsibilities for the survey follow-up that the Authority would like the Department to complete

Agency's Response

As noted in the finding, the Medical Service Verifications (MSVs) were expanded in ProviderOne to include social service claims in May of 2017. A Service Level Agreement detailing the roles and responsibilities of the Authority and the Department for processing and investigating any leads from MSVs was signed later that year.

The exclusion of nursing homes from MSVs was deliberate and is not indicative of poor internal controls. From a compliance standpoint, we believe it is more effective to conduct targeted, risk-based verifications with high return rates and believe federal regulation allows for this flexibility. We will work with our grantor to clarify and, until then, will include nursing homes in the MSV population.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.303 Internal controls.
The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

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

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

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in design

exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.

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

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

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

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

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

Title 42, U.S. Code of Federal Regulations, Chapter IV, Subpart C—Mechanized Claims Processing and Information Retrieval Systems, section 433.110 Basis, purpose and applicability, states in part:

(a) This subpart implements the following sections of the Act:
  (1) Section 1903(a)(3) of the Act, which provides for FFP in State expenditures for the design, development, or installation of mechanized claims processing and information retrieval systems and for the operation of certain systems. Additional HHS regulations and CMS procedures for implementing these regulations are in 45 CFR part 75, 45 CFR part 95, subpart F, and part 11, State Medicaid Manual; and
  (2) Section 1903(r) of the Act, which imposes certain standards and conditions on mechanized claims processing and information retrieval systems (including eligibility determination systems) in order for these systems to be eligible for Federal funding under section 1903(a) of the Act.

Title 42, U.S. Code of Federal Regulations, Section 433.116 FFP for operation of mechanized claims processing and information retrieval systems, states in part:

(a) Subject to paragraph (j) of this section, FFP is available at 75 percent of expenditures for operation of a mechanized claims processing and information retrieval system approved by CMS, from the first day of the calendar quarter after the date the system met the conditions of initial approval, as established by CMS (including a retroactive adjustment of FFP if necessary to provide the 75 percent rate beginning on the first day of that calendar quarter).

Subject to 45 CFR 95.611(a), the State shall obtain prior written approval from CMS when it plans to acquire ADP equipment or services, when it anticipates the total acquisition costs will exceed thresholds, and meets other conditions of the subpart.

(b) CMS will approve enhanced FFP for system operations if the conditions specified in paragraphs (c) through (i) of this section are met.

(c) The conditions of §433.112(b)(1) through (22) must be met at the time of approval.

(d) The system must have been operating continuously during the period for which FFP is claimed.

(e) The system must provide individual notices, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the plan.

(f) The notice required by paragraph (e) of this section—

(1) Must specify—

(i) The service furnished;

(ii) The name of the provider furnishing the service;

(iii) The date on which the service was furnished; and

(iv) The amount of the payment made under the plan for the service; and

(2) Must not specify confidential services (as defined by the State) and must not be sent if the only service furnished was confidential.

(g) The system must provide both patient and provider profiles for program management and utilization review purposes.

(h) If the State has a Medicaid fraud control unit certified under section 1903(q) of the Act and §455.300 of this chapter, the Medicaid agency must have procedures to assure that information on probable fraud or abuse that is obtained from, or developed by, the system is made available to that unit. (See §455.21 of this chapter for State plan requirements.)

Title 42, U.S. Code of Federal Regulations, Section 455.1 Basis and scope, states in part:

This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control.

(a) Under the authority of sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act, Subpart A provides State plan requirements for the identification, investigation, and referral of suspected fraud and abuse cases. In addition, the subpart requires that the State—

(1) Report fraud and abuse information to the Department; and

(2) Have a method to verify whether services reimbursed by Medicaid were actually furnished to beneficiaries.

Title 42, U.S. Code of Federal Regulations, Section 455.14 Preliminary investigation states:

If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

Title 42, U.S. Code of Federal Regulations, Section 455.20 Beneficiary verification procedure states:

(a) The agency must have a method for verifying with beneficiaries whether services billed by providers were received.
(b) In States receiving Federal matching funds for a mechanized claims processing and information retrieval system under part 433, subpart C, of this subchapter, the agency must provide prompt written notice as required by §433.116 (e) and (f).

Health Care Authority, Office of Program Integrity (OPI) Procedure No. 2.1.1 states:

Medical Service Verification (MSV) Procedure

Procedure:

I. Each month, using an automated process, ProviderOne will issue at least 400 MSV forms to randomly selected Medicaid beneficiaries.

MSV mailings:

A. Will include a self-addressed stamped envelope
B. Will exclude beneficiaries receiving confidential services
C. Will identify the specific service recipient

II. Each returned MSV will be stamped with date received and submitted to the Intake Coordinator.

The Intake Coordinator will:

A. Log all returned MSVs, whether services are designated as received or not, capturing:
   1. Dates of MSV issuance and return
   2. Name of beneficiary
   3. Services identified
   4. Service Provider
   5. Amounts Paid
   6. Date of Service
   7. Whether the service was received or not
   8. Co-pay amount
   9. Amount of services designated as "not received"
   10. Beneficiary notes/comments
   11. Flag for follow-up
   12. OPI Staff notes/comments
B. Refer all leads from MSVs with potential fraud, waste or abuse to the Case Management Team for additional research and analysis.

The Case Management Team will:

1. Review the work of the Intake Coordinator and determine if a full investigation is warranted.
2. Refer lead back to Intake Coordinator to close the MSV without action if a full investigation is not required.
3. Open a case and transfer the preliminary investigation of the lead into case tracking if credible for potential fraud, waste or abuse.
4. Communicate the case identification number of the opened case to the Intake Coordinator so the outcome can be logged into the Intake an Triage Log.

III. For Quality control, the supervisor of the Intake Coordinator will review MSV outcomes logged into the Intake and Triage Log at least once per month; the OPI Section Manager will review them at least once per year.

2017-035 The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure it sought reimbursement for all eligible Medicaid outpatient prescription drug rebate claims.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Activities Allowed/Unallowed Allowable Costs/Cost Principles	
Known Questioned Cost Amount:	$23,955,658	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and State funds during fiscal year 2017.

The Medicaid drug program began in 1991 and is described in Title 42 United States Code §1396r-8. For federal payments to be available for covered outpatient prescription drugs provided under Medicaid, drug manufacturers must enter into a rebate agreement with the Secretary of the U.S. Health and Human Services and pay quarterly rebates to states. Under these rebate agreements, manufacturers must give the average manufacturer price by national drug code for each of their covered drugs to the Centers for Medicare and Medicaid Services. The average manufacturer price and best price data are used to calculate the unit rebate amount for each national drug code included in the Medicaid drug rebate program; this price and rebate information is transmitted to the states so that drug rebate amounts can be accurately calculated.

States calculate the total quarterly rebates that participating manufacturers owe by multiplying the unit rebate amount for a specific drug by the number of units of that drug for which the state reimbursed providers in that quarter. Within 60 days of the quarter's end, states must invoice the manufacturers for the reimbursed units and indicate the total rebate due for each national drug code.

The manufacturers process the invoices and pay the rebates to states within 30 days.

Invoices must reflect only those drugs reimbursed in the reporting period (quarter) and must not include national drug codes paid under:

- Public Health Service drug pricing agreements
- State-funded-only general assistance programs or other state-funded-only programs; or
- Other federal non-Medicaid-funded drug programs

In fiscal year 2017, the Authority invoiced drug manufacturers for drug rebates totaling more than $644 million, of which $496 million was for managed care claims and $148 million was for fee-for-service claims.

In previous audits, we reported the Authority did not have adequate internal controls to ensure it sought reimbursement for all eligible fee-for-service Medicaid drug rebate claims. The prior finding numbers were 2015-034 and 2014-031. Managed care Medicaid drug rebate claims were addressed in prior finding number 2016-032.

Description of Condition

We found the Authority did not have adequate internal controls over and did not comply with requirements to ensure it sought reimbursement for managed care and fee-for-service eligible Medicaid outpatient prescription drug rebate claims.

The Authority's drug rebate invoicing system was not adequately configured to identify all rebate eligible prescription drugs for the managed-care program and fee-for-service claims. The Authority's drug rebate invoicing system automatically identifies rebate eligible prescription drug claims based on its system configuration. However, specific codes such as eligibility groups and managed care plan codes are added to the system periodically. Some functions of these processes are manual, which allowed some errors to be entered in necessary system updates. As a result, the drug rebate system did not identify all prescription drug claims eligible for the rebates.

The Authority also did not process rebates for some outpatient drugs because it was not able to obtain the correct number of units, which was needed to calculate the rebates.

We consider this control deficiency to be a material weakness.

Cause of Condition

The Authority did not have adequate oversight of its processes for determining rebate eligibility for claims. For example, the Authority did not identify the correct number of units because of the complexity of drug unit conversions for rebate. The rebate system automatically converts outpatient drug unit for rebate. However, some conversions were complex enough that the system could not accurately calculate the units for rebate.

The Authority did not identify rebate eligible claims because some procedure codes associated with rebate eligible drugs were not adequately configured into the rebate system. Eligibility for

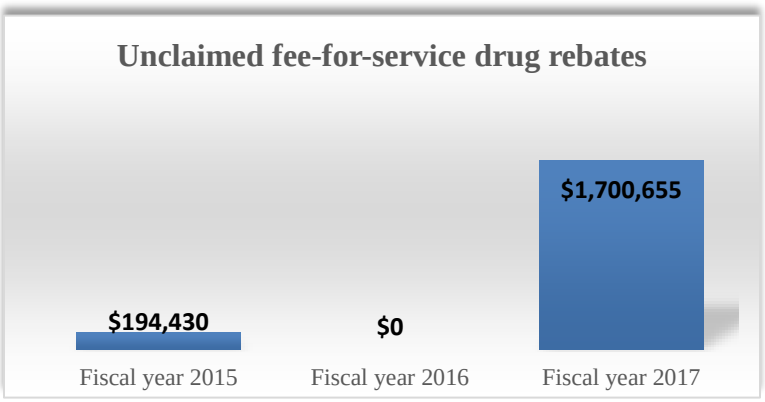
undocumented alien clients who received Medicaid emergency related services were also not properly identified in the rebate system.
The Authority said that more than 85,000 claims, out of 105,806, were retroactively invoiced as prior period adjustments after the managed care plan code and eligibility group code errors were corrected. Those adjusted claims were reported to the manufacturers as a part of the invoicing process. However, the rebate amounts for those claims were not actually included in the invoice total to be collected.

The U.S. Department of Health and Human Services, Office of Inspector General, published an audit report[2] in September 2017 that also found the Authority did not bill drug manufacturers for more than $16.9 million in rebates related to claims paid to managed-care organizations for April 2010 through December 2013. The Authority concurred with the recommendations made in the report and said it would address the issue.

Effect of Condition and Questioned Costs

By not assigning the proper Medicaid eligibility codes and managed care plan codes in its drug rebate system configuration and not identifying correct number of units, the Authority increases its risk of not collecting all valid rebates.

Using a statistical sampling method, we randomly selected 56 fee-for-service drug rebate invoices from a population of 556 fee-for-service drug rebate invoices and a sample of 84 managed care drug rebate invoices from a population of 1,061 managed care drug rebate invoices, which were processed in fiscal year 2017, to determine if they were accurately prepared. In addition, we judgmentally selected four fee-for-service invoices with the highest rebate amounts, totaling $84,485,118. The total rebate amount for the selected invoices was nearly $113 million for fee-for-service and $279 million for managed care drug rebates.



Fee-for-service

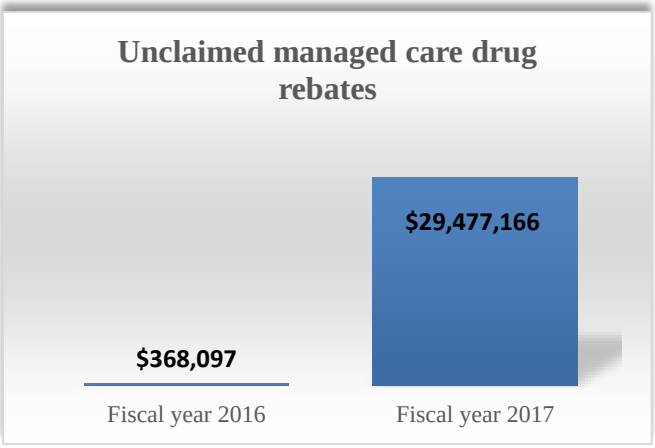
For fee-for-service drug rebates, we identified 3,811 claims, totaling $1,700,655, that were eligible for a drug rebate but not included in 27 of the 60 fee-for-service rebate invoices tested.

[2] https://oig.hhs.gov/oas/reports/region9/91602028.pdf

Managed care

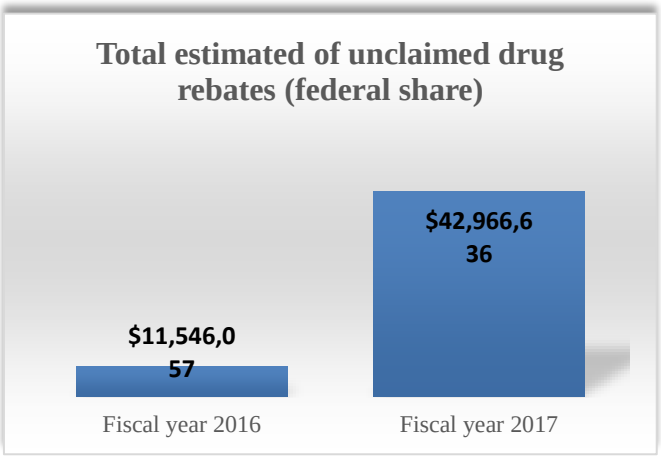
For managed care drug rebates, we identified 105,806 claims, totaling $29,477,166, that were eligible for a drug rebate but not included in 78 of the 84 managed care rebate invoices tested.

The following table summarizes the results of our review:



Rebate claim type	Known questioned costs – state and federal	Known questioned costs – federal share	Estimated missed rebates – state and federal	Estimated missed rebates – federal share
Fee-for-service	$1,700,655	$1,215,359	$2,590,568	$1,698,961
Managed care	$29,477,166	$22,740,299	$53,198,828	$41,267,675
Total	**$31,177,821**	**$23,955,658**	**$55,789,396**	**$42,966,636**

As a result, the Authority failed to claim $31,177,821in owed rebates. We are questioning the federal share of $23,955,658. When we project the results to the entire population of managed care and fee-for-service invoices, we estimate the Authority failed to collect $55,789,396 in fee-for-service and managed care drug rebates. The federal share of the estimated unclaimed rebates, or likely questioned costs, is $42,966,636.



We question costs when we find an agency has not complied with grant regulations or when it does not adequately offset Medicaid assistance expenditures.

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a very high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs" as

required by 2 CFR 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Recommendations

We recommend the Authority:

- Strengthen its review process to ensure all eligible drug rebate claims are included in the invoicing process
- Correct its drug rebate system configuration errors to ensure it seeks reimbursement for all eligible outpatient prescription drug rebate claims
- Ensure it obtains the correct number of units, which is information needed for rebate calculation
- Review managed care drug claims to determine the amount of drug rebates that should be requested from manufacturers
- Consult with the U.S. Department of Health and Human Services to determine if the questioned costs identified by the audit should be repaid

Agency's Response

The Authority does not agree with the SAO's Description of Condition, Cause of Condition, or Effect of Condition on Questioned Costs. The Authority has engaged in considerable discussion with the SAO regarding the drug rebate program, but HCA remains concerned that the SAO may not fully appreciate certain crucial facts regarding the program, which then seems to have led to erroneous audit conclusions. Explanations of the Authority's positions follow.

Description of Condition:
Although it is correct that eligibility groups and managed care plan codes are periodically added to the system, this condition was from a prior audit and was not present in any of the findings for this audit. As described in the corrective action plan from the 2016 audit, the Authority made all of the corrections, invoiced for the missed rebates in the first quarter of 2017, and set up a process to configure future managed care plan changes into the drug rebate subsystem. This information was provided to the SAO.

The Authority agrees with the condition that it was not able to process rebates for some outpatient drugs due to unit conversion issues. This was a finding from the 2016 audit, which the Authority has addressed and is releasing into ProviderOne production in April 2018. This information was shared with the SAO at the beginning of the audit.

Cause of Condition:
As stated above, the corrective action plan from the prior year's finding pertaining to unit conversions will move into production in April 2018.

The Authority agrees with the identified condition pertaining to improper exclusion of undocumented clients from the rebate process. However, because this condition impacts a very small, distinct client population - 119 clients in total – extrapolating the exceptions to the entire population is not an appropriate application of sampling methods and overstates the likely questioned costs.

Out of the 105,806 managed care encounters the SAO identified above, the Authority verified that 92,506 were either invoiced or excluded appropriately. It appears to the Authority that the SAO's conclusions stem from a misunderstanding of the prior period correction ("PPC") process.

The Authority believes that an understanding of the PPC process is a crucial part of adherence to auditing standards. It is unclear whether the SAO understood the Authority's explanations of, and evidence related to, the PPC process.

In sum, any PPC that is included in an invoice is deemed to be invoiced and payable. In the Authority's experience, the drug manufacturers are aware of this fact. The invoicing format that the Authority uses is mandated by CMS and is used by states nationwide. Under this format, the invoices are sent with a monetary total for the utilization of drugs in the current quarter. The PPCs are listed separately so that it is easier for the manufacturers to reconcile any additional amounts or credits that may be due. The first page of every invoice explains this process. The Authority is puzzled that, despite these facts, the SAO seems to maintain that the Authority did not properly invoice certain PPCs.

The Authority provided the SAO with copies of two of the invoices that the SAO had questioned. The Authority performed a full reconciliation of one of the invoices which verified that the entire invoice had been paid, both for the current quarter and for the PPC utilizations. The SAO's findings do not appear to take this reconciliation into account.

In addition, the SAO repeatedly references the OIG audit, but the Authority believes it would be more complete and accurate to also note that the Authority already has (1) addressed and resolved the OIG's audit finding; (2) invoiced the rebates in question; and (3) taken corrective actions. The Authority is concerned that the SAO may not have fully appreciated the degree to which the issues identified by the OIG have been addressed. The Authority is further concerned that the SAO may have gained an insufficient understanding of how drug manufacturers are invoiced.

Effect of Condition and Questioned Costs
As stated, the SAO's statement regarding the managed care plan codes was not present in the conditions in this finding; instead, it was from a 2016 finding that the Authority already has corrected. As noted, the Authority is implementing an enhancement to the ProviderOne system in April 2018 to address the unit conversion issues identified during the audit last year.

The figure of $1.7M includes PPC claims that the Authority already has invoiced. If, as appropriate, claims that have already been invoiced are removed, the amount remaining to be invoiced is $334,152 total computable.

The total exceptions identified for managed care is in error, as well. The SAO identified $29M that it believes had not been invoiced at the time of audit; however, the correct figure is $9,244,663 total computable. The Authority has already invoiced this balance.

Although a lack of understanding may have led the SAO to incorrect conclusions, the Authority believes much of the misunderstanding could have been resolved given a reasonable time frame. The SAO was operating on a compressed schedule, which prevented the Authority from being able to review and respond to the detailed exceptions prior to receiving the audit finding.

The following are the exceptions that the Authority agrees with:

Emergency medical eligibility – This issue was limited to medical claims and affected 119 specific clients in the ProviderOne system. A report exists that will allow staff to preemptively identify these specific scenarios and make eligibility updates as appropriate. This will occur on a weekly basis, which also allows the Authority to reprocess any affected claims prior to invoicing.

Procedure code configuration – ProviderOne allows numerically sequential procedure codes with like requirements to be configured in ranges or 'groups.' However, during the process of uploading new and changed codes, unintended gaps were created in certain ranges. This caused the NDC requirements on certain codes to be temporarily bypassed. The Authority intends to remove the grouping configuration, review the current list of codes, and maintain them individually going forward.

HCPCS to NDC conversion errors – This was a condition known to the Authority as a result of previous audits. A ProviderOne change request is being implemented that adds configurable fields to facilitate unit conversions on the more complex physician-administered drug claims. This change is currently in testing, and scheduled to be implemented in April 2018.

The Authority will consult with CMS to fully explain the actual audit results and will work to invoice and repay the amounts that are truly outstanding.

Auditor's Concluding Remarks

The audit objective was to determine whether the Authority properly sought drug rebate claims on a quarterly basis. The audit scope included drug rebates invoiced in fiscal year 2017, which covered four invoicing quarters: the second, third and fourth quarters of 2016 and the first quarter of 2017. The Authority said at the start of the audit that the eligibility groups and managed care plan code issues identified in the previous audit were not completely resolved during the audit period. For three out of four of the invoicing quarters, these coding issues remained in the rebate system and more than 85,000 rebate eligible claims were missed during the quarterly rebate process.

We used a stratified random sampling method to select the rebates examined in the audit. We found no evidence to support that the cause of the exceptions were limited to a distinct client population.

The audit report that was published by the U.S. Department of Health and Human Services, Office of Inspector General was published after this audit period ended. The audit was referenced to add context that the federal government had recently reported similar issues to those noted in this finding.

We reaffirm our finding, but we are committed to working through the disagreement with the Authority.

During our next audit we will:

- Follow-up to assess whether the Authority's corrective action plans have resolved these matters
- Determine whether the invoicing process, described by the Authority in its response, is mandated by CMS
- Work with the Authority to provide it more time to review preliminary audit results

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls.

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.
(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.
(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

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

> .11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows: …
>
> **Deficiency in internal control over compliance.** A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.
>
> **Material weakness in internal control over compliance.** A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of an event occurring is either reasonably possible or probable as defined as follows:
>
> **Reasonably possible.** The chance of the future event or events occurring is more than remote but less than likely.
>
> **Probable.** The future event or events are likely to occur.
>
> **Significant deficiency in internal control over compliance.** A deficiency, or a combination of deficiencies, in internal control over compliance that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.
>
> **Material noncompliance.** In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

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

> (b) Terms of rebate agreement
>
> (1) Periodic rebates
>
> (A) In general: A rebate agreement under this subsection shall require the manufacturer to provide, to each State plan approved under this subchapter, a rebate for a rebate period in an amount specified in subsection (c) of this section for covered outpatient drugs of the manufacturer dispensed after December 31, 1990, for which payment was made under the State plan for such period, including such drugs dispensed to individuals enrolled with a medicaid managed care organization if the organization is responsible for coverage of such drugs. Such rebate shall be paid by the

manufacturer not later than 30 days after the date of receipt of the information described in paragraph (2) for the period involved.

(B) Offset against medical assistance: Amounts received by a State under this section (or under an agreement authorized by the Secretary under subsection (a)(1) of this section or an agreement described in subsection (a)(4) of this section) in any quarter shall be considered to be a reduction in the amount expended under the State plan in the quarter for medical assistance for purposes of section 1396b(a)(1) of this title.

Health Care Authority Medicaid Drug Rebate Policy

C. PREPARING MEDICAID DRUG REBATE INVOICES

1. No later than 60 days after the end of the calendar quarter, HCA will prepare and transmit an invoice using the CMS-R-144 State Invoice format to each labeler participating in the drug rebate program. HCA will also transmit a copy of form CMS-R-144 to CMS and to the Office of Financial Recovery (OFR).
3. Invoices must reflect only those drugs reimbursed in the reporting period (quarter). Invoices must not include any NDCs paid for under:
   - Public Health Service drug pricing agreements;
   - State-funded only General Assistance programs; Other state-funded only programs; or
   - Other federal non-Medicaid funded drug programs.

2017-036 The Health Care Authority overpaid Medicaid hospitals for outpatient services.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Activities Allowed/Unallowed Allowable Costs/Cost Principles	
Known Questioned Cost Amount:	$118,679	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

The Health Care Authority pays for outpatient hospital services using several payment methods, including Enhanced Ambulatory Patient Group (EAPG), maximum allowable fee schedule and ratio of costs-to-charges (RCC). The Authority uses EAPG as its primary reimbursement method for outpatient hospital services.

The Authority pays outpatient hospitals using the following methods in the following order:

- EAPG to pay for covered services by EAPG weight established by 3M Health Information Systems
- The maximum allowable fee schedule to pay for covered services for which there is no established EAPG weight and for services exempted from EAPG payment
- The hospital's outpatient RCC to pay for the covered services for which the agency has not established a maximum allowable fee

EAPG payment is calculated by applying the EAPG weight to a hospital's specific outpatient rate or conversion factor. The payments are automatically calculated in ProviderOne, the state's Medicaid Management Information System.

In fiscal year 2017, the state Medicaid program paid about $42.3 million to hospitals for outpatient services.

Description of Condition

We found the Authority had adequate internal controls to materially ensure hospitals are paid correctly for outpatient services.

However, we found the Authority used an incorrect EAPG weight factor and made improper payments to hospitals for outpatient services from May 17, 2016, to July 6, 2016. The Authority identified and corrected this EAPG error in July 2016. The Authority also corrected more than 26,000 outpatient claims paid improperly during fiscal year 2017.

During the initial claim adjustment process, however, not all claims were captured. As a result, approximately 3,800 claims were missed from the adjustment process and the Authority overpaid hospitals for outpatient services by $203,122 during the audit period.

The Authority completed its adjustments in January 2018 after we brought this issue to its attention during the audit.

This condition was not reported in the prior audit.

Cause of Condition

The incorrect EAPG weights were loaded into the ProviderOne system in error. When the claim adjustments were processed, additional claims with incorrect payments had been missed in the adjustment.

Effect of Condition and Questioned Costs

The Authority made improper payments to hospitals for outpatient services totaling $203,122. The Authority said it refunded the federal portion of the unallowable costs to the U.S. Department of Health and Human Services, through its adjustments completed in January 2018. We are questioning the overpaid federal share amount of $118,679 because the Authority completed its adjustments in January 2018 after we brought this issue to the attention of the Authority.

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

Recommendations

We recommend the Authority:

- Ensure questioned costs were repaid to the federal grantor
- Ensure correct outpatient EAPG weights are loaded into ProviderOne in the future

Agency's Response

The Authority agrees that there were claims that were missed in the original mass adjustment to correct for the error of incorrect EAPG weight assignment. Those missing claims were identified and adjusted in November of 2017. A very small percentage of those missing claims had not yet fully processed in November, so approximately two percent of the claims did not adjust until January of 2018. All corrections were completed at that time and there are no outstanding questioned costs. We understand and appreciate that the SAO is compelled to report the questioned costs because those corrections occurred after the end of the audit period (June 30, 2017).

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.
(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

(a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Title 42 U.S. Code of Federal Regulations Part 433, Stat Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers

Section 433.300 Basis.

This subpart implements -

(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.
(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to

recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Section 433.316 When discovery of overpayment occurs and its significance.

(a) *General rule.* The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) *Requirements for notification.* Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of - -

(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

(d) *Overpayments resulting from fraud.*

(1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by § 455.15, § 455.21, or § 455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

(e) *Overpayments identified through Federal reviews.* If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an

overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) *Effect of changes in overpayment amount.* Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) *Effect of partial collection by State.* A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

(h) *Effect of administrative or judicial appeals.* Any appeal rights extended to a provider do not extend the date of discovery.

Washington Administrative Code 182-550-7000, Outpatient prospective payment system (OPPS)—General, states:

(1) The Medicaid agency pays for outpatient services using an outpatient prospective payment system (OPPS) for all hospitals that do not qualify as in-state critical access hospitals per WAC 182-550-2598.

(2) The agency uses the enhanced ambulatory payment group (EAPG) software provided by 3MTM Health Information Systems to group OPPS claims based on services performed and resource intensity.

(3) The agency uses the group established in subsection (2) of this section to determine payment for OPPS claims. Title 42 U.S. Code of Federal Regulations Part 433, Stat Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers

Washington Administrative Code 182-550-7400, OPPS EAPG relative weights, states:

(1) The Medicaid agency uses national relative weights established by 3MTM as part of its enhanced ambulatory patient group (EAPG) payment system.

(2) The agency may update the relative weights used for calculating OPPS payments on July 1st of each year, beginning on July 1, 2015.

(3) The agency may update relative weights more frequently for newly added EAPGs in order to maintain current EAPG grouper system functionality.
(4) The agency will post all relative weights used on the agency's web site.

2017-037 The Health Care Authority did not have adequate internal controls over and did not comply with suspension and debarment requirements for Medicaid medical fee-for-service providers.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Suspension and debarment	
Known Questioned Cost Amount:	None	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

Federal regulations prohibit recipients of federal awards from contracting with vendors suspended or debarred from doing business with the federal government. Grantees are required to verify vendors receiving $25,000 or more in federal funds are not suspended or debarred or otherwise excluded from participating in federal programs.

Grantees can meet this requirement by:

- Checking the federal Excluded Parties List System (EPLS)
- Collecting a written certification
- Adding a clause or condition to the contract

The Medicaid program has additional requirements to ensure Medicaid providers are not suspended or debarred. Federal regulations require the state Medicaid agency to determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS).

The regulation requires the state Medicaid agency to perform LEIE and EPLS checks upon enrollment and reenrollment of providers. For all enrolled providers, owners and managing employees, LEIE and EPLS checks must be completed at least monthly.

Over 98,000 Medicaid medical fee-for-service providers were active in Washington during fiscal year 2017. Over 44,000 owners or managing employees were associated with the active 98,000 providers. The Authority paid about $2.24 billion for fee-for-service claims billed by medical providers.

Description of Condition

We found the Authority did not have adequate internal controls over and did not comply with suspension and debarment requirements for Medicaid medical fee-for-service providers.

The Authority performs LEIE and EPLS database checks upon enrollment and reenrollment of medical fee-for-service providers. However, we found the Authority does not complete the required monthly LEIE and EPLS database checks. The Authority did not perform EPLS checks for any months during our audit period. The Authority completed LEIE database checks on a quarterly basis until it started a monthly check in December of 2016; although the Authority did not complete an LEIE check for June 2017.

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

This condition was not reported in the prior audit.

Cause of Condition

In November 2012, the EPLS system was replaced by SAM (System Award Management). The SAM database only has the ability to look up a single individual or an entity; therefore the Authority said it is unable to complete data matches of all 98,000 providers on a monthly basis. The Authority is currently working with the federal government to resolve this issue.

The Authority believed performing a quarterly LEIE check would be sufficient to identify suspended or debarred providers.

Effect of Condition

We tested all providers and determined that the Authority did not make payment to any debarred or suspended provider during the audit period. However, not conducting required monthly database checks timely increases the risk that the Authority would not detect and prevent suspended or debarred providers from receiving federal Medicaid funds. Payments to providers who are suspended or debarred would be unallowable and the Authority may have to repay the grantor.

Recommendation

We recommend the Authority implement adequate internal controls to ensure it completes required EPLS and LEIE checks no less frequently than monthly.

Agency's Response

As noted by the State Auditor's Office, the Authority began monthly LEIE database checks in December 2016. LEIE and EPLS database checks are completed during the provider enrollment process for new enrollees and during re-validation.

The EPLS database checks are currently not conducted on monthly basis as there is a price associated with the SAM/EPLS database checks for an upload of more than one individual provider at a time. The Authority does not have adequate staffing nor the budget to pay to have these checks conducted on a monthly basis due to the volume of its providers.

The Authority was recently approved as a pilot state to utilize the U.S. Department of Treasury's Do Not Pay database system and will be able to upload the volume of providers into SAM/EPLS and conduct the required checks on a monthly basis.

Although there is a current gap in conducting the SAM/EPLS database checks, there were no improper payments identified.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements.

Section 200.303 Internal controls.
The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).
(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.
(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit reporting, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.
(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

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

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

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

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

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

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

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

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

Title 2, U.S. Code of Federal Regulation, part 180, states in part:

Subpart B – Covered Transactions

A covered transactions is a nonprocurement or procurement transactions that is subject to the prohibitions of this part. It may be a transaction at –

(a) The primary tier, between a Federal agency and a person (see appendix to this part); or

(b) A lower tier, between a participant in a covered transaction and another person.

Subpart C–Responsibilities of Participants Regarding Transactions Doing Business With Other Persons

§180.300 What must I do before I enter into a covered transaction with another person at the next lower tier?

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

(a) Checking SAM Exclusions; or

(b) Collecting a certification from that person; or

(c) Adding a clause or condition to the covered transaction with that person.

Title 42 U.S. Code of Federal Regulations section 455 Subpart E – Provider Screening and Enrollment, states in part:

Section 455.436 Federal database checks

The State Medicaid agency must do all of the following:

(a) Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee

(b) Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded parties List System (EPLS) and any such other databases as the Secretary may prescribe.

(c) (1) Consult appropriate databases to confirm identity upon enrollment and reenrollment; and

(2) Check the LEIE and EPLS no less frequently than monthly.

2017-038 The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure Medicaid expenditures were allowable to claim Children's Health Insurance Program funds.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Activities Allowed/Unallowed Allowable Costs/Cost Principles	
Known Questioned Cost Amount:	$1,945	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

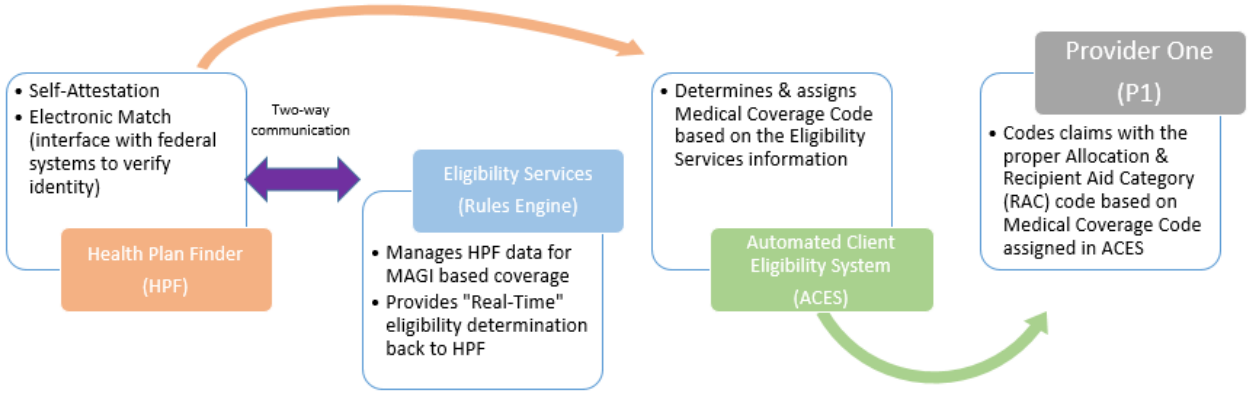
In fiscal year 2017, the State's Medicaid program paid about $131.8 million in additional Children's Health Insurance Program (CHIP) federal funds based on the eligibility of the children in the Medicaid program.

In Washington, Medicaid and the CHIP program provide medical and behavioral health assistance for children up to 19 years old who reside in low-income households. Both the Medicaid and CHIP programs are jointly funded by State and federal money. Federal funds reimburse the State for about 88 percent of CHIP expenditures and 50 percent of Medicaid expenditures for both the Health Care Authority (Authority) and the Department of Social and Health Services (Department). In prior audits, the Authority claimed over 90 percent of the additional CHIP funding, so Department expenditures were not examined in our audits.

The State may claim additional CHIP funding when two conditions are met: The child's family income equals or exceeds 133 percent of the federal poverty level but does not exceed the Medicaid applicable income level (which is 210 percent of the federal poverty level). If the Medicaid costs have already been claimed and reimbursed, the State submits a claim for the difference between the CHIP and Medicaid rates.

The following describes the process the Authority uses to identify Medicaid expenditures that are allowable for the additional CHIP funds:

- Medicaid eligibility is determined in the Eligibility Services system based on income information submitted by applicants through Health Plan Finder, the online application system (see diagram below).
- ProviderOne, the Authority's Medicaid Management Information system, then automatically assigns a Recipient Aid Category (RAC) code to the children who are eligible for additional CHIP funds based on income information in the Automated Client Eligibility System (Eligibility System), Washington's social service program client eligibility system.
- The Authority creates a report showing all payments that ProviderOne assigns both a RAC code of 1204 and an allocation code of 3MXA; payments that are assigned both those codes are identified as allowable for additional CHIP funding.



While both the Authority and the Department use ProviderOne to identify Medicaid expenditures, each agency prepares its own journal vouchers based on the RAC and allocation codes to identify allowable Medicaid expenditures.

In prior audits, we reported the Authority did not have adequate internal controls to ensure additional CHIP funds were properly claimed for allowable Medicaid expenditures. The prior finding numbers were 2016-034, 2015-039, and 2014-037. Prior findings reported inadequate internal controls over additional CHIP funds for the Authority's fee-for service and managed care claims. Claims for the Department were not included in prior audits, so the inadequate internal controls reported as a condition in any of the previously stated findings were not for the Department.

Description of Condition

We found the Authority did not have adequate internal controls to ensure additional CHIP federal funds were claimed only for allowable Medicaid expenditures.

The Authority performs a post-eligibility review to ensure Medicaid eligibility is properly determined. However, it performs the review only when household income is above the Medicaid applicable income level. The applicable income level for Medicaid children is 210 percent of the federal poverty level. Additional CHIP funds are allowable only for Medicaid children whose household income equals or

exceeds 133 percent of the level, but does not exceed 210 percent. When a client's verified income is below 133 percent, the Authority does not conduct a post-eligibility review.

Because the Authority did not perform post-eligibility reviews for clients whose income was below 133 percent, it did not detect when RAC codes were incorrectly assigned to clients. This resulted in the Authority and Department improperly claiming additional CHIP funds.

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

This same condition was identified and reported in the prior year audit for the Authority claims only.

Cause of Condition

The Authority uses specific client eligibility criteria to determine claims that are allowable for additional CHIP federal funding. Clients attest to household income at the time of application. The Eligibility System determines client eligibility based on the first self-attested income that is entered, which is then coded to help identify within ProviderOne if the claim is allowable for additional CHIP federal funds. However, the Eligibility System does not re-determine eligibility of the client if changes to the household income are subsequently entered.

The Eligibility System is configured to accept changes to self-attested household income in Health Plan Finder during the certification period, but it is not updated to adequately determine eligibility for additional CHIP federal funds.

The post-eligibility review is not designed to capture updates to household income when it falls below 133 percent, making those claims unallowable for the additional CHIP funds.

Effect of Condition and Questioned Costs

Authority Claims

We used a statistical sampling method to randomly select and examine 86 clients out of a total population of 166,547 who had a RAC code of 1204 and had paid fee-for-service and managed care claims with an allocation code of 3MXA during the period the claim was made for. In addition, we judgmentally selected four clients with paid amounts above $100,000. We reviewed claims to determine if the Authority properly coded the clients and the claims as allowable for additional CHIP federal funds. We found that for 6 clients, claims of $1,783 in additional CHIP federal funds were unallowable. When we project the results to the entire population of Authority claims, we estimate the total improper payments to be $1,952,670.

Department Claims

We used a statistical sampling method to randomly select and examine 86 clients out of a total population of 180,922 with a RAC code of 1204 and had paid fee-for-service and managed care claims with an allocation code of 3MXA during the period the claim was made for. In addition, we judgmentally selected three clients with paid amounts above $15,000. We reviewed claims to determine

if the Department properly coded the clients and the claims as allowable for additional CHIP federal funds. We found that for 4 clients, claims of $162 in additional CHIP federal funds were unallowable. When we project the results to the entire population of Department claims, we estimate the total improper payments to be $365,080.

	Known questioned costs – federal share*	**Estimated improper payments – federal share***
Authority claims	$1,783	$1,952,670
Department claims	$162	$365,080
Total expenditures	**$1,945**	**$2,317,750**

*Note: CHIP claims do not have a State match

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

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a very high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Recommendations

We recommend the Authority implement procedures to ensure additional CHIP funds are only claimed for eligible expenditures.

Because some of the claims we questioned were recorded in the Department's accounting records, we recommend the Authority work with the Department when it consults with the U.S. Department of Health and Human Services to discuss whether the questioned costs and improper payments identified in the audit should be repaid.

Agency's Response

The Authority does not agree with the SAO's Description of Condition, Cause of Condition, Effect of Condition, or the estimated amount of improper payments. The Authority agrees with the actual questioned cost amount of $1,945.

The questioned costs were due to a system issue identified during the 2016 audit. Certain RAC codes were not updating in ProviderOne when specific elements were missing during the annual renewal process. This RAC assignment issue was corrected in July of 2017. We appreciate that the SAO is required to question the costs identified since the correction occurred after the end of the audit period (June 30, 2017).

The Authority is concerned that the SAO may not have an understanding of the program sufficient to accurately assess the control structure. While the Authority agrees there were some ineligible costs, the cause of those instances was not due to PERs not being conducted as required and approved by CMS.

The Authority will consult with its grantor to resolve the $1,945 in unallowable charges.

Auditor's Concluding Remarks

During our fieldwork, we asked the Authority if it had a monitoring or review process to ensure it only claimed CHIP funds for allowable Medicaid payments made for eligible children. The Authority said the post-eligibility review (PER) was its only monitoring tool. As stated in the finding, the PER is not an adequate monitoring tool for claiming additional CHIP funds because the PER is only performed when a client's income is above the 210 percent federal poverty line (FPL) and not for client's income that falls below the 133 percent FPL causing transactions that are not allowable for the additional CHIP funds to be claimed.

Because we used a statistical sampling method to randomly select our testing samples, we project the results of identified unallowable expenditures to the entire population.

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls.

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller

General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).

(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

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

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

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

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

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

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

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

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

42 U.S. Code §1397ee. Payments to States, states in part:

(g) Authority for qualifying states to use certain funds for Medicaid expenditures. -
(1) State option.—
(A) In general.—Notwithstanding any other provision of law subject to paragraph (4), a qualifying State (as defined in paragraph (2)) may elect to use not more than 20 percent of any allotment under section 1397dd of this title for fiscal year 1998, 1999, 2000, 2001, 2004, 2005, 2006, 2007, or 2008 (insofar as it is available under subsections (e) and (g) of such section) for payments under subchapter XIX of this chapter in accordance with subparagraph (B), instead of for expenditures under this subchapter .
(B) Payments to states.—
(i) In In general.—In the case of a qualifying State that has elected the option described in subparagraph (A), subject to the availability of funds under such subparagraph with respect to the State, the Secretary shall pay the State an amount each quarter equal to the additional amount that would have been paid to the State under subchapter XIX of this chapter with respect to expenditures described in clause (ii) if the enhanced FMAP (as determined under subsection (b) of this section) had been substituted for the Federal medical assistance percentage (as defined in section 1396d(b) of this title).
(ii) Expenditures described.—For purposes of this subparagraph, the expenditures described in this clause are expenditures, made after August 15, 2003, and during the period in which funds are available to the qualifying State for use under subparagraph (A), for medical assistance under subchapter XIX of this chapter to individuals who have not attained age 19 and whose family income exceeds 150 percent of the poverty line.
(iii) No impact on determination of budget neutrality for waivers.—In the case of a qualifying State that uses amounts paid under this subsection for expenditures described in clause (ii) that are incurred under a waiver approved for the State, any budget neutrality determinations with respect to such waiver shall be determined without regard to such amounts paid.
(2) Qualifying state.—In this subsection, the term "qualifying State" means a State that, on and after April 15, 1997, has an income eligibility standard that is at least 184 percent of the poverty line with respect to any 1 or more categories of children (other than infants) who are eligible for medical assistance under section 1396a(a)(10)(A) of this title or, in the case of a State that has a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that was first implemented on August 1, 1994, or July 1, 1995, has an income eligibility standard under such waiver for children that is at least 185 percent of the poverty line, or, in the case of a State that has a statewide waiver in effect under section 1315 of this title with respect to subchapter

XIX of this chapter that was first implemented on January 1, 1994, has an income eligibility standard under such waiver for children who lack health insurance that is at least 185 percent of the poverty line, or, in the case of a State that had a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that was first implemented on October 1, 1993, had an income eligibility standard under such waiver for children that was at least 185 percent of the poverty line and on and after July 1, 1998, has an income eligibility standard for children under section 1396a(a)(10)(A) of this title or a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that is at least 185 percent of the poverty line.

(3) Construction.—Nothing in paragraphs (1) and (2) shall be construed as modifying the requirements applicable to States implementing State child health plans under this subchapter.

(4) Option for allotments for fiscal years 2009 through 2015.—

(A) Payment of enhanced portion of matching rate for certain expenditures.—In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State's allotment made under section 1397dd of this title for any of fiscal years 2009 through 2015 (insofar as the allotment is available to the State under subsections (e) and (m) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under subchapter XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1396d(b) of this title).

(B) Expenditures described.—For purposes graph (A), the expenditures described in this subparagraph are expenditures made after February 4, 2009, and during the period in which funds are available to the qualifying State for use under subparagraph (A), for the provision of medical assistance to individuals residing in the State who are eligible for medical assistance under the State plan under subchapter XIX or under a waiver of such plan and who have not attained age 19 (or, if a State has so elected under the State plan under subchapter XIX, age 20 or 21), and whose family income equals or exceeds 133 percent of the poverty line but does not exceed the Medicaid applicable income level.

2017-039 The Health Care Authority made improper payments to Medicaid managed care recipients with Medicare insurance coverage.

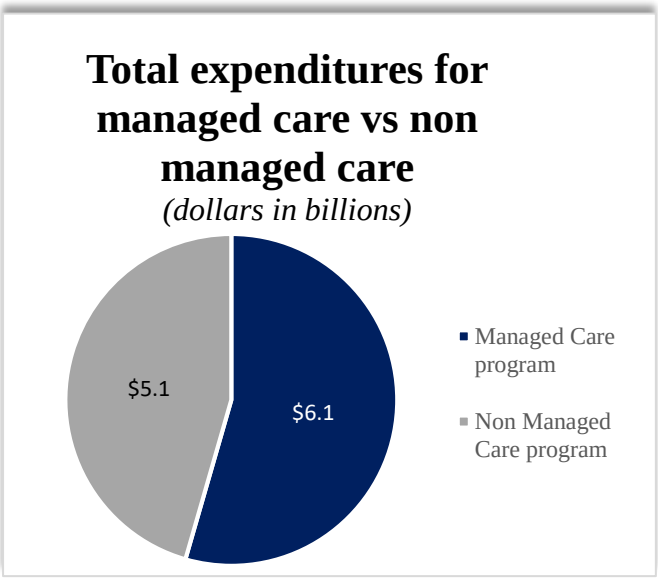
Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles
Known Questioned Cost Amount:	$4,268,059

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

The Health Care Authority (Authority), the state's Medicaid agency, administers Washington's managed-care program. Managed care is a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty and ancillary health care services. The program is designed to reduce the cost of providing health benefits, improve the quality of care and deliver health care to clients. The State contracts with health insurance plans, known as managed-care organizations to cover the costs of Medicaid client claims.

The Authority pays managed-care organizations a uniform, pre-determined per-enrollee monthly premium to cover medical costs for Medicaid eligible clients. In Washington, certain client groups are excluded from managed care, including clients who are eligible to receive Medicare. According to Washington's Medicaid state plan, Medicare recipients should not be enrolled in managed care, and any monthly premium payments made for Medicare recipients are unallowable.



In fiscal year 2017, the State's Medicaid program paid about $6.1 billion in managed care premiums on behalf of more than 1.9 million Medicaid clients.

Description of Condition

We found the Authority had adequate internal controls to materially ensure clients with Medicare coverage did not receive Medicaid managed care premium payments.

We obtained Medicare coverage information from the Authority for all Medicaid-eligible clients. Using computer assisted auditing techniques, we tested to determine if the Authority made monthly managed care premium payments for clients during the same time period when Medicare coverage was effective.

We found 9,979 improper premium payments made on behalf of 4,065 clients who had Medicare coverage during the same month as their monthly, managed care premium payment. The Authority paid $6,591,143 to the managed-care organizations serving these clients.

Cause of Condition

The Authority had automated processes in place in ProviderOne, the state's Medicaid Management Information System, designed to materially detect clients with Medicare coverage to prevent payments to managed-care organizations for those clients. However, the system edits did not prevent or detect all unallowable premium payments.

The Authority began performing post-payment reviews in March 2016 to detect improper managed-care premiums paid to Medicare recipients during the audit period. The Authority's most recent review began in November 2017. However, the review is ongoing and has not addressed all managed care premiums paid during the audit period.

Effect of Condition and Questioned Costs

Payments that are duplicative in nature, or made to an ineligible recipient, are unallowable and cannot be claimed for federal reimbursement. As seen in the following table, the federal share of the improper premium payments totaled $4,268,059.

Client group	Number of clients	Number of premiums paid	Known questioned costs	Federal share of known questioned costs
Clients with Medicare Part A (hospital) and Part B (physician) coverage	4,064	9,964	$6,585,363	$4,265,169
Clients with Medicare Part C coverage	1	15	$5,779	$2,890
Total	**4,065**	**9,979**	**$6,591,143**	**$4,268,059**

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

Recommendations

We recommend the Authority:

- Recoup overpayments made to managed-care organizations identified in the audit
- Consult with the U.S. Department of Health and Human Services to discuss whether the questioned costs identified in the audit should be repaid

Agency's Response

As noted by the State Auditor's Office, the Authority is currently identifying any duplicate per member per month (PMPM) premium payments for clients enrolled in Medicare. The Authority developed an algorithm to identify duplicate PMPM premium payments in March 2016. The Authority will continue to run the algorithm to identify and recoup duplicate PMPM premium payments, as appropriate, until enhancements are made to the MMIS/ProviderOne to automate recoup of PMPM premiums for clients who are retro-enrolled in Medicare. This anticipated upgrade will begin in April 2018.

The Authority will consult with the U.S. Department of Health and Human Services regarding resolution of questioned costs.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).

(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion

on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Title 42 U.S. Code of Federal Regulations Part 433, Stat Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers

Section 433.300 Basis.

This subpart implements -

(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.

(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Section 433.316 When discovery of overpayment occurs and its significance, states in part:

(a) *General rule.* The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) *Requirements for notification.* Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of - -

(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

(d) *Overpayments resulting from fraud.*

(1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by § 455.15, § 455.21, or § 455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

(f) *Effect of changes in overpayment amount.* Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) *Effect of partial collection by State.* A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

(h) *Effect of administrative or judicial appeals.* Any appeal rights extended to a provider do not extend the date of discovery.

Title 42 U.S. Code of Federal Regulations Chapter 7, Social Security, Subchapter XIX – Grants To States For Medical Assistance Programs, § 1396u-2 – Provisions relating to managed care, states in part:

(a) State Option to Use Managed Care

(2) Special Rules

(B) Exemption of medicare beneficiaries.

A state may not require under paragraph (1) the enrollment in a managed care entity of an individual who is a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title) or an individual otherwise eligible for benefits under subchapter XVIII.

The Health Care Authority, Apple Health Managed Care Contract, Section 4.3 – "Eligible Client Groups" states in part:

Clients in the following eligibility groups at the time of enrollment are eligible for enrollment under this Contract.

4.3.6 Categorically Needy – Blind and Disabled Children and Adults who are not eligible for Medicare.

The Health Care Authority, Apple Health Managed Care Contract, Section 4.11 – "Termination of Enrollment" states in part:

4.11.5 Involuntary Enrollment Termination Initiated by the Health Care Authority for Comparable Coverage or Duplicate Coverage:

4.11.5.1 The Contractor shall submit to HCA a monthly report of enrollees with any other health care insurance coverage with any carrier, including the contractor. The Contractor is not responsible for the determination of comparable coverage as defined in this subsection.

4.11.5.2 The Health Care Authority will involuntarily terminate the enrollment of any enrollee with duplicate coverage or comparable coverage as follows:

4.11.5.2.1 When the enrollee has duplicate coverage that has been verified by HCA, HCA shall terminate enrollment retroactively to the beginning of the month of duplicate coverage and recoup premiums as described in the Recoupments provisions of the Payment and Sanctions Section of this Contract.

4.11.5.2.2 When the enrollee has comparable coverage which has been verified by HCA, HCA shall terminate enrollment prospectively.

Medicaid State Plan, Scope of Care and Types of Services, Attachment 3.1 F Part 2, Apple Health Managed Care, E. Populations and Geographic Area, states in part:

IV. Included Populations. Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

Population	M	Geographic Area	V	Geographic Area	**Excluded**
Recipients Eligible for Medicare					**X**

2017-040 The Health Care Authority made improper Medicaid pharmacy fee-for-service payments for clients enrolled in managed care.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles
Known Questioned Cost Amount:	$111,756

Background

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.9 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

The Health Care Authority (Authority), the State's Medicaid agency, administers Washington's managed-care program. Managed care is a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty and ancillary health care services. The program is designed to reduce the cost of providing health benefits, improve the quality of care and deliver health care to clients. The State contracts with health insurance plans, known as managed-care organizations, to cover the costs of Medicaid client claims.

In Washington, five managed care organizations operate with managed care contracts. The Authority pays the managed-care organizations a uniform, pre-determined, per-enrollee monthly premium to cover medical costs for Medicaid-eligible clients.

The Authority's contracts with managed-care organizations specify the types of services covered and not covered for Medicaid clients enrolled in the managed-care program. Any services not covered by the managed-care organization's contract are billed directly to the Authority and paid as a fee-for-service claim.

During fiscal year 2017, the Authority paid about $5.6 billion in managed care payments on behalf of more than 1.9 million Medicaid clients. The Authority paid more than $2.2 billion in fee-for-service claims.

Description of Condition

We found the Authority had adequate internal controls to materially prevent providers from being improperly paid for claims billed as fee-for-service that should have been covered by the client's managed care plan.

Using computer assisted auditing techniques, we tested to determine if the Authority made additional fee-for-service payments on behalf of clients for services that should have been covered by the client's monthly managed care premium.

We found the Authority made 3,515 improper fee-for-service payments to providers for prescription services, totaling $147,666.

This condition was not reported in the prior audit.

Cause of Condition

The improper payments were made for pharmacy claims for clients who were retroactively enrolled in the managed-care program. At the time the pharmacy services were provided, the clients were covered by the Medicaid fee-for-service program. The clients were later enrolled in managed care, and their enrollment was applied retroactively to the beginning of the service month. This created an overlap between the dates for which the pharmacy claims were paid as fee-for-service and when the client's managed care coverage was effective. The Authority did not recover the paid fee-for-service claims for the month.

The Authority said it would not recover the fee-for-service pharmacy payments made for the clients who were retroactively enrolled in managed care because the Centers for Medicare and Medicaid Services approved this practice. Specifically, Washington's Medicaid state plan allows retroactive payment of managed-care premiums to the first of the retroactively enrolled month. However, the plan does not explicitly allow for the fee-for-service duplicate payments for the month to be eligible for federal reimbursement. Therefore, we concluded the duplicate fee-for-service claims for the retroactively enrolled month were improper.

Effect of Condition and Questioned Costs

When providers submit fee-for-service claims for services that are covered under managed care, and the Authority authorizes payment of these claims, the Medicaid program incurs duplicate costs.

Each client's monthly managed care premium is intended to cover all medical care expenses for the client, for services specified in the State's Apple Health Managed Care contract. As such, any payments of fee-for-service claims that the Authority made for services required to be provided under the managed-care contract are unallowable and cannot be claimed for federal reimbursement.

We are questioning the federal share of the improper fee-for-service pharmacy claims, which total $111,756.

We question costs when we find an agency has not followed grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendation

We recommend the Authority consult with the U.S. Department of Health and Human Services to discuss whether the questioned costs identified in the audit should be repaid.

Agency's Response

The Authority disagrees with the finding that pharmacy claims paid fee-for-service for clients retroactively enrolled in managed care are unallowable. Payments made for pharmacy services are made in real time, based on the client's eligibility and enrollment at the time of service. The pharmacy claims selected under this review were appropriately paid with the client being covered under the fee-for-service program at the time of claim submission and payment. The Authority does not recoup pharmacy payments for appropriately billed and paid services when the client's enrollment retroactively changes. The Authority determined that the cost of doing so, both quantitatively and qualitatively, outweighs the benefit and could result in a loss of access to pharmacy services, particularly in rural areas. The Authority received informal guidance from CMS stating that this cost/benefit approach is appropriate. This position was further supported when CMS did not identify the practice as unallowable when asked by the SAO. The Authority is requesting official guidance from CMS.

Auditor's Concluding Remarks

Our finding is based on the fact that the Authority made duplicate payments for fee-for-services covered by the managed care program. The Medicaid program incurs a duplicate payment when providers submit fee-for-service claims for services that are covered under managed care, and the Authority makes payment of these services when a monthly premium was already paid for the client to the managed care organization.

In addition, Center for Medicare and Medicaid Services (CMS) has not formally concluded that the duplicate fee-for-service payments are allowable based on the Authority's cost/benefit approach.

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and
(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.
(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.
(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.
(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.
(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.
(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Include if finding has question costs

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

(a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
    (3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically

identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Title 42 U.S. Code of Federal Regulations Part 433, Stat Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers

Section 433.300 Basis.

This subpart implements -

(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.

(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Section 433.316 When discovery of overpayment occurs and its significance.

(a) *General rule.* The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) *Requirements for notification.* Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of - -

(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

(d) *Overpayments resulting from fraud.*

(1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by § 455.15, § 455.21, or § 455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

(e) *Overpayments identified through Federal reviews.* If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) *Effect of changes in overpayment amount.* Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) *Effect of partial collection by State.* A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

(h) *Effect of administrative or judicial appeals.* Any appeal rights extended to a provider do not extend the date of discovery.

The Health Care Authority, Apple Health Managed Care Contract, Section 16.8 – "General Description of Contracted Services" states in part:

16.8.17 Pharmaceutical Products:

16.8.17.1 Covered drug products shall include:

16.8.17.1.1 Prescription and over-the-counter drug products according to the HCA approved formulary. The Contractor's formulary shall include:

16.8.17.1.1.1 All therapeutic classes covered by the HCA's fee-for-service Prescription Drug Program, and a sufficient variety of drugs in each therapeutic class to meet enrollees' medically necessary health care needs;

16.8.17.1.1.2 Only those over-the-counter products covered under HCA's FFS. The Contractor's formulary must include all products or therapeutic classes of products covered under FFS and may not include any additional OTCs beyond those determined by HCA to be medically necessary alternatives to prescription medications. HCA will provide the Contractor a list of covered OTC medications for the purpose of formulary development.

16.8.17.1.2 Antigens and allergens;

16.8.17.1.3 Therapeutic vitamins and iron prescribed for prenatal and postnatal care;

16.8.17.1.4 Insulin Pens without requiring authorization and approval for:

16.8.17.1.4.1 Pregnant women; and

16.8.17.1.4.2 Children under age 21.

16.8.17.1.5 Psychotropic medications according to the contractor's approved formulary when prescribed by a medical or mental health professional, when he or she is prescribing medications within his or her scope of practice with appropriate.

16.8.17.1.6 Hemophiliac Blood Product – Blood factors VII, VIII and IX and the anti-inhibitor provided to enrollees with a diagnosis of hemophilia or von Willebrand disease when the enrollee is receiving services in an inpatient setting.

16.8.17.1.7 All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies, including emergency contraception, all long acting reversible contraceptives, all over-the-counter (OTC) contraceptives and contraceptive methods which require administration or insertion by a health care professional in a medical setting. Coverage of contraceptive drugs, devices and supplies must include:

16.8.17.1.7.1 All OTC contraceptives without a prescription. This includes but is not limited to condoms, spermicides, sponges and any emergency contraceptive drug that is FDA-approved to be dispensed over the counter. There are no limits to these OTC contraceptives. OTC contraceptives must be covered without authorization or quantity limits.

16.8.17.1.7.2 Coverage when dispensed by either a pharmacy or a Family Planning Clinic at the time of a family planning visit. Contraceptives dispensed by a Family Planning Clinic must be covered under the medical benefit.

16.8.17.1.7.3 Dispensing of 12 months of contraceptives at one time without authorization requirements related to quantity or days supplied. Duration of any authorization for contraceptives for other reasons must be no less than 12 months.

16.8.17.1.7.4 Contraceptive dispensing in twelve (12) month supplies unless otherwise prescribed by the clinician or the enrollee requests a smaller supply.

16.8.17.1.7.5 Encourage prescribers to write contraception prescriptions for dispensing in twelve (12) month supplies and pharmacists to dispense in twelve (12)month supplies.

16.8.17.1.7.6 Appropriate prescribing and dispensing practices in accord with clinical guidelines to ensure the health of the enrollee while maximizing access to effective birth control methods or contraceptive drugs.

16.8.17.1.8 All drugs FDA labeled or prescribed as Medication Assisted Treatment (MAT) or maintenance therapy for substance use disorders, with the exception of methadone dispensed directly by opiate substitution treatment programs. The Contractor will cover all MAT according to guidelines and requirements determined by HCA.

The Health Care Authority, Apple Health Managed Care Contract, Section 16.10 – "Exclusions" states in part:

The following services and supplies are excluded from coverage under this Contract.

16.10.1 Unless otherwise required by this Contract, ancillary services resulting solely from or ordered in the course of non-contracted services are also non-contracted services.

16.10.2 The Contractor shall not provide or pay for services that violate the Assisted Suicide Funding Restriction Act of 1997 (SSA § 1903(i)(16)).

16.10.3 Early, elective inductions (before 39 weeks) that do not meet medically necessary indicators set by the Joint Commission. Because the Joint Commission's criteria do not capture all situations in which an early delivery is medically indicated, the Contractor shall provide a process for facilities to request a review of cases that do not meet that criteria, but which the hospital and delivering provider believe were medically necessary.

16.10.4 The following covered services are provided by HCA and are not contracted services. The Contractor is responsible for coordinating and referring enrollees to these services through all means possible, e.g., action letter notices, call center communication or Contractor publications.

16.10.4.1 Inpatient Hospital charges at Certified Public Expenditure (CPE) hospitals for Categorically Needy – Blind and Disabled identified by HCA;

16.10.4.2 School-based Health Care Services for Children in Special Education with an Individualized Education Plan or Individualized Family Service Plan

who have a disability, developmental delay or are diagnosed with a physical or mental condition;

16.10.4.3 Eyeglass frames, lenses, and fabrication services covered under HCA's selective contract for these services for children under age twenty-one (21), and associated fitting and dispensing services. The Contractor is encouraged to inform eye practitioners of the availability of Airway Heights Correctional Center to access glasses for adult clients age twenty-one (21) and over if not offered by the Contractor as a value added benefit;

16.10.4.4 Voluntary Termination of Pregnancy;

16.10.4.5 Court-ordered transportation services, including ambulance services;

16.10.4.6 Transportation Services other than ambulance, including but not limited to: taxi, ambulance, voluntary transportation, public transportation and common carriers;

16.10.4.7 Air ambulance services. The Contractor remains responsible for all ground ambulance transportation services as described in this Contract;

16.10.4.8 Services provided by dentists and oral surgeons for dental diagnoses; anesthesia for dental care;

16.10.4.9 Orthodontics;

16.10.4.10 HCA First Steps Program - Maternity Support Services (MSS), consistent with the Marketing and Information, Subcontracts, and Care Coordination provisions of this Contract;

16.10.4.11 Sterilizations for enrollees under age twenty-one (21), or those that do not meet other federal requirements (42 C.F.R. § 441 Subpart F);

16.10.4.12 Health care services provided by a neurodevelopmental center recognized by the Department of Health;

16.10.4.13 Services provided by a health department when a client self-refers for care if the health department is not contracted with the Contractor;

16.10.4.14 Inpatient psychiatric services, including psychiatric consultations when the inpatient admission is approved by a Behavioral Health Organization;

16.10.4.15 Long-term private duty nursing for enrollees 18 and over. These services are covered by DSHS, Aging and Long-Term Services Administration;

16.10.4.16 Prenatal Genetic Counseling;

16.10.4.17 Substance use treatment services covered through the DSHS, Behavioral Health and Service Integration Administration (BHSIA). Drugs prescribed as Medication Assisted Treatment or maintenance therapy for substance use disorders are a separate course of treatment, not ancillary to other treatment services and are a contracted service under the Pharmaceutical Products provisions of this Contract;

16.10.4.18 Community-based services (e.g., COPES and Personal Care Services) covered through the Aging and Long Term Services Administration (ALTSA);

16.10.4.19 Nursing facility stays that do not meet rehabilitative or skilled criteria;

16.10.4.20 Mental health services separately purchased for all Medicaid clients by the DSHS, BHSIA;

16.10.4.21 Health care services covered through the DSHS, Developmental Disabilities Administration (DDA) for institutionalized clients;

16.10.4.22 Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health;

16.10.4.23 Any service provided to an enrollee while incarcerated with the Washington State Department of Corrections (DOC);

16.10.4.24 Hemophiliac Blood Product – Blood factors VII, VIII and IX and the anti-inhibitor indicated for use in treatment for hemophilia and von Willebrand disease distributed for administration in the enrollee's home or other outpatient setting; and.

16.10.4.25 Immune modulators and anti-viral medications to treat Hepatitis C. This exclusion does not apply to any other contracted service related to the diagnosis or treatment of Hepatitis C.

16.10.4.26 Sexual reassignment surgery as described in WAC 182-5311675(6)(d) and (e) as well as hospitalizations, physician, and ancillary services required to treat postoperative complications of these procedures.

16.10.4.27 Chemical-Using Pregnant (CUP) Women program as described in WAC 182-533-0730 when provided by an HCA-approved CUP provider.

2017-041 The Health Care Authority made improper Medicaid payments to Federally Qualified Health Centers.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Activities Allowed/Unallowed Allowable Costs/Cost Principles	
Known Questioned Cost Amount:	$29,518	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

Federally Qualified Health Centers (FQHC) are "safety net" providers that serve a range of populations, including the uninsured, publicly insured and underinsured low-income populations, as well as special populations such as migrant seasonal farm workers and homeless people. FQHCs are certified by Centers for Medicare and Medicaid Services and designed to provide medical help for people in medically challenged areas. FQHCs offer comprehensive services that must be accessed through formal arrangements. Services include diagnostic and lab, pharmaceutical, behavioral and oral, hospital and specialty, after-hours care, case management, transportation and interpretation.

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

Incidental services are factored into the encounter rate established for each FQHC. Those services must not be billed separately as a fee-for-service. Services not factored into the encounter rate are paid at the appropriate fee schedule amount as a fee-for-service.

Encounters are limited to one a day for each client, except in the following circumstances:

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

In fiscal year 2017, the state Medicaid program paid about $257 million to FQHCs.

In prior audits, we found that the Authority made improper payments to FQHCs. The prior finding numbers for FQHCs are 2016-030, 2015-033, 2014-036 and 2013-026.

Description of Condition

We found the Authority had adequate internal controls to materially ensure FQHC providers were properly paid for Medicaid services.

Using computer assisted auditing techniques, we examined all $257 million in payments by performing tests to determine if fee-for-service claims were paid in addition to encounter payments, if encounter payments were made when services did not qualify for them, and if multiple encounters were paid for the same client. In total, we found the Authority made improper payments to FQHC providers totaling $41,676.

The following table summarizes the results:

Description	Total unallowable payments	Federal portion of unallowable payments
Fee-for-service claims were paid in addition to encounter payments	$12,495	$9,833
Encounter payments were made when services did not qualify as an encounter	$26,512	$17,920
More than one encounter payment was made for the same client	$2,669	$1,765
Total	**$41,676**	**$29,518**

Cause of Condition

The Medicaid claim adjudication and payment process is highly automated. The Authority relies mostly on the internal controls of ProviderOne, Washington's Medicaid Management Information System, to identify and deny charges that are unallowable or billed improperly.

In response to our prior findings, the Authority said the new system edits were implemented in October 2015, which would better prevent overpayments and improper billings by providers. However, the new system edits did not prevent all improper payments.

Effect of Condition and Questioned Costs

The Authority improperly claimed reimbursement for unallowable payments of $41,676. We are questioning $29,518, which is the federal portion of the unallowable costs.

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

Recommendations

We recommend the Authority:

- Recoup the overpayments made to FQHCs
- Consult with the U.S. Department of Health and Human Services to discuss whether the questioned costs and improper payments identified in the audit should be repaid

Agency's Response

The Authority agrees with the audit finding. We will consult with our federal grantor regarding the resolution of question costs.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.
(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.
(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.
(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.
(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.
(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

(a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Title 42 U.S. Code of Federal Regulations Part 433, Stat Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers

Section 433.300 Basis.

This subpart implements -

(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.

(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Section 433.316 When discovery of overpayment occurs and its significance.

(a) *General rule.* The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) *Requirements for notification.* Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of - -

(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

(d) *Overpayments resulting from fraud.*

(1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a

provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by § 455.15, § 455.21, or § 455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

(e) *Overpayments identified through Federal reviews.* If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) *Effect of changes in overpayment amount.* Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) *Effect of partial collection by State.* A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

(h) *Effect of administrative or judicial appeals.* Any appeal rights extended to a provider do not extend the date of discovery.

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

(8) The agency limits encounters to one per client, per day except in the following circumstances:

(a) The visits occur with different health care professionals with different specialties; or

(b) There are separate visits with unrelated diagnoses.

(9) FQHC services and supplies incidental to the provider's services are included in the encounter rate payment.

2017-042 The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls to ensure compliance with survey requirements for Medicaid intermediate care facilities.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT
Applicable Compliance Component:	Special Tests and Provisions – Provider Health and Safety Standards
Known Questioned Cost Amount:	None

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

Residential Care Services, under the Department of Social and Health Services, Aging and Long-Term Support Administration, is the State's Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) survey agency. An ICF/IID is an institution with the primary purpose of providing health or rehabilitation services to people with intellectual disabilities or related conditions that receive care and services under Medicaid.

In fiscal year 2017, the state Medicaid program spent about $16.5 million to survey and certify healthcare providers. The Department of Social and Health Services spent about $7.8 million certifying ICF/IID facilities during fiscal year 2017. The State had 12 ICF/IID facilities that were Medicare and/or Medicaid certified.

The Department is required to perform an annual certification survey of each ICF/IID. The certification survey is a resident-centered inspection that gathers information about the quality of service provided in a facility to determine compliance with the participation requirements. The survey focuses on the facility's administration and patient services, as well as the outcome of the facility's implementation of ICF/IID active treatment services. The survey also assesses compliance with federal health, safety and quality standards designed to ensure patients receive safe and quality care services.

The State must complete a standard survey for each ICF/IID facility within 15.9 months after the previous survey, and the statewide average for all ICF/IID facilities must not exceed 12.9 months for all ICF/IID facilities, as required by Centers for Medicare and Medicaid Services (CMS). If a survey uncovers deficiencies, the Department must mail a Statement of Deficiency to the facility within 10 working days of the survey date. The facility must submit a Plan of Correction that the Department determines is acceptable within 60 calendar days of receipt or risk forfeiting its Medicaid certification. In addition to federal requirements, the Department has established its own policies and procedures requiring that it review a submitted Plan of Correction within five working days after receiving it. The Department initially created these policies and procedures for nursing home surveys; however, the Department extends the application of these policies and procedures to ICF/IID facilities.

In prior audits, we reported the Department did not have adequate internal controls to ensure timely conducting of surveys and follow up on deficiencies. The prior finding numbers were 2016-037, 2015-045 and 2014-046.

Description of Condition

The Department did not establish adequate internal controls to ensure compliance with federal requirements for completing recertification surveys of ICF/IID facilities. The Residential Care Services Unit did not have policies and procedures for reviewing Plans of Correction submitted by ICF/IID facilities. The Department requested staff to follow the same procedures outlined under Residential Care Services policy for nursing homes.

We examined all 12 certification surveys completed during the audit period and found three instances (25 percent) where the Department did not review the submitted Plan of Correction for acceptability within five working days.

We also found one facility (8 percent) did not submit an acceptable Plan of Correction to the Department. The Department cited the facility for multiple deficiencies, and the facility did not achieve the required compliance within 60 days of receiving the Statement of Deficiencies. Further, the Department did not recommend CMS terminate the facility's Medicaid status, as required.

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

Cause of Condition

The Department follows Nursing Home procedures for ICF/IID to ensure that standard surveys are completed in a timely manner, Statements of Deficiencies are mailed and Plans of Corrections are received according to federal standards in the State Operations Manual. The ICF/IID field unit did not follow these procedures requiring reviews of Plans of Correction within five working days of receiving the Plan. Management also failed to ensure the reviews were completed within five working days.

The facility that failed to submit a Plan of Correction had violated the conditions of participation, and the Department believed that a Plan of Correction was not required if these conditions had not been met. Instead, the Department advised the facility in writing to voluntarily submit a Plan of Correction.

Effect of Condition

When the Department does not follow up on deficiencies promptly, the State pays the facilities for services provided to Medicaid clients without assurance the facilities are complying with federal and state health standards and regulations. Clients residing in facilities that do not meet federal health and safety requirements for participating in the Medicaid program could be at increased risk of abuse, mistreatment, neglect or substandard care.

Recommendations

We recommend the Department:

- Establish policies and procedures unique to ICF/IID facility certification surveys
- Ensure submitted Plans of Correction are reviewed for acceptability no later than five working days after they are received by the Department
- Follow up with facilities found to have deficiencies to ensure the facilities are in compliance with federal health and safety standards no later than 60 days after the facility receives the Statement of Deficiency
- Refer to CMS the facility that did not submit an acceptable Plan of Correction to determine if the facility's Medicaid certification must be revoked

Agency's Response

The Department concurs with the finding.

The Department has an established internal mechanism to track acceptability of Plans of Correction however, the tracking log indicates a ten-day review instead of five-day review. The Department's failure to review the Plans of Correction as required occurred due to a lack of policy and procedure. The Department developed a policy and procedure to ensure POCs are reviewed within five days and will submit it for review and approval.

The Department agrees a facility that was non-compliant with a condition of participation did not submit a plan of correction. The unit's initial correspondence to the facility requested a credible allegation of compliance for the condition of participation and made a plan of correction optional. The department has changed the contents of letters to the facilities to be very clear a plan of correction is required. The department will develop a standard operating procedure to ensure plans of correction are required from facilities whenever a facility is non-compliant with condition of participation in addition to the credible allegation of compliance. The department has since scheduled a revisit survey to determine whether the facility is in compliance with condition of participation.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following requirements:

> Section 200.303 Internal controls.
>
> The non-Federal entity must:
>
> (a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

> Section 200.516 Audit reporting, states in part:
>
> (a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
>
> (1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

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

> .11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows: …
>
> **Deficiency in internal control over compliance.** A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.
>
> **Material weakness in internal control over compliance.** A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when

the likelihood of an event occurring is either reasonably possible or probable as defined as follows:

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

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

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

Title 42 U.S. Code of Federal Regulations, Part 488, *Survey, Certification, and Enforcement Procedures*, states in part:

Section 488.28 – Providers or suppliers, other than Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs), and Home Health Agencies (HHAs) with deficiencies

(a) If a provider or supplier is found to be deficient in one or more of the standards in the conditions of participation, conditions for coverage, or conditions for certification or requirements, it may participate in, or be covered under, the Medicare program only if the provider or supplier has submitted an acceptable plan of correction for achieving compliance within a reasonable period of time acceptable to CMS. In the case of an immediate jeopardy situation, CMS may require a shorter time period for achieving compliance.

(b) The existing deficiencies noted either individually or in combination neither jeopardize the health and safety of patients nor are of such character as to seriously limit the provider's capacity to render adequate care.

(c) (1) If it is determined during a survey that a provider or supplier is not in compliance with one or more of the standards, it is granted a reasonable time to achieve compliance.

(2) The amount of time depends upon the -

(i) Nature of the deficiency; and

(ii) State survey agency's judgment as to the capabilities of the facility to provide adequate and safe care.

(d) Ordinarily a provider or supplier is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies but the State survey agency may recommend that additional time be granted by the Secretary in individual situations, if in its judgment, it is not reasonable to expect compliance within 60 days, for example, a facility must obtain the approval of its governing body, or engage in competitive bidding.

Section 42 CFR 488.456 - Termination of provider agreement, states in part:

(b) Basis for termination.

1. CMS and the State may terminate a facility’s provider agreement if a facility –

(i) Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present; or

(ii) Fails to submit an acceptable plan of correction within the timeframe specified by CMS or the State.

Title 42, U.S. Code of Federal Regulations, Section 488.402 General provisions, states in part:

> (d) Plan of correction requirement. (1) Except as specified in paragraph (d)(2) of this section, regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements must submit a plan of correction for approval by CMS or the survey agency.

Title 42 U.S. Code of Federal Regulations, Part 489, *Provider Agreements and Supplier Approval*, states in part:

> Section 489.53 Termination by CMS.
>
> (a) Basis for termination of agreement. CMS may terminate the agreement with any provider if CMS finds that any of the following failings is attributable to that provider, and may, in addition to the requirements in this chapter governing the termination of agreements with suppliers, terminate the agreement with any supplier to which the failings in paragraphs (a)(2), (13) and (18) of this section are attributable:
>
> (3) It no longer meets the appropriate conditions of participation or requirements (for SNFs and NFs) set forth elsewhere in this chapter.

Centers for Medicare and Medicaid Services, State Operations Manual, Chapter 2 – The Certification Process, states in part:

> 2728 – Statement of Deficiencies and Plan of Correction, Form CMS-2567
>
> The SA mails the provider/supplier a copy of Form CMS-2567 within 10 working days after the survey. If there are deficiencies, the SA allows the provider/supplier 10 calendar days to complete and return the PoC.
>
> 2728B – PoC
>
> Failure to submit a PoC could result in termination of the provider agreement as authorized by 42 CFR 488.28(a), 488.456(b)(1)(ii), and 489.53(a)(1). After a PoC is submitted, the surveying entity makes the determination of the appropriateness of the PoC. (See §7500 for SNFs/NFs.)
>
> This "reasonable period of time" (to achieve compliance) is generally no longer than 60 calendar days…
>
> The provider/supplier cited with deficiencies has the following three options:
>
> - Accept the deficiencies stated on Form CMS-2567 and submit a PoC;
> - Record objections to the cited deficiencies on Form CMS-2567 **and** submit a PoC; or
> - Record objections to cited deficiencies on Form CMS-2567, do not submit a PoC, and provide convincing arguments and documented evidence that the deficiencies are invalid.
>
> As indicated above, the provider/supplier may attempt to refute the deficiency(ies) on Form CMS-2567. If so, the SA tries to resolve the disagreement and document the resolution. If the provider/supplier has attempted to refute a deficiency or deficiencies without submitting a PoC, but has not provided the SA with **documented evidence** that successfully refutes the validity of the deficiency, the SA notifies the provider/supplier in writing that its arguments are rejected and the reasons for the rejection. The SA advises the provider/supplier that

failure to submit an acceptable PoC may result in recommendations to terminate its participation. If the provider then refuses to submit an acceptable PoC, the SA recommends termination to the RO (or the SMA for Title XIX only providers) via a Form CMS-1539. The SA includes in the termination packet all pertinent documentation and correspondence related to the survey in question.

Centers for Medicare and Medicaid Services, State Operations Manual, Chapter 7 – Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities, states in part:

7304.4 - Acceptable Plan of Correction –

The plan of correction serves as the facility's allegation of compliance and, without it, CMS and/or the State have no basis on which to verify compliance. A plan of correction must be submitted within 10 calendar days from the date the facility receives its Form CMS-2567.

If an acceptable plan of correction is not received within this timeframe, the State notifies the facility that it is recommending to the RO and/or the State Medicaid Agency that remedies be imposed effective when notice requirements are met. The requirement for a plan of correction is in 42 CFR 488.402(d).

Further, 42 CFR 488.456(b)(ii) requires CMS or the State to terminate the provider agreement of a facility that does not submit an acceptable plan of correction.

The Department of Social and Health Services, Residential Care Services Division *Operational Principles and Procedures for Nursing Homes – Enforcement Process – Plan of Correction (POC)* states in part:

III. Operational Principles

B. The NH must submit an acceptable, written plan of correction (POC) in response to deficiency citations on the Statement of Deficiencies (SOD) report (this does not apply in revocations or suspensions).

H. Within five (5) working days of receipt, the department will review the POC and verify that it meets all elements for an acceptable POC.

IV. Procedures

B. The Surveyor will:

1. Review the POC within five working days of receipt. Confirm that the POC for each deficiency includes:
   a. How the home will correct the deficiency for each numbered resident;
   b. How the home will protect residents in similar situations
   c. Measures the home will take or the systems it will change to ensure that the problem does not recur;
   d. How the home plans to monitor its ongoing performance to sustain compliance;
   e. Dates corrective action will be completed; and
   f. Title of person responsible for correction.

2017-043 The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls to ensure compliance with survey requirements for Medicaid nursing home facilities.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Special Tests and Provisions – Provider Health and Safety Standards	
Known Questioned Cost Amount:	None	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

Residential Care Services, under the Department of Social and Health Services, Aging and Long-Term Support Administration, is the state nursing home survey agency for Washington.

In fiscal year 2017, the state Medicaid program spent about $16.5 million to survey and certify health care providers. The Department of Social and Health Services spent about $6.8 million certifying nursing homes during fiscal year 2017. The State had 221 nursing facilities that were Medicare and/or Medicaid certified.

The survey for certification of a nursing home is a resident-centered inspection that gathers information about the quality of service furnished in a facility to determine compliance with the requirements of participation. The survey focuses on the nursing home's administration and patient services. The survey also assesses compliance with federal health, safety and quality standards designed to ensure patients receive safe and quality care services.

The State must complete a standard survey within 15.9 months after the previous survey, and the statewide average must not exceed 12.9 months for nursing homes, as required by Centers for Medicare and Medicaid Services' (CMS), Mission and Priority Statement. If surveys uncover deficiencies, the Department must mail a Statement of Deficiency to the facility within 10 working days of the survey

date. The facility must submit a Plan of Correction that the Department determines is acceptable within 60 calendar days of receipt or risk forfeiting its Medicaid certification.

In addition to federal requirements, the Department has established its own policies and procedures requiring that it review a submitted Plan of Correction within five working days after receiving it.

In prior audits, we reported the Department did not have adequate internal controls to ensure surveys were conducted timely and that follow up on deficiencies were conducted in a timely manner. The prior finding numbers were 2016-036, 2015-044, and 2014-046.

Description of Condition

The Department did meet federal regulations, which require the Department to survey nursing homes every 15.9 months and meet a statewide average of 12.9 months. However, the Department did not establish adequate internal controls to ensure all Statement of Deficiencies were submitted to nursing facilities timely or review all submitted Plans of Correction within five working days for acceptability.

We used a statistical sampling method and randomly sampled 30 out of 207 nursing home surveys completed during the audit period. We examined the 30 nursing home surveys to determine if the Department mailed Statements of Deficiencies within 10 working days as required. We found three (10 percent) exceeded the required timeframe.

In addition, we were not able to test this requirement for one survey due to lack of documentation to verify the date on which the Statement of Deficiencies was mailed.

We examined the same nursing home surveys and found six instances (20 percent) where the Department did not review the submitted Plan of Correction for acceptability within five working days.

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

Cause of Condition

The Department has procedures in place to ensure that standard surveys are completed timely, Statement of Deficiencies are mailed and Plans of Corrections are received according to federal standards in the State Operations Manual. It is up to regional field survey and investigative staff to ensure a provider has achieved compliance through follow-up reviews, phone calls and/or visits. The Department asserts the cause of delays for mailing of the Statement of Deficiencies was due to regional administrative review of deficiencies to assure technical accuracy in the documents, achieving compliance with principles of documentation and allowing adequate time for comprehensive enforcement review and action and their interpretation of what is deemed an acceptable Plan of Correction.

In April 2017, the Department implemented an automated electronic Plan of Correction (ePOC) system to electronically distribute Statements of Deficiencies, and receive Plans of Correction from nursing home facilities. This system upgrade reduced the number of Statements of Deficiencies issued late.

Effect of Condition

When the Department does not mail Statements of Deficiencies according to the CMS State Operations Manual, the provider and/or facility is not able to begin the development and submission of an acceptable Plan of Correction preventing the Department from following up on deficiencies.

When the Department does not follow up on deficiencies timely, the State pays facilities for services provided to Medicaid clients without assurance they are complying with federal and state health standards and regulations. Clients residing in facilities that do not meet federal health and safety requirements for participating in the Medicaid program could be at increased risk of abuse, mistreatment, neglect or substandard care.

Recommendations

We recommend the Department strengthen internal controls to ensure:

- Statements of Deficiencies are submitted within 10 working days after completing the initial survey
- Submitted Plans of Correction are reviewed for acceptability no later than five working days after they are received by the Department

Agency's Response

The Department concurs with the finding.

The Department recognizes mailing of Statements of Deficiencies (SODs) by certified mail were not completed within 10 working days for three nursing homes and the SAO was not able to test one survey due to lack of documentation to verify the date the department mailed the SOD. We also agree review of the Plans of Correction (POCs) within 5 days upon receipt was not met for six nursing homes per the SAO's testing methodology.

In April 2017, the Department enhanced its ability to electronically track the mailing of SODs and review of POC upon receipt with the use of CMS' electronic tracking application called ASPEN Electronic Plan of Correction (ePOC). The ePOC system time stamps distribution of SODs, provider submission of POCs, and state agency POC approvals. This will ensure nursing homes receive their SOD within 10 working days by eliminating the mailing process through certified mail, which was the cause of the exceptions.

In comparison to other years, the Department now has the ability to electronically monitor compliance versus manually monitoring compliance.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.303 Internal controls.

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

Section 200.516 Audit reporting, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

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

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

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

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

the likelihood of an event occurring is either reasonably possible or probable as defined as follows:

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

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

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

Title 42, U.S. Code of Federal Regulations, Section 488.402 General provisions. States in part:

(d) Plan of correction requirement.

(1) Except as specified in paragraph (d)(2) of this section, regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements must submit a plan of correction for approval by CMS or the survey agency.

Centers for Medicare and Medicaid Services, State Operations Manual, Chapter 2 – The Certification Process, states in part:

2728 – Statement of Deficiencies and Plan of Correction, Form CMS-2567

The SA mails the provider/supplier a copy of Form CMS-2567 within 10 working days after the survey. If there are deficiencies, the SA allows the provider/supplier 10 calendar days to complete and return the PoC.

Washington Administrative Code 388-97-4400 "Acceptable and unacceptable plans of correction." states in part:

(2) The department will review the nursing home's plan of correction to determine whether it is acceptable.

The Department of Social and Health Services, Residential Care Services Division *Operational Principles and Procedures for Nursing Homes – Enforcement Process – Plan of Correction (POC)* states in part:

III. Operational Principles

B. The NH must submit an acceptable, written plan of correction (POC) in response to deficiency citations on the Statement of Deficiencies (SOD) report (this does not apply in revocations or suspensions).

H. Within five (5) working days of receipt, the department will review the POC and verify that it meets all elements for an acceptable POC.

IV. Procedures

B. The Surveyor will:

1. Review the POC within five working days of receipt. Confirm that the POC for each deficiency includes:

a. How the home will correct the deficiency for each numbered resident;

b. How the home will protect residents in similar situations
c. Measures the home will take or the systems it will change to ensure that the problem does not recur;
d. How the home plans to monitor its ongoing performance to sustain compliance;
e. Dates corrective action will be completed; and
f. Title of person responsible for correction.

2017-044 The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls over and was not compliant with requirements to ensure Medicaid payments to supported living providers were allowable.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Activities Allowed / Unallowed Cost Principles	
Known Questioned Cost Amount:	$2,922,088	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care and social service support. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

The Department of Social and Health Services' (Department) Developmental Disabilities Administration administers the Home and Community Based Services (HCBS) program for people with developmental disabilities. HCBS is a waiver program that permits states to provide an array of community-based services to help Medicaid clients live in the community and avoid institutionalization. States have broad discretion to design waiver programs, but those programs must be approved by the Centers for Medicare and Medicaid Services (CMS).

Supported living is a core service of the HCBS program. Supported living services support Medicaid clients to live in their own homes with one to three other people and receive instruction and support delivered by contracted service agencies (providers). Supported living clients pay their own rent, food and other personal expenses.

In fiscal year 2017, the state Medicaid program paid about $422 million in federal and state funds to providers who supported about 4,200 clients.

Client assessments

The Department uses an assessment to evaluate client support needs and to calculate the number of support hours a client needs to live in the community. The assessment predicts a level of support as if the client lives alone. However, because some support hours can be shared with roommates, the Department looks for such shared-hour opportunities to help providers support clients in a cost-effective manner.

Through a rate setting process, Department resource managers work with providers to determine how the assessed level of support will be delivered and the number of daily direct service hours that will be provided. State rule requires providers to obtain Department approval of schedules to provide 24-hour support when household configurations change or when additional staffing is requested or needed by a client. Once determined, a daily rate is loaded into the Department's payment system, and providers access the system to claim payment for each day of service that was provided.

Cost Reports

Providers must prepare and submit a cost report at the end of each calendar year. The Department uses cost report information to:

- Provide program cost data to regional managers and residential providers;
- Provide information to establish rates or allocate appropriated funds;
- Determine settlements with supported living providers;
- Provide information to the Legislature and the Department for budget development and policy decisions; and
- Provide accountability and transparency for the use of public funds.

Cost reports consist of 16 different schedules of provider information. The Department has established a template, accompanied by detailed instructions that all providers must use when preparing cost reports. Providers must attest to the accuracy of the reported information.

In its approved Core waiver, the Department states that cost reports are desk audited to determine accuracy and the reasonableness of reported costs. The Department has also established a policy that states it will analyze the cost reports and financial statements of each provider to determine if the submitted information is correct and complete, and that it conforms with generally accepted accounting principles and applicable policies rules and regulations.

Provider documentation requirements

According to Department policy, providers must maintain detailed payroll records, by employee, of the hours and costs reported on their cost reports. The Department may request job descriptions for employees to verify the duties of positions. Paid hours and payroll costs for direct hours to clients must be verifiable in provider records. This includes employee timesheets and schedules for actual hours worked. In its cost report instructions, the Department states the detailed payroll information does not need to be submitted with cost reports. The Department has established a template that providers can use to organize the information, but providers are allowed to use their own payroll records.

When a provider uses its own payroll records, the Department requires in its instructions that the information clearly show the distinction between direct and non-direct hours and wages for the provider's employees and that each employee be assigned to one of seven different job classification categories. The instructions further state that the detailed payroll records must be made available if requested by the Department for auditing purposes.

Settlements

After reviewing cost reports, the Department establishes settlements when providers were paid for more direct service hours than they provided in a calendar year (Settlement A) or when providers received more reimbursement (in dollars) for direct support costs compared with what was actually incurred during the year (Settlement B). Settlements are based on a provider's attestation of total hours provided or the total direct support dollars reimbursed, during the year. The Department's policy requires that providers refund the greater amount of Settlement A or B.

Once settlements are assessed, they are forwarded to the Department's collection arm, the Office of Financial Recovery (OFR), which records an overpayment and seeks repayment from providers.

Cost of Care Adjustments

When a client is temporarily out of the home and the economy of scale is altered, providers can request a Cost of Care Adjustment to cover the administrative and staff support costs necessary to maintain the client's residence and affairs while the client is away. If a client permanently leaves the household, providers can request a Cost of Care Adjustment to maintain the household's shared hours until a new housemate can be found, or the rate for existing clients is revised. In fiscal year 2017, the Department paid over $1.3 million to supported living providers for Cost of Care Adjustments.

Prior audit findings

In prior audits, we reported the Department did not have adequate internal controls over and was not compliant with requirements to ensure payments to supported living providers were allowable. The prior finding numbers were 2016-041, 2016-045, 2015-049, 2015-052, 2014-041, 2014-042, 2013-036, 2013-038 and 12-39. Inadequate internal controls over cost reports was not reported as a condition in any of the previously stated findings.

Description of Condition

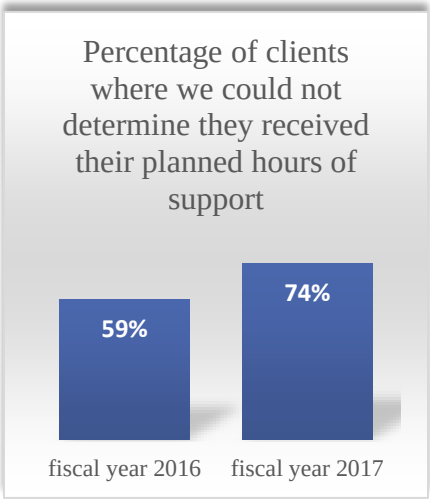
We found the Department did not have adequate internal controls over and was not compliant with federal regulations to ensure payments to supported living providers were allowable.

Cost reports and provider documentation

After obtaining cost reports from providers for the 2016 calendar year, the Department did not establish procedures to verify if the direct hours reported as worked, or the cost to provide those hours, were accurate and conformed with generally accepted accounting principles.

We obtained copies of the cost reports submitted by 124 providers to the Department for the 2016 calendar year. We then independently requested payroll records from the providers to perform our own reconciliation. All but one provider responded to our request for records. This provider's payments were suspended because the Washington Attorney General's Office, Medicaid Fraud Control Unit, filed a lawsuit in King County Superior Court and the provider did not respond to requests for information from the Department. In 34 instances (27 percent), the payroll records submitted by providers did not fully support the number of direct service hours that were reported on their cost reports. Additionally, in 75 instances (60 percent), providers did not properly categorize their employees as required by the Department's instructions.

The Department pays providers for a client's assessed level of support hours. We used a statistical sampling method to randomly select and examine 86 monthly payments from a population of 48,232 monthly payments made for client support hours. We requested employee timesheets and work schedules from providers for the selected months and reconciled employee direct support hours provided to clients to the hours the providers said they planned to provide to clients during the month. In 64 instances (74 percent), we were unable to determine that providers delivered a client's planned level of hourly support. During fiscal year 2016, we identified 51 instances (59 percent) where we were unable to determine that clients received their planned level of support hours.



Specifically, we identified 96,554 support hours that providers reported to the Department they planned to provide to clients based on their residential staffing plans. Of those hours, we verified providers delivered 86,284 support hours. For 10,270 hours (11 percent), we could not determine if the hours were provided because employees were not scheduled to work or supporting documentation was lacking.

For four of the households in our sample, totaling 3,625 planned hours of support, providers responded to our request for timesheets, but because of poor record keeping we were unable to determine if any hours of support were delivered to sampled clients.

Settlements

In 48 instances (39 percent), providers were paid for more direct service hours than they reported on their cost reports. Before making this conclusion, we reviewed and considered the information the Department forwarded to OFR to be collected.

We consider these control deficiencies to be a material weakness.

Cost of Care Adjustments

We found the Department had adequate internal controls to materially ensure Cost of Care Adjustment payments were adequately supported.

We used a statistical sampling method to randomly select and examine 84 monthly payments from a population of 927 payments for Cost of Care Adjustments. We requested the forms used by the Department to review and approve provider requests for payment and found all forms were approved. In 15 instances (18 percent), we found the approved forms contained inaccurate rate or payment information, a duplicate payment was made, or the justification for the payment did not meet Department policy.

Duplicate payments

We conducted a test to determine if the Department made duplicate payments to providers. We found 59 duplicate payments totaling $21,169 were made to providers.

Cause of Condition

Cost reports and provider documentation

The Department said it did not dedicate resources to verify the accuracy of the information submitted by providers. The Department said it has never implemented a consistent process where detailed payroll records from providers are requested for reconciling to cost records. The Department also said it performed no monitoring to confirm if providers comply with cost-report instructions.

The Department does not perform procedures to determine if a client received their assessed level of support hours, or reconcile the payments to provider timesheets. Rather, it relies on the cost settlement process to determine if a provider delivered the total number of contracted hours to all clients in their agency during the calendar year.

A provider that provides services at multiple locations said they did not keep detailed timesheet records by employee because of changes in administrative personnel or they were lost. Another provider said it was too much of an administrative burden because they were providing support to multiple clients.

Settlements

During the audit period, the Department issued guidance to providers to request an exception to credit the cost of overtime on their cost reports when calculating Settlement A (hours paid minus hours provided). This practice was not described in its Core waiver with CMS or Department policy.

Cost of Care Adjustments

Requests are reviewed and approved by regional staff, making continuity and oversight challenging. The process used to request, review, approve, and authorize payment is manual, which increases the likelihood of error and carries greater risk.

Duplicate payments

We found duplicate payments were made to providers because an edit in the Department's payment system had not been activated to prevent claims on the same date of service for differing amounts.

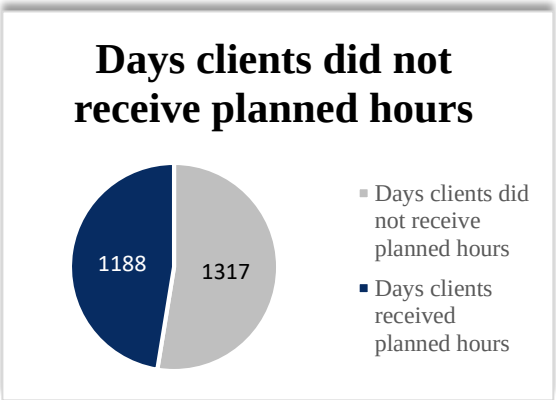
Effect of Condition and Questioned Costs

Cost Reports and provider documentation

For the provider that did not submit its detailed payroll records, we are questioning all $804,741 that the Department paid for calendar year 2016 because of a lack of supporting documentation. The Department also requested detailed records from the provider, who did not respond to the request. The federal share of these costs is $402,370. We are also questioning $2,906,998 that was paid to the 34 providers when their detailed payroll records did not support the hours reported on their cost reports. The federal share of these questioned costs is $1,453,499.

For payments to providers where we were unable to determine if clients received their assessed support hours, we are questioning $112,969 because the payments lacked adequate supporting documentation. The federal share of these questioned costs is $56,484.

Because a statistical sampling method was used to select the payments, we estimate the total improper payments to be $63,357,084. The federal share of the estimated improper payments totals $31,678,542.



When reconciling household schedules to employee timesheets, we identified 1,317 days out of a total of 2,505 days when clients did not receive the number of hours providers reported to the Department they planned to provide to clients. We also identified 198 days out of a total of 2,505 days when employee timesheets did not show that households assessed to receive 24 hours of support were provided 24 hours of support.

Settlements

We are questioning $1,985,809 for the 48 providers who were paid for more direct service hours than they reported on their cost reports. The federal share of these questioned costs is $992,905. These amounts include the Department's exception for overtime consideration.

Cost of Care Adjustments

We used a statistical sampling method to randomly select and examine 84 monthly cost of care payments totaling $242,474 from a population of 927 monthly payments totaling $1.3 million. We requested the forms that the Department used to review and approve provider requests for payment and found all forms were approved. In 15 instances (18 percent), we found the approved forms contained

inaccurate rate or payment information, a duplicate payment was made or the justification for the payment did not meet Department policy. We identified $12,491 in known questioned costs. We are questioning the federal share of the unallowable payments of $6,246.

Because a statistical sampling method was used to select the payments, we estimate the total improper payments to be $137,851. The federal share of the estimated improper payments totals $68,925.

We found the Department improved its training and review of Cost of Care Adjustments since the previous audit. We found field staff and providers were more aware of Department policy and more requests for payment from providers were adequately documented.

Duplicate payments

We found the Department made duplicate payments to providers totaling $21,169 because an edit in the payment system had not been activated. We are questioning $10,584, which is the federal share of the unallowable payments.

Summary of questioned costs

In total, we identified $5,844,177 in known questioned costs. The federal share of these known questioned costs is $2,922,088.

Because a statistical sampling method was used to select the payments for two of the areas we examined, we estimate the total improper payments to be $63,494,935. The federal share of the estimated improper payments totals $31,747,467.

The table below summarizes, by audit area, the known questioned costs and likely improper payments:

Audit area	Known questioned costs – state and federal	Known questioned costs – federal share	Likely improper payments – state and federal (estimate)	Likely improper payments – federal share (estimate)
Cost reports	$5,697,548	$2,848,774		
Timesheets	$112,969	$56,484	$63,357,084	$31,678,542
Cost of care	$12,491	$6,246	$137,851	$68,925
Duplicate payments	$21,169	$10,584		
Totals	**$5,844,177**	**$2,922,088**	**$63,494,935**	**$31,747,467**

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

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining whether or not expenditures were in compliance with

program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance with a 95 percent confidence of whether exceptions were above our materiality threshold. This conclusion is reflected in our audit report and finding. However, the estimated improper payments are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Recommendations

We recommend the Department:

- Implement procedures to verify if information submitted by providers is accurate and conforms with generally accepted accounting principles
- Establish consistent activities for monitoring providers to ensure they comply with cost report instructions
- Discontinue the practice of crediting providers for the cost of overtime when calculating Settlement A
- Establish policy and monitoring activities to ensure individual clients receive their assessed hours of support
- Ensure reviewers of Cost of Care Adjustment forms are trained in Department policy for these requests and forms are reviewed for accuracy
- Activate the system edit that prevents duplicate payments to supported living providers
- Seek recovery of overpayments made to providers identified by the audit
- Consult with the U.S. Department of Health and Human Services regarding whether the questioned costs identified by the audit should be repaid

Agency's Response

The Department does not concur with the finding.

As stated in previous findings, RCW 71A.12.060 provides the Secretary the authority to authorize payments for individuals in community residential programs. The authorized system requires payment for the total annual contracted Instruction and Support Services (ISS) hours to be reconciled to the actual hours provided. The system allows for more efficient use of taxpayer resources, by allowing additional staffing for peak demand, and allows for better service and flexibility by allowing providers to move resources to meet the daily changing needs of clients.

The system is designed to allow for resource flexibility by the Supporting Living (SL) provider throughout the year to enable the provider to meet the changing needs of the individual clients. The Department requires that over the course of a year clients receive all authorized ISS hours. Providers are expected to provide hours in a flexible way within a calendar year, in order to address clients' individualized instruction and support needs.

SL providers are required to complete an annual cost report. The cost report reconciles hours and ISS dollars authorized to hours and ISS dollars provided. The SL provider attests to the accuracy of the cost report. A settlement is issued to any SL provider who fails to meet either standard.

Cost Reports

The cost reports are not used to provide information to establish rates or allocate appropriate funds. Rates are established through a rate assessment process which includes a method to adjust for the sharing of service hours within households or clusters. The assessment also includes a method to account for needed supports that occur on an infrequent basis over time, such as weekly, monthly or annual events. All of these items are factored into calculating a daily rate for the individual client. Funding is appropriated by the legislature.

In regards to the one provider who did not respond to the request for records; this provider did not have a contract for FY17. The cost report for the supported living providers are for the calendar year, not the fiscal year. The service provider passed away and did not submit a cost report for the 2016 calendar year. The Department completed an ISS hour review during May 2016 to evaluate the ISS reimbursement. The settlement notice was sent to the provider by the Office of Financial Recovery.

During the cost settlement process the Department works in tandem with the provider to document and adequately verify that the records, such as payroll records, are correct. The analysts often request additional details in the process of cost settlement. We do not believe the State Auditor's Office (SAO) requested this additional information as the Department would have.

In relation to provider employees not being properly categorized, Department policy 6.04 states that for staff who perform both administrative functions and ISS, the service provider may include that portion of the employee's hours that are dedicated to ISS function. In order to have accurately reviewed the job classifications, the auditors would have had to review every job description. The Department believes this in-depth review was not completed during the audit. In determining which payments were not allowed, it appears that SAO relied upon the job title rather than the job functions of a position. However, as per the excerpt above from policy 6.04, it is necessary to consider the actual job task performed by an employee when determining whether that employee's time should be reimbursed as ISS hours. As an example, a valid claim for reimbursement of ISS hours could be made under the job class of Custodian or Handyman, if the Custodian or Handyman worked side-by-side with the client, providing individual support and services to fix a household item. In a case such as this the employee provided habilitation services to the client. In regard to service providers listing ISS staff correctly, some of the discrepancies were possibly due to a lack of understanding of the auditor's request, rather than the lack of understanding of the cost reporting process.

Documents provided by SAO show some of the providers' record keeping does not adequately support the hours. Training to the providers will be offered and will focus on having adequate back up information to support the ISS hours. The Developmental Disabilities Administration's (DDA) Rate Unit will continue to review a targeted sample of provider records to evaluate whether supporting documentation is adequate.

The DDA Rate Analyst team will continue to complete desk audits. When payment discrepancies are identified, Department staff work with the provider to address the payment discrepancies. This ensures the adequate rates are being paid and many of the over/under payments are addressed prior to receiving the cost reports.

The Department will continue to use its sampling method procedures to verify that information submitted by providers is accurate, and will continue to request additional supporting documents.

Consistent activities for monitoring providers will be emphasized in cost report training.

Settlements

The Department has the authority to reimburse the service provider for services delivered. The Department can grant an exception to the benchmark rate for the hours purchased. The hours purchased at the higher benchmark may be adjusted for the total hours purchased. Overtime costs are necessary to adequately support clients when the following conditions apply:

- *The ISS cost exceeds the reimbursed rate;*
- *A service provider has to fund the delivery of ISS by the use of overtime since there is an industry-wide staffing shortage;*
- *Surveys show that turnover rate in the supported living industry is approximately 50%. Due to the high staff turnover and vacancy rates, overtime is necessary.*

All ISS hours are documented initially in the cost report as delivered at the benchmark. As part of settlement, the provider is given a credit to account for the hours delivered at the overtime rate of time and a half. Overtime hours are calculated using 1.5 times the average benchmark when determining Settlement A. The consideration of the overtime credit is intended to credit the provider for the additional ½ the average benchmark for the overtime hours provided in settlement A. See the example below:

Contracted Hours for the Agency	*Regular Hours Delivered*	*Overtime Hours Delivered*	*Total Hours Delivered*	*Hours Not Delivered*
1000 (i.e. $10/hour)	*900*	*50*	*950*	*50*
Amount to be Paid per Contract	*Amount to be Paid for Hours Delivered*	*Amount to be Paid For Overtime Hours Delivered*	*Total Amount to be Paid*	*Settlement*
Department: $10,000	*$9,000*	*750 ($10 x 1.5)*	*$9,750*	*-$250*
Auditors: $10,000	*$9,000*	*$500*	*$9,500*	*-$500*
The Department is disallowing $250 ($10,000 -$9,750)				
Auditor's believe the $500 should be disallowed ($10,000 - $9,500)				

The above chart is explained below.

- *The provider delivered 950 hours of the 1000 hours in contract. The provider did not deliver 50 of the contracted hours.*
- *900 of the 950 hours were delivered at $10/hr. 50 of the 950 hours were delivered at the overtime cost of the $15/hour. Therefore, the total cost to deliver the ISS services = $9,750.*
- *Settlement: $10,000 – 9,750 = $250.*

It appears that in the SAO's analysis they appear to have overlooked the second bullet above.

The Department will continue to use its authority to consider provider circumstances, such as overtime and grant exceptions as necessary when calculating Settlement A.

Current policy and monitoring activities will remain in place to ensure individual client assessed support needs are met.

Duplicate Payments
The Department will work with HCA and Provider-One on the duplicate payment issues identified in this audit. If duplicate payments are confirmed after this work, overpayments will be processed.

Hours
The discrepancy of hours written in the report does not take into consideration that the rate assessment is based on a client's daily, weekly and annual needs for support services.

Support services such as medical appointments and essential shopping are not always done on a daily basis, rather, they are evaluated and spread out over the entire year. The daily rate encompasses these support hours. Looking at snapshot of these hours does not reflect the true usage of these hours.

The Department will work with the federal grantor regarding questioned costs.

Auditor's Concluding Remarks

Since fiscal year 2012, we have issued a finding regarding these matters. We are committed to working through the disagreement with Department management. However, the Department has made assertions in their response that mischaracterize the audit work and require clarification.

The Department states that, during the cost settlement process, it works with providers to document and adequately verify that the records, such as payroll records, are correct. It also states that analysts often request additional details in the process of cost settlement and that it does not believe the State Auditor's Office requested this additional information as the Department would have. This is incorrect. During our fieldwork, we met numerous times with program staff, management and provider stakeholder groups. In these conversations, staff, managers and stakeholders acknowledged that the level and amount of documentation we requested and examined during the audit was not used by the Department during the audit period when it reviewed cost reports.

Specifically, we requested detailed payroll records from all providers and performed an independent reconciliation of their cost reports. Department staff who reconcile the cost reports said they do not have procedures in place to verify or review the accuracy of provider cost reports. Had such procedures been in place, we would have reviewed them as part of the audit. We did review the Department's desk audit process, which reconciles hours a provider attested were provided to all clients in the agency to the provider's payment data. There are no procedures performed to verify if the information is accurate.

Regarding our review of the categorization of ISS employee hours in provider cost report schedules, we did not question costs because the 75 providers did not properly classify their employees in their

cost reports. We included this in the finding because, in its instructions to providers, the Department required the information be submitted when requested, and it was not provided 60 percent of the time.

When reconciling employee timesheets, we requested that providers supply us with the job classification for all employees who provided direct support hours to clients in the sample. If we were unsure of an employee's job classification and provision of hours, we contacted providers directly to seek clarification.

Regarding the cost report settlements, our Office did not overlook or misunderstand the process. We questioned costs when providers were paid for hours it did not provide to clients. We acknowledge the Department decided to issue some providers a credit when their employees worked overtime. This credit should have been accounted for when calculating Settlement B (total payments to providers minus cost to provide the services), not Settlement A (total hours paid to providers minus the actual hours provided to clients).

The Department states that it expects clients will receive all authorized ISS hours within a calendar year. The Department pays providers for clients' daily assessed support hours multiplied by a set rate. When providers claimed payment for hours they planned to provide in the future but did not actually provide, the Department made improper payments. 2 CFR §200.53(b) states in part that an improper payment includes any payment for a good or service not received. In addition, at the end of the calendar year, the Department reconciled the hours provided at the agency level and were unable to demonstrate any method used to determine if individual clients received all their authorized ISS hours.

We reaffirm our finding and will follow up in our next audit.

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls.

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in

compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).

(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant

deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Title 42 U.S. Code of Federal Regulations Part 433, Stat Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers

Section 433.300 Basis.

This subpart implements -

(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.

(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Section 433.316 When discovery of overpayment occurs and its significance.

(a) *General rule.* The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) *Requirements for notification.* Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State

agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of - -

(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

(d) *Overpayments resulting from fraud.*

(1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by § 455.15, § 455.21, or § 455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

(e) *Overpayments identified through Federal reviews.* If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) *Effect of changes in overpayment amount.* Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.
(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) *Effect of partial collection by State.* A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

(h) *Effect of administrative or judicial appeals.* Any appeal rights extended to a provider do not extend the date of discovery.

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

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

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

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

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

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

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

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

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

Department of Social and Health Services - Application for a §1915(c) Home and Community – Based Services Waiver, approved in 2015.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims, states in part:

a. Rate Determination Methods

Personal Care

Annual cost reports are required that itemize the cost of providing the contracted service for the calendar year. Cost reports are desk audited to determine accuracy and the reasonableness of reported costs. Reported revenue received is reconciled to DSHS/SSPS payment information to determine over/under payments for services.

Settlements are calculated by ADSA staff to determine pay back amounts in cases where providers contracted for more direct service hours than they provided, or received more reimbursement for direct care costs than was paid out. There is no settlement provisions for the non-direct care staff components of the payment rate.

Washington Administrative Code WAC 388-101D-0025

Service provider responsibilities.

(1) Service providers must meet the requirements of:
   (a) This chapter;
   (b) Each contract and statement of work entered into with the department;
   (c) Each client's individual support plan when the individual support plan identifies the service provider as responsible; and
   (d) Each client's individual instruction and support plan.

(2) The service provider must:
   (a) Have a designated administrator and notify the department when there is a change in administrator;
   (b) Ensure that clients have immediate access to staff, or the means to contact staff, at all times;
   (c) Provide adequate staff within contracted hours to administer the program and meet the needs of clients;
   (d) Not routinely involve clients in the unpaid instruction and support of other clients;
   (e) Not involve clients receiving crisis diversion services in the instruction and support of other clients; and
   (f) Retain all records and other material related to the residential services contract for six years after expiration of the contract.

Department of Social and Health Services, Developmental Disabilities Administration Policy 6.02 states in part:

PROCEDURES

III. Cost of Care Adjustments

Cost of Care Adjustments (COCA) are intended to cover the necessary costs of ISS staff support and/or administrative costs to continue uninterrupted services to clients when there is a temporary absence of a household member. Examples of a temporary absence include, hospital or nursing home stay, RHC short-term stay, incarceration, or a client who shared hours moving out, either temporarily or permanently. Only administrative costs can be requested for a single person household. ISS hours will not be approved for persons residing in a single person household. Agencies requesting a COCA must include a clear and detailed justification highlighting client need.

A. Providers will complete form DSHS 06-124, *Cost of Care Adjustment Request*, within 30 days of a client being away from services. The service provider will identify the household members impacted by the absence of the house mate and their corresponding shared and individual hours. The service provider will include justification and indicate the anticipated duration of the COCA.
B. A request for COCA can include both ISS hours and administrative dollars.
C. A COCA that only includes a request for the shared ISS hours identified in the rate assessment can be authorized for up to ninety (90) days.
D. Requests that include individual hours of the absent client to support remaining client(s) in the household will be considered when the client is away from service for up to thirty (30) calendar days based on client need. For any individual hours requested, the service provider must justify the need. When individual hours of the absent client are needed to maintain the household beyond the first fifteen (15) days, the staff add-on portion of the COCA form will be completed by the RMA. The first fifteen (15) days requested may be approved regionally by the RM. Days sixteen (16) through thirty (30) may be approved regionally by the RMA or designee.
E. DDA will review each COCA and send a signed copy of the COCA request to the service provider and the rate analyst. Copies will be maintained by DDA in the contract file and the service provider records for (7) seven years.
F. If a COCA is expected to go beyond ninety (90) days, the residential service provider may request a new rate assessment.
G. The Resource Manager will authorize payment for an approved COCA.

Department of Social and Health Services, Developmental Disabilities Administration Policy 6.04 states in part:

POLICY

A. Service providers shall report costs of operations for the purpose of certifying the costs of services provided and to determine any settlements due.

PROCEDURES

I. REPORTING

A. Cost Reports

C. In order for a service provider to receive payments under the residential reimbursement system, the service provider must submit an annual DDA cost report covering the completed calendar year. Completing Cost Reports and Maintaining Records

2. DDA Rates Unit will analyze the submitted cost report and financial statement of each service provider to determine if this information is correct, complete, and reported and conforms with generally accepted accounting principles and the requirements of this contract and the referenced policies, rules, and regulations. If the analyst finds that the cost report or financial statements are incorrect or incomplete, DDA may make adjustments to the reported information or request that the service provider makes revisions.

II. COST REPORT COMPONENTS

A. Instruction and Support Services

4. DDA may request job descriptions for employees to verify the duties of the positions. Paid hours worked and payroll costs charged to ISS for cost reporting purposes must be verifiable in the service provider's records, including time sheets and schedules for actual hours worked. The number of ISS paid hours reported for any individual employee or owner of a service provider must not exceed 3,120 hours per year (designated live-in staff are exempt from this limitation.)

6. The cost report will include schedules to report summary totals of employee hours and costs. The provider must maintain on file the details by employee, as this information may be requested by DDA.

III. SETTLEMENT

1. Settlement Definition. The settlement shall be for underutilization of contracted and paid service hours and dollars in the instruction and support service cost center.

2017-045 The Department of Social and Health Services, Aging and Long- Term Support Administration, did not have adequate internal controls over and did not comply with requirements to ensure Medicaid Community First Choice client support plans were properly approved.

Federal Awarding Agency:	U.S. Department of Health and Human Services
Pass-Through Entity:	None
CFDA Number and Title:	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT
Applicable Compliance Component:	Activities Allowed /Unallowed Allowable Costs/Cost Principles Eligibility
Known Questioned Cost Amount:	$186,549

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

The Aging and Long-Term Support Administration within the Department of Social and Health Services (Department) offers personal care and other services to support Medicaid clients in community settings through the Community First Choice program. Clients may receive personal care services, skills acquisition training, assistive technology, personal emergency response systems and other services that help them remain in community settings. The Department must ensure clients are eligible before authorizing services.

A client's eligibility consists of two parts: functional and financial. Functional and financial eligibility must be re-determined every 12 months. A valid financial eligibility re-determination includes reviewing and verifying income and resources. A valid functional eligibility re-determination includes assessing the client's needs to determine whether the client needs the level of care provided in a hospital, nursing facility, intermediate care facility for the intellectually disabled, institution providing psychiatric services for individuals under age twenty-one, or an institution for mental diseases for individuals age sixty-five or over, or will likely need this level of care within thirty days, unless Community First Choice services are provided.

For Community First Choice services, federal regulation and state rules require the client (or a legal representative) to agree to receive services and both the client and the Department to sign the service plan. If a client does not sign the plan within two months of the needs assessment's completion, state rules authorize the Department to terminate services.

Before August 2015, Department staff accepted verbal agreements from clients, rather than requiring signatures from them or their legal representatives. In August 2015, the Department trained staff on the federal regulation that person-centered service plans must be agreed to in writing.

In fiscal year 2017, the state Medicaid program paid about $1.3 billion for Community First Choice personal care services.

Description of Condition

We found the Department did not have adequate internal controls to ensure client person-centered service plans were properly approved and adequately documented.

We used a statistical sampling method to randomly select 86 Community First Choice clients, from a total population of 45,568, which received services from an individual provider during the audit period. We examined the client files and found 26 instances (30 percent) when the Department did not monitor to ensure signed plans were received within 60 days; contained valid signatures; or ensured received plans were scanned into its imaging system.

Specifically, we found:

- 16 instances (19 percent) when the Department was unable to locate a signed plan
- Eight instances (9 percent) when plans lacked required signatures by - the client (3), a client's legal representative (2) or the Department (3)
- Two instances (2 percent) when the Department did not receive all required signatures within 60 days of the plan completion as required by state rule

During the audit period, Department management did not monitor to ensure staff obtained signatures from all parties before paying providers for client services.

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

This condition was not reported in the prior audit.

Cause of Condition

Management said staff might not have obtained all required signatures because the Department's policy changed in 2015 to align with the federal requirement to obtain written approval from clients. Management did not monitor to ensure staff were following the federal requirement.

Management staff acknowledged a backlog with scanning documents into the client's record. The department believes this backlog and the process in getting documents to the Document Management System unit for scanning contributed to the number of client records without a signed service summary.

Effect of Condition and Questioned Costs

Questioned costs

Because some plans were not properly approved or adequately documented, we determined the Department made $278,300 in unallowable payments to providers. We are questioning $155,683, which is the federal portion of the unallowable payments.

When unallowable payments are identified, federal regulations suggest auditors consider if associated costs, such as benefits, were also paid. The Department pays payroll-related benefits, which are considered associated costs, on behalf of Community First Choice providers. Examples of these costs include health insurance, retirement, payroll taxes and training.

For the $278,300 in payments we determined were unallowable, we identified $56,159 in associated costs that we also consider to be unallowable. We are questioning $30,866, which is the federal portion of the unallowable payments.

Estimated improper payments

Because a statistical sampling method was used to select the payments we examined, we estimate the amount of likely improper payments to be $86,951,412. The federal share of this estimate is $48,591,452.

For the $86,951,412 in likely improper payments, we estimate the amount of likely associated improper payments to be $20,477,299. The federal share of this estimate is $11,226,999.

The statistical sample used for testing was also used to test compliance with activities allowed and provider eligibility requirements. Because some unallowable payments we examined violated multiple federal compliance requirements, some of the questioned costs reported here might also be reported in finding numbers 2017-046, 2017-049 and 2017-050.

Projection to population	Known questioned costs	Estimated improper payments
Federal expenditures	$186,549	$59,818,451
State expenditures	$147,910	$47,610,260
Total expenditures	**$334,459**	**$107,428,711**

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a very high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality

threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total improper payments" as required by 2 CFR 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Recommendations

We recommend the Department:

- Provide additional training to staff on the federal regulation and State rule that requires client plans to be agreed to in writing
- Establish monitoring activities to ensure staff comply with federal and state requirements
- Consult with the U.S. Department of Health and Human Services to determine if the questioned costs identified by the audit should be repaid

Agency's Response

The Department does not concur with this finding.

The Department agrees person-centered service plans are an important component of the delivery of Community First Choice services and are required by federal regulations, Washington's state Medicaid plan, and the Washington Administrative code. The department also acknowledges the participant must agree to services and signing the service plan documents that agreement with the client and the case manager. Person centered service plans must be reviewed and revised upon reassessment of functional need, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

However, a signed person-centered service plan is not necessary nor required by the Code of Federal Regulations (CFR), Washington's state Medicaid plan or the Washington Administrative Code (WAC) to properly determine or establish a client's eligibility to receive benefits. While the determination of eligibility and the development of the person-centered service plan may often take place during the same visit (assessment) with the client, completion of the two tasks are separate and distinct endeavors and are governed by different laws and requirements. As the state described in the CMS approved Medicaid state plan;

> *"There is no lag between the person-centered planning and determination of eligibility. Initial and on-going person-centered service plans are developed in conjunction with the CARE assessment and functional eligibility determination. Access to services begins as soon as the participant selects the services and supports they are eligible to receive and identifies their qualified provider".*

The department also disagrees with the conclusion that the lack of signed service plans results in improper payments. In this case, the department made payments to qualified providers for covered services delivered to eligible beneficiaries.

Current practice includes training staff on the federal requirement to obtain signatures on service plans. The department will formally remind staff of these requirements. The Department also notes federal regulations provide latitude to obtain consent in an alternate manner for those clients who are not able to provide a signature: As reflected on page 26865, Vol. 77, No. 88 of the Federal Register:

> *"**Response:** After consideration of these comments, we have revised the final regulation to indicate that the plan be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation. While we understand that some individuals may not be able to provide an actual signature, we believe that it is important to capture that the individual agrees to the service plan as finalized. Should an individual not be able to make any indication that they agree with the plan in writing or the individual does not have a representative who can do so on the individual's behalf, States will need to explain the methods they propose to use to indicate that the individual agrees with the service plan.*

Staff will also receive training on actions to take when the participant is not able to provide a signature.

Further analysis of these results shows that in 18 out of 26 instances client files had documentation indicating staff received a signed service summary from the client and sent it to the division's imaging hub HIU/DMS. With 69% of the cited cases stating the case manager received the signed service summary, the department believes this indicates there are issues with the department's process for getting documents to DMS and the timeliness of the digital scanning process. Based on this analysis, the department will revise and clarify the document mailing and scanning process.

Effective January 2018, ALTSA QA also, as part of its established annual audit cycle, initiated a process to monitor staff compliance with federal and state requirements regarding tracking and documenting efforts to obtain signed service plans.

Auditor's Concluding Remarks

In its response, the Department acknowledges person-centered service plans are required by federal regulation. In addition, the Department acknowledges the participant must agree to services and signing the service plan documents that agreement.

The Department states that a signed person-centered service plan is not necessary nor required by the Code of Federal Regulations (CFR), Washington's state Medicaid plan or the Washington Administrative Code (WAC) to properly determine or establish a client's eligibility to receive benefits.

According to federal and State rule a person-centered service plan is required.

- 42 Code of Federal Regulations, Section 441.540, states – Person-centered service plan must be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation.
- Washington Administrative Code 388-106-0045 states - The department will authorize long-term care services when you …have given written consent for services and approved your plan of care

The department also disagrees with the conclusion that the lack of signed service plans result in improper payments.

According to Washington Administrative Code 388-106-0047(3):

- The department will terminate long-term care services if you do not sign and return your service summary document within sixty days of your assessment completion date.

During the audit, the Department acknowledged it could not locate 18 signed service summaries. While the case file notes indicated a signed service summary was received, we could not verify this based on a lack of supporting documentation.

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls.

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).

(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Title 42 U.S. Code of Federal Regulations Part 433, State Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers

Section 433.300 Basis.

This subpart implements -

(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.

(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Section 433.316 When discovery of overpayment occurs and its significance.

(a) *General rule.* The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) *Requirements for notification.* Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of - -

(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

(d) *Overpayments resulting from fraud.*

(1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by § 455.15, § 455.21, or § 455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

(e) *Overpayments identified through Federal reviews.* If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) *Effect of changes in overpayment amount.* Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) *Effect of partial collection by State.* A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.
(h) *Effect of administrative or judicial appeals.* Any appeal rights extended to a provider do not extend the date of discovery.

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

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

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

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

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

Title 42, Code of Federal Regulations, Section 441 Services: Requirements and Limits Applicable to Specific Services, states in part:

Section 441.540 Person-centered service plan.

(b) The person-centered service plan. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under Community First Choice, the plan must:
  (9) Be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation.
(c) Reviewing the person-centered service plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need, at least every 12 months,

when the individual's circumstances or needs change significantly, and at the request of the individual.

Section 441.720 Independent assessment, states in part:

(a) Requirements. For each individual determined to be eligible for the State plan HCBS benefit, the State must provide for an independent assessment of needs, which may include the results of a standardized functional needs assessment, in order to establish a service plan. In applying the requirements of section 1915(i)(1)(F) of the Act, the State must:

(1) Perform a face-to-face assessment of the individual by an agent who is independent and qualified as defined in § 441.730, and with a person-centered process that meets the requirements of § 441.725(a) and is guided by best practice and research on effective strategies that result in improved health and quality of life outcomes.

(i) For the purposes of this section, a face-to-face assessment may include assessments performed by telemedicine, or other information technology medium, if the following conditions are met:

(C) The individual provides informed consent for this type of assessment.

(3) Examine the individual's relevant history including the findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the person-centered service plan as required in § 441.725.

(b) Reassessments. The independent assessment of need must be conducted at least every 12 months and as needed when the individual's support needs or circumstances change significantly, in order to revise the service plan.

Washington Administrative Code WAC 388-106-0045 When will the department authorize my long-term care services? states in part:

The department will authorize long-term care services when you:

(1) Are assessed using CARE;

(2) Are found financially and functionally eligible for services including, if applicable, the determination of the amount of participation toward the cost of your care and/or the amount of room and board that you must pay;

(3) Have given written consent for services and approved your plan of care;

Washington Administrative Code WAC 388-106-0047 When can the department terminate or deny long-term care services to me? states in part

(3) The department will terminate long-term care services if you do not sign and return your service summary document within sixty days of your assessment completion date.

Washington Administrative Code WAC 388-106-0283 How do I remain eligible for CFC services? states in part:

(1) In order to remain eligible for CFC, you must remain financially eligible and be in need of services in accordance with WAC 388-106-0310 as determined through a CARE

assessment. The assessment in CARE must be completed at least annually or more often when there are significant changes in your functional or financial circumstances; or

Washington State Medicaid State Plan-Community First choice State Plan Option, states in part:

X. Person-Centered Service Plan Development Process

a. Indicate how the service plan development process ensures that the person-centered service plan addresses the individual's goals, needs (including health care needs), and preferences, by offering choices regarding the services and supports they receive and from whom.

The person-centered service plan will be developed and implemented in accordance with 42 CFR 441.550 (b).

The person-centered service plan will be understandable to the participant, will indicate the individual and/or entity responsible for monitoring the plan, and will be agreed to in writing by the participant and those responsible for implementing the plan.

2017-046 The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls over and did not comply with requirements to ensure Medicaid Community First Choice client support plans were properly approved.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Activities Allowed / Unallowed Allowable Costs/Cost Principles Eligibility	
Known Questioned Cost Amount:	$215,082	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

The Developmental Disabilities Administration within the Department of Social and Health Services (Department) offers personal care and other services to support Medicaid clients in community settings through the Community First Choice program. Clients may receive personal care services, skills acquisition training, assistive technology, personal emergency response systems and other services that help them remain in community settings. The Department must ensure clients are eligible before authorizing services.

A client's eligibility is based on three factors: statutory, functional and financial. For statutory eligibility, individuals submit an initial application to the Department, which reviews it to determine if the client's disability meets Department eligibility requirements. The Department makes re-determinations on a varying schedule, based on a client's age and eligibility condition. Functional and financial eligibility must be re-determined every 12 months. A valid financial eligibility re-determination includes a review and verification of income and resources. Per federal regulation, a valid functional eligibility determination includes assessing the client's needs determining whether the client needs the level of care provided in a hospital, nursing facility, intermediate care facility for the intellectually disabled, institution providing psychiatric services for individuals under age twenty-one,

or an institution for mental diseases for individuals age sixty-five or over (or will likely need this level of care within thirty days unless Community First Choice services are provided).

For Community First Choice services to be allowable, federal regulation and State rules require the client (or their legal representative) to agree to receive services and both the client and the Department to agree on client service plans in writing. If a client does not sign the plan within two months of the needs assessment's completion, State rules authorize the Department to terminate services.

Before August 2015, Department staff accepted verbal agreements from clients, rather than requiring signatures from them or their legal representatives. In August 2015 and in the spring of 2017, the Department trained staff on the federal regulation that client service plans must be agreed to in writing.

In fiscal year 2017, the state Medicaid program paid about $1.3 billion to providers on behalf of Community First Choice clients.

In our prior audit, we reported the Department did not have adequate internal controls in place to ensure client support plans were properly approved. The prior finding number was 2016-043.

Description of Condition

We found the Department did not have adequate internal controls to ensure client service plans were properly approved and adequately documented before paying providers for client services.

We used a statistical sampling method to randomly select 86 Community First Choice clients, from a total population of 13,324, that received services from an individual provider during the audit period. We examined the client files and found eight instances (9 percent) when the Department did not monitor to ensure signed plans were received within 60 days or contained valid signatures.

Specifically, we found:

- Four instances (5 percent) when the Department did not receive all required signatures within 60 days of the plan completion as required by state rule
- Two instances (2 percent) when plans lacked client signatures
- Two instances (2 percent) when plans were signed by a client's legal guardian, but the Department did not have legal guardian paperwork in the file

We also performed follow-up testing on our 2016 audit finding that identified 18 instances when the Department either did not monitor to ensure the plans were received within 60 days or that plans had valid signatures. For 11 of the previously reported 18 instances, client service plans were still not completed or had invalid signatures for part or all of the current audit period.

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

This condition was reported in the prior audit.

Cause of Condition

A possible reason why staff did not obtain all required signatures was that the Department's policy changed in 2015 to align with the federal requirement to obtain written approval from clients.

Formal training was provided during the audit period, but the Department said it did not have time since the last audit to fully implement its corrective action.

Effect of Condition and Questioned Costs

Because some plans were not properly approved or adequately documented, we determined the Department made $305,096 in unallowable payments to providers. We are questioning $170,706, which is the federal portion of the unallowable payments.

When unallowable payments are identified, federal regulations suggest auditors consider if associated costs, such as benefits, were also paid. The Department pays payroll-related benefits, which are considered associated costs, on behalf of Community First Choice providers. Examples of these costs include health insurance, retirement, payroll taxes and training.

For the $305,096 in payments we determined were unallowable, we identified $79,943 in associated costs that we also consider to be unallowable. We are questioning $44,376, which is the federal portion of the unallowable payments.

Including associated costs, the total amount we are questioning is $215,082.

Estimated improper payments

Because a statistical sampling method was used to select the payments we examined, we estimate the total improper payments to be $11,478,485. The federal share of this estimate is $6,422,324.

For the $11,478,485 in likely improper payments, we estimate the amount of likely associated improper payments to be $3,355,104. The federal share of this estimate is $1,864,981.

The following table summarizes the known questioned costs and estimated improper payments by federal or state funds.

Projection to population	Known questioned costs	Estimated improper payments
Federal expenditures	$215,082	$8,287,305
State expenditures	$169,958	$6,546,284
Total expenditures	**$385,040**	**$14,833,589**

The statistical sample of 86 clients used to perform these tests was also used to test compliance with activities allowed and provider eligibility requirements. Because some unallowable payments we examined violated multiple federal compliance requirements, some of the questioned costs reported in this finding might also be reported in finding numbers 2017-045, 2017-049 and 2017-050.

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a very high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Recommendations

We recommend the Department:

- Provide additional training to staff on the federal regulation and state rule that require client service plans to be agreed to in writing
- Continue monitoring activities to ensure staff follow federal and state requirements
- Consult with the U.S. Department of Health and Human Services to determine if the questioned costs identified by the audit should be repaid

Agency's Response

The Department does not concur with the finding.

The Department agrees person-centered service plans are an important component of the delivery of Community First Choice services and are required by federal regulations, Washington's state Medicaid plan, and the Washington Administrative Code (WAC). The Department also acknowledges the participant must agree to services and signing the service plan indicates agreement to receipt of services. Person-centered service plans must be reviewed and revised upon reassessment of functional need, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

However, a signed person-centered service plan is not necessary nor required to properly determine or establish a client's eligibility to receive benefits by the Code of Federal Regulations (CFR), Washington's state Medicaid plan, or WAC. While the determination of functional eligibility and the development of the person-centered service plan may often take place during the same visit with the client, completion of the two tasks are separate and distinct endeavors and are governed by different laws and requirements. 42 CFR 441.510 is entitled "Eligibility" and explains the functional and financial requirements to be eligible for Community First Choice services. 42 CFR 441.540 is entitled "Person-centered Service Plan" and explains what is required to be included in a person centered service plan, including that the plan must be signed and contain an assessment of functional need. Additionally, in the CMS approved Medicaid state plan the Department allows paid services to begin as soon as functional eligibility and the person centered plan are completed:

> *"There is no lag between the person-centered planning and determination of eligibility. Initial and on-going person-centered service plans are developed in conjunction with the CARE assessment and functional eligibility determination. Access to services begins as soon as the participant selects the services and supports they are eligible to receive and identifies their qualified provider. (Washington State Medicaid State Plan, Attachment 3.1-k, page 12, item b.)."*

The Department also disagrees with the SAO's determination that the lack of signed service plans result in improper payments. In this case, the Department made payments to qualified providers for covered services delivered to clients who were both functionally and financially eligible.

Department staff receive direction through written policy and training on the federal requirement to obtain signatures on service plans. The Department completed policy refresher training in March and April 2016, but this was late in the time period reviewed in the FY17 audit. Therefore, the benefits of the training would only be evident in the final few months of the period reviewed. DDA will initiate a process to monitor, on a monthly basis, staff compliance with federal and state requirements regarding tracking and documenting efforts to obtain signed service plans.

The Department notes that federal regulations provide latitude to obtain consent in a person centered way unique to the needs of any client who is not able to provide a signature: As reflected on page 26865, Vol. 77, No. 88 of the Federal Register:

> *"**Response:** After consideration of these comments, we have revised the final regulation to indicate that the plan be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation. While we understand that some individuals may not be able to provide an actual signature, we believe that it is important to capture that the individual agrees to the service plan as finalized. Should an individual not be able to make any indication that they agree with the plan in writing or the individual does not have a representative who can do so on the individual's behalf, States will need to explain the methods they propose to use to indicate that the individual agrees with the service plan.*

Staff will also receive training on actions to take when the participant is not able to provide a signature.

Auditor's Concluding Remarks

In its response, the Department acknowledges person-centered service plans are required by federal regulation. In addition, the Department acknowledges the participant must agree to services and signing the service plan documents that agreement.

The Department states that a signed person-centered service plan is not necessary nor required by the Code of Federal Regulations (CFR), Washington's state Medicaid plan or the Washington Administrative Code (WAC) to properly determine or establish a client's eligibility to receive benefits.

According to federal and state rule a person-centered service plan is required:

- 42 Code of Federal Regulations, Section 441.540, states – Person-centered service plan must be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation.
- Washington Administrative Code 388-106-0045 states - The department will authorize long-term care services when you …have given written consent for services and approved your plan of care

The department also disagrees with the conclusion that the lack of signed service plans result in improper payments.

According to Washington Administrative Code 388-106-0047(3):

- The department will terminate long-term care services if you do not sign and return your service summary document within sixty days of your assessment completion date.

During the audit, the Department acknowledged it did not have the proper written consent on the person-centered service plans that must be finalized and agreed to in writing according to federal code for the exceptions we identified.

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service

not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls.

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).

(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—

Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Title 42 U.S. Code of Federal Regulations Part 433, State Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers

Section 433.300 Basis.

This subpart implements -

(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.

(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Section 433.316 When discovery of overpayment occurs and its significance.

(a) *General rule.* The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) *Requirements for notification.* Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of - -

(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

(d) *Overpayments resulting from fraud.*

(1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by § 455.15, § 455.21, or § 455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

(e) *Overpayments identified through Federal reviews.* If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS

will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) *Effect of changes in overpayment amount.* Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) *Effect of partial collection by State.* A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

(h) *Effect of administrative or judicial appeals.* Any appeal rights extended to a provider do not extend the date of discovery.

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

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

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

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

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

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

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

Title 42, Code of Federal Regulations, Section 441 Services: Requirements and Limits Applicable to Specific Services, states in part:

Section 441.540 Person-centered service plan.

(b) The person-centered service plan. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under Community First Choice, the plan must:

(9) Be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation.

(c) Reviewing the person-centered service plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

Section 441.720 Independent assessment, states in part:

(a) Requirements. For each individual determined to be eligible for the State plan HCBS benefit, the State must provide for an independent assessment of needs, which may include the results of a standardized functional needs assessment, in order to establish a service plan. In applying the requirements of section 1915(i)(1)(F) of the Act, the State must:

(1) Perform a face-to-face assessment of the individual by an agent who is independent and qualified as defined in § 441.730, and with a person-centered process that meets the requirements of § 441.725(a) and is guided by best practice and research on effective strategies that result in improved health and quality of life outcomes.

(i) For the purposes of this section, a face-to-face assessment may include assessments performed by telemedicine, or other information technology medium, if the following conditions are met:

(C) The individual provides informed consent for this type of assessment.

(3) Examine the individual's relevant history including the findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the person-centered service plan as required in § 441.725.

(b) Reassessments. The independent assessment of need must be conducted at least every 12 months and as needed when the individual's support needs or circumstances change significantly, in order to revise the service plan.

Washington Administrative Code WAC 388-106-0045 When will the department authorize my long-term care services? states in part:

The department will authorize long-term care services when you:

(1) Are assessed using CARE;

(2) Are found financially and functionally eligible for services including, if applicable, the determination of the amount of participation toward the cost of your care and/or the amount of room and board that you must pay;
(3) Have given written consent for services and approved your plan of care;

Washington Administrative Code 388-106-10047 When can the department terminate or deny long-term care services to me? states in part

(3) The department will terminate long-term care services if you do not sign and return your service summary document within sixty days of your assessment completion date.

Washington Administrative Code 388-106-0283 How do I remain eligible for CFC services? states in part:

(1) In order to remain eligible for CFC, you must remain financially eligible and be in need of services in accordance with WAC 388-106-0310 as determined through a CARE assessment. The assessment in CARE must be completed at least annually or more often when there are significant changes in your functional or financial circumstances; or

Washington State Medicaid State Plan-Community First choice State Plan Option, states in part:

X. Person-Centered Service Plan Development Process
a. Indicate how the service plan development process ensures that the person-centered service plan addresses the individual's goals, needs (including health care needs), and preferences, by offering choices regarding the services and supports they receive and from whom.

The person-centered service plan will be developed and implemented in accordance with 42 CFR 441.550 (b).

The person-centered service plan will be understandable to the participant, will indicate the individual and/or entity responsible for monitoring the plan, and will be agreed to in writing by the participant and those responsible for implementing the plan.

2017-047 The Department of Social and Health Services, Aging and Long-Term Support Administration made improper Medicaid nursing facility fee-for-service payments for clients enrolled in managed care.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles	
Known Questioned Cost Amount:	$6,991	

Background

Medicaid is a jointly funded State and federal partnership providing coverage for about 1.9 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and State funds during fiscal year 2017.

The Health Care Authority (Authority), the State's Medicaid agency, administers Washington's managed care program for eligible recipients in Washington. The Department of Social and Health Services (Department), Aging and Long-Term Support Administration, administers all nursing and skilled nursing facility services in Washington. Managed care is a prepaid, comprehensive system of medical and health care delivery, including preventative, primary, specialty and ancillary health care services. The program is designed to deliver health care to clients, improve the quality of care and reduce the cost of providing health benefits.

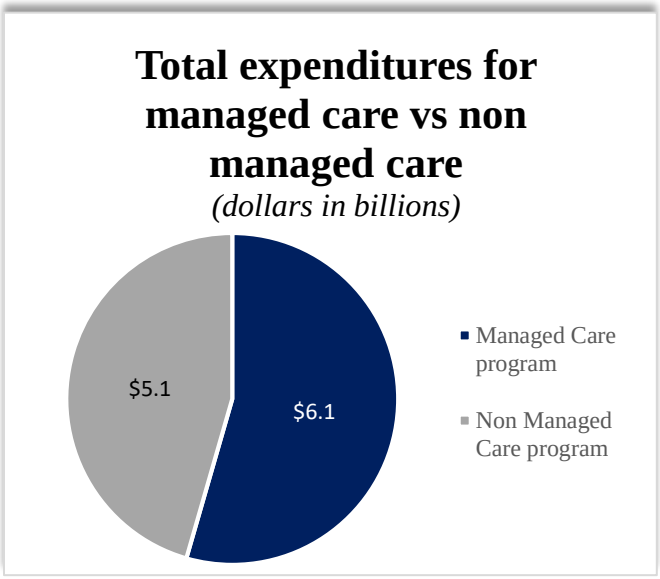
The Authority pays managed care organizations a uniform, pre-determined, per-enrollee monthly premium to cover medical costs for Medicaid-eligible clients.

The State's Apple Health Managed Care Contract (Contract) specifies the types of services covered and not covered for Medicaid clients enrolled in the managed care program. Any services not covered by the Contract are billed directly by providers and paid directly by the Department or Authority on a fee-for-service claim basis.

According to the Contract, any nursing facility services that do not meet rehabilitative or skilled nursing criteria are not covered by managed care. Managed care organizations must deny any nursing facility authorization request that does not meet rehabilitative or skilled nursing criteria and send a denial-of-

authorization letter to the client and the facility. For the claim to be paid as a fee-for-service, the facility must submit the managed care organization's denial letter with the nursing facility claim.

The Authority's Claims Adjudication Unit has set adjudication rules and reviews each nursing facility fee-for-service claim and authorization denial letter against these rules to determine whether a claim should be paid as fee-for-service based on criteria established by the Authority and the Department.



In fiscal year 2017, the State's Medicaid program paid about $6.1 billion in managed care premiums on behalf of more than 1.9 million Medicaid clients. The program also paid over $626 million in nursing facility fee-for-service claims.

Description of Condition

We found the Department had adequate internal controls to materially prevent managed care clients from receiving fee-for-service payments for nursing facility services that should be covered by the client's managed care plan.

Using computer assisted auditing techniques, we tested to determine if the Department made additional payments on clients' behalf for services that should have been covered by the client's monthly managed care premium. We found the Department paid 13,664 nursing facility fee-for-service claims, totaling $37.2 million, for clients enrolled in the managed care program. The Department is responsible for nursing facility stays for clients enrolled in managed care that meet eligibility criteria, but do not meet rehabilitative or skilled nursing criteria established by the managed care organization. This is not a covered benefit in the managed care contract.

We reviewed the payments and found 3,007 claims were processed with a claim note indicating a denial letter was reviewed. We also removed 505 claims from the population that were not materially significant based on the payment amount. For the remaining 10,152 claims without a denial letter claim note, we used a statistical sampling method to randomly select 65 nursing facility claims to determine whether the claim was allowed to be paid as fee-for-service.

We found the Department made two improper fee-for-service payments to providers for nursing facility services totaling $8,065. There was no evidence supporting that the requested services did not meet rehabilitative or skilled nursing criteria; to qualify for a fee-for-service payment, the Contract requires that the managed care organization pay for services that do meet rehabilitative or skilled criteria.

This condition was not reported in the prior audit.

Cause of Condition

The two improper payments were manually reviewed and approved by claims analysis staff. The Department relies on the Authority's Claims Adjudication Unit to review each claim to determine whether the claim should be paid as fee-for-service based on criteria established by the Authority and the Department. On certain occasions, the Authority works with the Department's Aging and Long-Term Support Administration policy staff to review claims submitted by nursing facilities as fee-for-service.

For these two payments, the reviews were not effective to ensure the facility submitted the required denial letter from the clients' managed care organizations prior to authorizing payment of the claims. In November 2016, the Authority in coordination with the Department issued written guidance to each managed care organization requiring each organization to submit an updated denial of authorization template to the Authority to approve for use moving forward. The Authority obtained all required templates from the managed care organizations in February 2017, and the Authority required all managed care organizations to implement these changes effective June 2017.

All improper payments identified in this audit were paid prior to these changes.

Effect of Condition and Questioned Costs

When providers submit fee-for-service claims for services that are covered under managed care, and the Department authorizes payment of these claims, the Medicaid program incurs a duplicate payment.

Each client's monthly managed care premium covers all medical care expenses for the client, for services specified in the State's Apple Health Managed Care contract. As such, any payments of fee-for-service claims by the Department for services required to be provided under the managed care contract are unallowable and cannot be claimed for federal reimbursement.

We determined the Department made $8,065 in unallowable payments to nursing facilities. We are questioning $6,991, which is the federal portion of the unallowable nursing facility fee-for-service claims.

Because a statistical sampling method was used to select fee-for-service nursing facility claims, we estimate the amount of likely improper payments to be $721,493. The federal share of this estimate is $548,781.

Projection to nursing facility claim population	Known questioned costs	Estimated improper payments
Federal expenditures	$6,991	$548,781
State expenditures	$1,074	$172,712
Total expenditures	**$8,065**	**$721,493**

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

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Recommendations

We recommend the Department:

- Recover the unallowable payments for improper fee-for-service transactions
- Consult with the U.S. Department of Health and Human Services to discuss whether the questioned costs identified in the audit should be repaid

Agency's Response

The Department partially concurs with this finding.

The Department concurs that the facilities either did not submit the required denial letter from the managed care organization (MCO) or the submitted letter did not read as a denial. The Department does not concur that these services would have been paid by the MCO or are duplicative.

Patients are frequently admitted to nursing facilities who do not meet skilled or rehabilitative level of care or reside in nursing facilities past the time when they may have been eligible. These stays are not eligible for managed care coverage. The Department is responsible for payment of claims to nursing facilities when patients do not meet skilled or rehabilitative level of care.

Since the dates on which these claims were processed, the Authority and Department have been engaged in a continuous process improvement. This improvement includes multiple updates to MCO contract language to clarify the roles and responsibilities of the MCO and updates to the nursing facility billing guide to provide further clarification of policy. The Department has also issued guidance via listserv message to facilities, provided direct training, and coordinated with provider associations.

The Department believes there are times when exceptions to the contract language must be made in order to maintain a patient's care at a facility. When these exceptions are made the Department communicates with both the MCO and the facility regarding the claims in question. The Department will document how these decisions will be made and who has the authority to make these decisions.

Auditor's Concluding Remarks

As described above, the Apple Health Managed Care Contract states that the Contractor (MCO) must provide notification in writing to the facility and the enrollee (client) when the client's stay does not

meet skilled or rehabilitative criteria. Both nursing facility claims that were reported in this finding did not show evidence of this communication from the Contractor to the facility and client. The Department responded that it is responsible for payment of nursing facility claims when patients do not meet skilled or rehabilitative criteria for care. However, this statement is in conflict with the Contract Section 16.10 – "Exclusions" which states that nursing facility stays that do not meet skilled or rehabilitative criteria are excluded from coverage by the Contractor. Our Office interprets this requirement to mean that nursing facility stays determined not to meet skilled or rehabilitative criteria should be paid for by the Department as fee-for-service. The nursing facility did not submit documentation from the Contractor confirming this information to justify payment as fee-for-service, which is our basis for questioning the payments.

The Medicaid program incurs a duplicate payment when providers submit fee-for-service claims for services that are covered under managed care, and the Department made payment of these services when a monthly premium was already paid for the client to the managed care organization.

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.
(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.
(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

(a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Title 42 U.S. Code of Federal Regulations Part 433, Stat Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers

Section 433.300 Basis.

This subpart implements -

(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.
(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to

recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Section 433.316 When discovery of overpayment occurs and its significance.

(a) *General rule.* The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) *Requirements for notification.* Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of - -

(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

(d) *Overpayments resulting from fraud.*

(1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by § 455.15, § 455.21, or § 455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or

appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

(e) *Overpayments identified through Federal reviews.* If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) *Effect of changes in overpayment amount.* Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) *Effect of partial collection by State.* A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

(h) *Effect of administrative or judicial appeals.* Any appeal rights extended to a provider do not extend the date of discovery.

The Health Care Authority, Apple Health Managed Care Contract, Section 14.6 – "Skilled Nursing Facility Coordination" states in part:

14.6.1 The Contractor is responsible for medically necessary Skilled Nursing Facility (SNF) or Nursing Facility (NF) stays when the Contractor determines that nursing facility care is more appropriate than acute hospital care. The contractor shall coordinate with hospital or other acute care facility discharge planners and nursing facility care managers or social workers, as described in the Coordination Between the Contractor and External Entities Subsection of this Contract to ensure a smooth transition of the enrollee to or from a SNF or NF.

14.6.2 The Contractor shall coordinate with the SNF or NF to provide care coordination and transitional care and shall ensure coverage of all medically necessary services, prescriptions and equipment not included in the negotiated SNF daily rate. This includes but is not limited to: prescription medications, durable medical equipment, therapies, intravenous medications, and any other medically necessary service or product.

14.6.3 If the enrollee remains in the SNF/NF, the enrollee remains enrolled in AFH and ALTSA is responsible for payment of SNF/NF room and board beginning on the date the enrollee

is determined not to meet or no longer meets criteria for the rehabilitative or skilled benefit. The MCO continues to be responsible for all medically necessary services, prescriptions, and equipment not included in the ALTSA nursing facility rate. The Contractor shall continue to monitor the enrollee's status and assist in coordination of transitions back to the community.

14.6.5 The Contractor must provide written notice to the facility and the enrollee if the enrollee:

14.6.5.1 Does not meet rehabilitative or skilled nursing criteria;

The notice must include dates of coverage and the date coverage will end.

The Health Care Authority, Apple Health Managed Care Contract, Section 16.5 – "16.5 Enrollee in Facility at Enrollment" states in part:

16.5.4 DSHS is responsible for payment of any nursing facility admissions including when the enrollee meets rehabilitation or skilled level of care criteria, provided from the date of admission until the date the enrollee is discharged from the nursing facility when:

16.5.4.1 the client was admitted to the nursing facility in the same month Medicaid eligibility is established but enrollment is not completed until the following month; or

16.5.4.2 the client was on fee-for-service before the admission and is enrolled in AHMC during the admission; or

16.5.4.3 the client's eligibility is retroactive to a month prior to the current month, the client is admitted, and enrollment is completed during the admission.

The Health Care Authority, Apple Health Managed Care Contract, Section 16.10 – "Exclusions" states in part:

The following services and supplies are excluded from coverage under this Contract.

16.10.4.15 Long-term private duty nursing for enrollees 18 and over. These services are covered by DSHS, Aging and Long-Term Services Administration;

16.10.4.19 Nursing facility stays that do not meet rehabilitative or skilled criteria;

2017-048 The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls over and did not comply with requirements to ensure Adult Family Home providers had proper background checks.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Allowable Costs/Cost Principles	
Known Questioned Cost Amount:	$98,399	

Background

Medicaid is a jointly funded State and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and State funds during fiscal year 2017.

Medicaid is the primary funding source for long-term care providers. The Medicaid Home and Community Based Services program permits states to furnish long-term care services to Medicaid beneficiaries in community settings. These services are provided in adult family homes by individuals or agencies most often chosen by the Medicaid client or their family.

All providers must meet the basic qualifications to provide services to Medicaid clients, which include background checks, certifications and training. Adult Family Home providers and their employees must complete a Washington background check every two years. In addition to the State background check requirement, after January 7, 2012, new providers must complete an initial national fingerprint background check through the Department's Background Check Central Unit.

The Department's Aging and Long-Term Support Administration, Residential Care Services Division, is responsible for ensuring all adult family homes and their providers meet and maintain minimum licensing requirements to serve Medicaid clients. The Department inspects every adult family home at least every 18 months to ensure the adult family home provider is meeting licensing requirements to remain eligible to provide Medicaid services to clients. During the inspection, Department staff review background check result letters for the provider, resident manager and all adult family home employees who have worked in the home since the previous inspection to ensure they are eligible to work and have completed a required background check in the past two years.

The Department establishes a list of crimes that automatically disqualify individuals from having unsupervised access to vulnerable clients. This list was referred to as "the Secretary's List" but now has been incorporated into State regulation (WAC 388-113). Individuals who commit any crime listed in State rule are automatically prohibited from "licensing, contracting, certification, or from having unsupervised access to children, vulnerable adults or to individuals with a developmental disability."

If an individual is found to have committed a crime not listed in State rule, they are not automatically disqualified from having unsupervised access to vulnerable clients. The provider must perform a Character, Competence and Suitability review to assess and determine if they or their employees may have unsupervised access to clients. In cases where a crime is listed as time-limited in State rule, those crimes would no longer be disqualifying but would still require a Character, Competence and Suitability review .

In fiscal year 2017, the State's Medicaid program paid about $167.6 million for the Adult Family Home Program administered by Residential Care Services.

In prior audits, we reported the Department did not ensure providers completed background checks before providing services to Medicaid clients. The prior finding numbers were 2016-044, 2015-051, 2014-048 and 2013-37.

Description of Condition

We found the Department did not have adequate internal controls over and did not comply with requirements to ensure Adult Family Home providers received proper background checks timely.

The Department currently lacks a centralized monitoring process for ensuring that Adult Family Home providers renew their background checks in a timely manner, and detecting provider non-compliance before it occurs.

We used a statistical sampling method to randomly select and examine 130 of 2,235 total Adult Family Home providers authorized to accept Medicaid clients. We reviewed supporting documentation from the Department to ensure:

- A proper background check had been completed in the past two years
- No individuals with disqualifying crimes listed in State rule provided care to vulnerable adult clients at the time of the audit, or during the month(s) when they were paid by the Department
- Providers and their staff who had committed crimes that were not listed in State rule of Automatically Disqualifying Convictions and Pending Charges passed a Character, Competence and Suitability review permitting them to work unsupervised with vulnerable adults
- The entire period when the provider had access to Medicaid clients was covered by a Washington background check and, if required, a national fingerprint background check

We found:

- No evidence a national fingerprint background check was performed for two providers
- A State background checks was not renewed on time for one provider

We consider this control deficiency to be a material weakness.

Cause of Condition

The Department has procedures in place to ensure adult family homes meet minimum licensing requirements. However, the high rate of employee turnover in adult family homes increases the risk of provider noncompliance with State and federal background check requirements.

Residential Care Services licensors examine the records of all adult family home staff for background checks during their onsite visits. Because of the Department's regulatory scope and allotted resources, unless there is a complaint, up to 18 months can pass before the Department inspects an adult family home again. This could allow an individual to work without a background check for a significant period of time before the Department is informed of any records or disqualifying crimes.

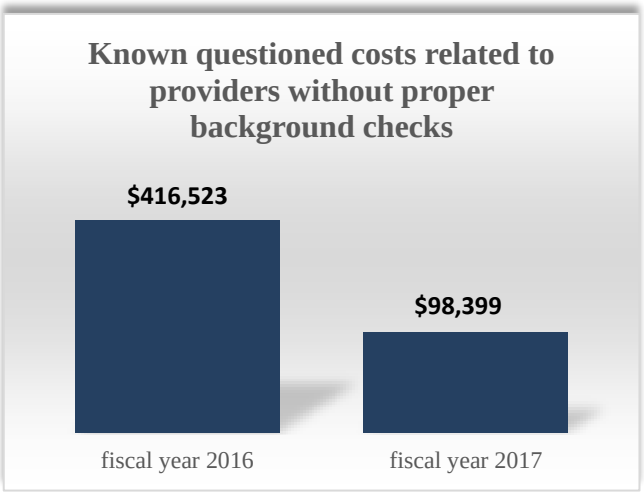
State rule (WAC 388-76-10930) requires that the adult family home must comply with all applicable licensing laws and regulations at all times. The Department said that each provider is responsible for renewing their own background checks, and preparing and documenting the results of their own Character, Competence and Suitability reviews. The Department relied on the providers to ensure they were complying with Adult Family Home licensing requirements.

Effect of Condition and Questioned Costs

Adult Family Home providers

We determined the Department made $196,798 in unallowable payments to the providers. We are questioning $98,399, which is the federal portion of the unallowable payments.

Because a statistical sampling method was used to select the Adult Family Home providers that we examined, we estimate the amount of likely improper payments to be $2,703,654. The federal share of this estimate is $1,351,827.



Projection to population	Number of providers	Known questioned costs – state and federal	Known questioned costs – federal share
Providers that did not renew their background checks*	1	$0	$0
Providers that did not complete a fingerprint background check*	2	$196,798	$98,399
Total	**3**	**$196,798**	**$98,399**

**No evidence action was taken by the end of the audit period (June 30, 2017)*

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

When providers who do not meet background check requirements have unsupervised access to vulnerable Medicaid clients, those clients are at greater risk of neglect, harm, exploitation and abuse. Therefore, providers who do not meet the background check requirement are not eligible to provide services to Medicaid clients. Any payments the Department makes to ineligible providers are unallowable.

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a very high level of assurance, with a 99 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3). To ensure a representative sample, we stratified the population by dollar amount (if applicable).

Adult Family Home employees

Using wage information reported by employers, we identified 1,616 employees working for the 130 adult family home providers in the audit sample in fiscal year 2017. Of the 1,616 employees, 1,242 of them were for one of the adult family home providers. We performed a Social Security number and date-of-birth match with the Department's background check database to determine if background checks were completed for each employee.

We found:

- No evidence a Washington background check was performed for 1,014 employees
- No evidence a national fingerprint background check was performed for 69 employees
- 80 instances when Washington background checks were not performed on time
- 123 instances when an employee had a record of crimes that were not disqualifying, but no Character, Competence and Suitability review was completed

Noncompliance related to Adult Family Home employees was not factored into the federal questioned costs.

Recommendations

We recommend the Department:

- Improve internal controls to ensure adult family home providers complete background checks on time
- Ensure all adult family home providers renew their background checks every two years, as Department rules require
- Consult with the U.S. Department of Health and Human Services to discuss whether the questioned costs identified in the audit should be repaid.

Agency's Response

The Department partially concurs with the finding.

The Department concurs with the exception for the single background check that was not renewed in a timely fashion.

However, the Department does not concur with the two exceptions regarding the missing national fingerprint background check for the two providers. The relevant WAC states:

> *"(1) An adult family home applicant and anyone affiliated with an applicant must have the following background checks before licensure: … (b) If applying after January 7, 2012, a national fingerprint background check."*

The individuals in question had both applied in 2011, and therefore are not required by rule to have a fingerprint check.

The same WAC goes on to state:

> *"(2)The adult family home must ensure that all caregivers, entity representatives, and resident managers who are employed directly or by contract after January 7, 2012, have the following background checks: (a) A Washington state name and date of birth background check; and (b) A national fingerprint background check."*

This section of the WAC does not apply to these individuals because they were not "caregivers, entity representatives, resident managers who are employed directly or by contract." While an adult family home owner may designate themselves as an entity representative or resident manager, they remain the owner of the business and are not employed directly or by contract with an employment agency or as an independent contractor.

Similarly, the definition of "caregiver" in WAC explicitly excludes the provider. There are two types of employees:

- *Owner employing themselves*
- *Employee employed by the owner.*

The individuals in question were the business owners, and not employees or contractors, and therefore subject only to subsection (1)(b). If subsections (1) and (2) were to be read in the way the auditor is proposing, all adult family home owners applying prior to January 7th 2012 would still be "employed" after the same date, in effect completely nullifying the language of (1)(b) -- a result in violation of well-established legal principles of regulatory interpretation. It has never been the practice of the Department to treat owners as both owners and their own employees and subject to the requirements of both groups simultaneously, and the Department disagrees with the auditor's findings suggesting this should be so.

The Department also does not agree the findings should be tied to questioned costs. SAO did not identify any providers who did in fact have a disqualifying crime or negative action. This is the critical question because the relevant minimum qualifications under the RCW only require that an AFH operator not have a disqualifying crime or negative action. RCW 70.128.120(8):

> *"Each adult family home provider, applicant, and each resident manager shall have the following minimum qualifications, except that only applicants are required to meet the provisions of subsections (10) and (11) of this section…:*
>
> > *(8) Not been convicted of any crime that is disqualifying under RCW 43.43.830 or 43.43.842, or department rules adopted under this chapter, or been found to have abused, neglected, exploited, or abandoned a minor or vulnerable adult as specified in RCW 74.39A.056(2);…"*

Neither RCW 70.128.120 nor RCW 74.39A.056 require that the department or the provider conduct additional background checks after the initial screening. Consistent with the RCW requirement, WAC 388-76-10130 requires that an Adult Family Home must ensure that the operator "have no disqualifying criminal convictions or pending criminal charges under chapter 388-113 WAC" and "have none of the negative actions listed in WAC 388-76-10180."

While the Adult Family Homes in question are out of compliance with the licensing requirements of chapter 388-76 WAC by not having current background check results in their files—and are therefore subject to corrective action and sanctions by the department—the providers are not unqualified to provide Medicaid paid services. Thus, the payments to the providers were proper. The Department will consult with the U.S. Department of Health and Human Services regarding disagreement with repayment of questioned costs.

At this time, the Department is unable to comment regarding the audit exceptions for the adult family home employees as the Department was not afforded the opportunity to validate or review the findings related to those employees.

The Department has created a report that will proactively identify provider renewals coming due. When a provider has 60 days left before expiration, the Department will send a reminder notice. This report was implemented in November 2017 and is currently being used.

Auditor's Concluding Remarks

In reviewing the applications for the Adult Family Homes, we observed that both providers designated themselves as the Entity Representative/Resident Manager of their respective Adult Family Homes and attested in writing they would be providing direct care to clients. Both provider contracts *were not executed* until after January 7, 2012. Therefore the individuals should have passed a national fingerprint background check before providing services to clients and being paid by the Department.

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.303 Internal controls.

The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.

(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).

(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.

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(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

(4) Known questioned costs that are greater than $25,000 for a Federal program which is not audited as a major program. Except for audit follow-up, the auditor is not required under this part to perform audit procedures for such a Federal program; therefor, the auditor will normally not find questioned costs for a program that is not audited as a major program. However, if the auditor does become aware of questioned costs for a Federal program that 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 $25,000, then the auditor must report this as an audit finding.

(5) The circumstances concerning why the auditor's report on compliance for each major program is other than an unmodified opinion, unless such circumstances are otherwise reported audit findings in the schedule of findings and questioned costs for Federal awards.

(6) Known or likely fraud affecting a Federal program award, unless such fraud is otherwise reported as an audit finding in the schedule of findings and questioned costs for Federal awards. This paragraph does not require the auditor to report publicly information which could compromise investigative or legal proceedings or to make an additional reporting when the auditor confirms that the fraud was reported outside the auditor's report under the direct reporting requirements of GAGAS.

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

Title 42 U.S. Code of Federal Regulations Part 433, Stat Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers

Section 433.300 Basis.

This subpart implements -

(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.

(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal

Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Section 433.316 When discovery of overpayment occurs and its significance.

(a) *General rule.* The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) *Requirements for notification.* Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of - -

(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

(d) *Overpayments resulting from fraud.*

(1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by § 455.15, § 455.21, or § 455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

(e) *Overpayments identified through Federal reviews.* If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) *Effect of changes in overpayment amount.* Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) *Effect of partial collection by State.* A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

(h) *Effect of administrative or judicial appeals.* Any appeal rights extended to a provider do not extend the date of discovery.

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

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

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

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

the likelihood of an event occurring is either reasonably possible or probable as defined as follows:

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

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

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

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

Washington Administrative Code 388-76-10015, License-Adult family home-compliance required, states:

(1) The licensed adult family home must comply with all the requirements established in chapters 70.128, 70.129, 74.34 RCW, this chapter and other applicable laws and regulations including chapter 74.39A RCW; and
(2) The provider is ultimately responsible for the day-to-day operation of each licensed home.
(3) The provider must promote the health, safety, and well-being of each resident residing in each licensed adult family home.

Washington Administrative Code 388-76-10161, Background checks -- Who is required to have.

(1) An adult family home applicant and anyone affiliated with an applicant must have the following background checks before licensure:
    (a) A Washington state name and date of birth background check; and
    (b) If applying after January 7, 2012, a national fingerprint background check.
(2) The adult family home must ensure that all caregivers, entity representatives, and resident managers who are employed directly or by contract after January 7, 2012, have the following background checks:
    (a) A Washington state name and date of birth background check; and
    (b) A national fingerprint background check.
(3) All household members over the age of eleven, volunteers, students, and noncaregiving staff who may have unsupervised access to residents must have a Washington state name and date of birth background check. They are not required to have a national fingerprint background check.

Washington Administrative Code 388-76-10165 Background checks – Washington State name and date of birth background check – Valid for two years – National fingerprint background check – Valid indefinitely, states:

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The adult family home must ensure:
   (a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for each individual listed in WAC 388-76-10161;
   (b) There is a valid Washington state background check for all individuals listed in WAC 388-76-10161.
(2) A national fingerprint background check is valid for an indefinite period of time. The adult family home must ensure there is a valid national fingerprint background check for individuals hired after January 7, 2012 as caregivers, entity representatives or resident managers. To be considered valid, the individual must have completed the national fingerprint background check through the background check central unit after January 7, 2012.

Washington Administrative Code 388-76-10166 Background checks – Household members, noncaregiving and unpaid staff – Unsupervised access, states:

(1) The adult family home must not allow individuals specified in WAC 388-76-10161(3) to have unsupervised access to residents until the home receives results of the Washington state name and date of birth background check from the department.
(2) If the background check results show that an individual specified in WAC 388-76-10161 has a criminal conviction or pending charge for a crime that is not automatically disqualifying under chapter 388-113 WAC, then the adult family home must:
   (a) Determine whether or not the person has the character, competence and suitability to have unsupervised access to residents; and
   (b) Document in writing the basis for making the decision.
   (c) Nothing in this section should be interpreted as requiring the employment of any person against the better judgment of the adult family home.

Washington Administrative Code 388-76-10175 Background checks – Employment – Conditional hire – Pending results of Washington state name and date of birth background check, states:

An adult family home may conditionally employ a person directly or by contract, pending the result of a Washington state name and date of birth background check, provided the home:
(1) Submits the Washington state name and date of birth background check no later than one business day after conditional employment;
(2) Requires the individual to sign a disclosure statement and the individual denies having a disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113 WAC, or a negative action that is listed in WAC 388-76-10180;
(3) Does not allow the individual to have unsupervised access to any resident;
(4) Ensures direct supervision, as defined in WAC 388-76-10000, of the individual; and

(5) Ensures the individual is competent and receives the necessary training to perform assigned tasks and meets the staff training requirements under chapter 388-112 WAC.

Washington Administrative Code 388-76-10176 Background checks – Employment – Provisional hire – Pending results of national fingerprint check.

The adult family home may provisionally employ individuals hired after January 7, 2012 and listed in WAC 388-76-10161(2) for one hundred twenty-days and allow those individuals to have unsupervised access to residents when:

(1) The individual is not disqualified based on the results of the Washington state name and date of birth background check; and
(2) The results of the national fingerprint background check are pending.

Washington Administrative Code 388-76-10180 Background checks – Employment – Disqualifying information. [Disqualifying negative actions] states:

(1) The adult family home must not employ, directly or by contract, a caregiver, entity representative, or resident manager if:
  (a) The caregiver, entity representative or resident manager will have unsupervised access to vulnerable adults, as defined in RCW 43.43.830; and either:
  (b) The caregiver, entity representative or resident manager has a disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113 WAC; or
  (c) The caregiver, entity representative, or resident manager has one or more of the following negative actions:
    (i) A court has issued a permanent restraining order or order of protection, either active or expired, against the person that was based upon abuse, neglect, financial exploitation, or mistreatment of a child or vulnerable adult;
    (ii) The individual is a registered sex offender;
    (iii) The individual is on a registry based upon a final finding of abuse, neglect or financial exploitation of a vulnerable adult, unless the finding was made by adult protective services prior to October 2003;
    (iv) A founded finding of abuse or neglect of a child was made against the person, unless the finding was made by child protective services prior to October 1, 1998;
    (v) The individual was found in any dependency action to have sexually assaulted or exploited any child or to have physically abused any child;
    (vi) The individual was found by a court in a domestic relations proceeding under Title 26 RCW, or under any comparable state or federal law, to have sexually abused or exploited any child or to have physically abused any child;
    (vii) The person has had a contract or license denied, terminated, revoked, or suspended due to abuse, neglect, financial exploitation, or mistreatment of a child or vulnerable adult; or
    (viii) The person has relinquished a license or terminated a contract because an agency was taking an action against the individual related to alleged abuse, neglect, financial exploitation or mistreatment of a child or vulnerable adult.

Washington Administrative Code 388-76-10181 Background checks – Employment – Nondisqualifying information, states:

(1) If any background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not disqualifying under chapter 388-113 WAC, then the adult family home must:
   (a) Determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care; and
   (b) Document in writing the basis for making the decision, and make it available to the department upon request.
(2) Nothing in this section should be interpreted as requiring the employment of any person against the better judgment of the adult family home.

2017-049 The Department of Social and Health Services, Aging and Long-Term Support Administration did not ensure all Medicaid Community First Choice individual providers had proper fingerprint background checks.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Activities Allowed/Unallowed Allowable Costs/Cost Principles	
Known Questioned Cost Amount:	$2,383	

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and state funds during fiscal year 2017.

The Aging and Long-Term Care Administration in the Department of Social and Health Services (Department) offers personal care and other services to support Medicaid clients in community settings through the Community First Choice program. The Department uses an assessment to evaluate a client's support needs and to calculate the number of personal care hours the client needs to successfully live in the community. Individual providers contract with the Department to provide personal care services to clients.

Medicaid is the primary funding source for long-term-care providers. The Medicaid Home and Community Based Services program permits states to furnish long-term-care services to Medicaid clients in home and community settings. These services are provided in the client's home by individuals or agencies chosen by the Medicaid client or the client's legal representative. Payments to individual providers contracted with the Aging and Long-Term Support Administration accounted for more than 4 percent of all Medicaid payments the Department made in fiscal year 2017.

In fiscal year 2017, the state Medicaid program paid about $1.3 billion for Community First Choice personal care services.

All individual providers must meet the basic qualifications to provide services to Medicaid clients, which include being at least 18 years old, passing background checks, and receiving required

certifications and training. Individual providers must complete a Washington background check every three years and, effective January 8, 2012, all new contracted providers or applicants who have not lived in Washington for three consecutive years must complete a national fingerprint-based background check. Some clients might wish to receive care from their parent or legal guardian. Unless the parent applicant first contracted with the Department after January 7, 2012, a background check is not required under State law.

The Department's Secretary establishes a list of crimes that automatically disqualify individuals from having unsupervised access to vulnerable clients. This list was referred to as "the Secretary's List" but now has been incorporated into regulation (WAC 388-113). Individuals who commit any crime listed in State rule are automatically prohibited from "licensing, contracting, certification, or from having unsupervised access to children, vulnerable adults or to individuals with a developmental disability."

If an individual is found to have committed a crime not listed in State rule, they are not automatically disqualified from having unsupervised access to vulnerable clients. The provider must perform a Character, Competence and Suitability review to assess and determine if they or their employees may have unsupervised access to clients.

In prior audits, we reported questioned costs when the Department made payments on behalf of individual providers without valid background checks. The prior finding numbers were 2016-040, 2015-040, 2014-049, 2013-40, 12-41, and 11-34.

Description of Condition

We found the Department had adequate internal controls to materially ensure Community First Choice individual providers had proper back checks.

We used a statistical sampling method to randomly select and examine 86 out of 31,155 Community First Choice individual providers who provided in-home care services to in-home clients during fiscal year 2017 to ensure:

- A proper background check had been completed within the past three years
- No individuals with disqualifying crimes listed in State rule provided care to vulnerable adult clients at the time of the audit, or during the month(s) when the Department paid them
- Providers who had committed crimes that were not listed as disqualifying in State rule passed a Character, Competence and Suitability review permitting them to work unsupervised with vulnerable adults
- The entire period when the provider had access to Medicaid clients was covered by a Washington background check and, if required, a national fingerprint background check

We found one instance when the Department did not perform a fingerprint background check of a provider. While this provider did have a Washington background check, State law requires a fingerprint check is also completed.

Cause of Condition

The Department said it did not perform the provider's fingerprint background check because of an oversight by staff members.

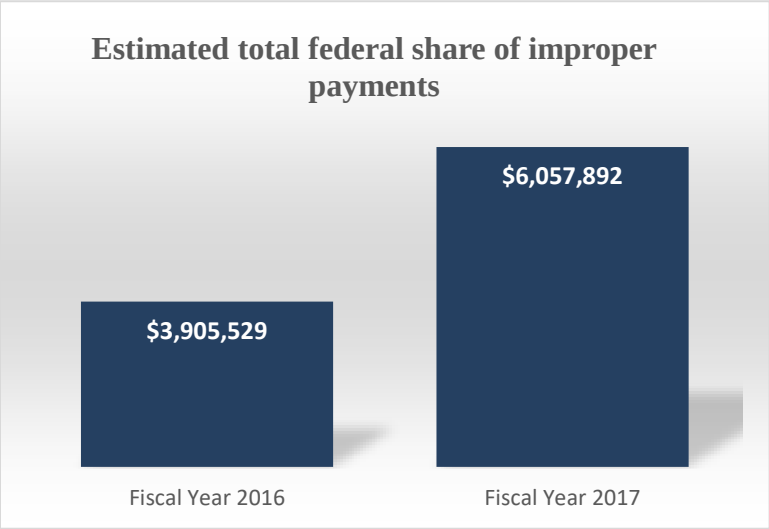
Effect of Condition and Questioned Costs

When providers who do not meet background check requirements have unsupervised access to vulnerable Medicaid clients, those clients face an increased risk of neglect, harm, exploitation and abuse. Therefore, providers who do not meet the background check requirement are not eligible to provide services to Medicaid clients. Any payments made by the Department to ineligible providers are unallowable.

We found one individual provider did not have a completed fingerprint check as State law requires. We determined the Department made $4,255 in unallowable payments to the provider. We are questioning $2,383, which is the federal portion of the unallowable payments.

When unallowable payments are identified, federal regulations suggest auditors consider if associated costs, such as benefits, were also paid. The Department pays payroll related benefits, which are considered associated costs, on behalf of Community First Choice providers. Examples of these costs include health insurance, retirement, payroll taxes and training.

For the $4,255 in payments we determined were unallowable, we identified $1,297 in associated costs that we also consider to be unallowable. We are questioning $727, which is the federal portion of the unallowable payments.



Because a statistical sampling method was used to select the Community First Choice individual providers that we examined, we estimate the amount of likely improper payments to be $10,817,664. The federal share of this estimate is $6,057,892.

The statistical sample used for testing was also used to test compliance with activities allowed and provider eligibility requirements. Because some unallowable payments we examined violated multiple federal compliance requirements, some of the questioned costs reported here might also be reported in finding numbers 2017-045, 2017-046 and 2017-050.

Projection to population	Known questioned costs	Estimated improper payments
Federal expenditures	$2,383	$6,057,892
State expenditures	$1,872	$4,759,772
Total expenditures	**$4,255**	**$10,817,664**

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

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Because this finding reports non-compliance with State law, the Office of Financial Management must (RCW 43.09.312 (1)) submit the agency's response and plan for remediation to the Governor, the Joint Legislative Audit and Review Committee, and the relevant fiscal and policy committees of the Senate and House of Representatives.

Recommendations

We recommend the Department:

- Ensure that all providers' background checks are completed as State law requires
- Consult with the U.S. Department of Health and Human Services to discuss whether the questioned costs and improper payments identified in the audit should be repaid

Agency's Response

The Department concurs with this finding.

The Department will continue to follow established internal controls to materially ensure Community First Choice individual providers have proper background checks.

The Department will work with the U.S. Department of Health and Human Services to repay the identified questioned costs.

Auditor's Concluding Remarks

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

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(2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

42 U.S. Code §1397ee. Payments to States, states in part:

(g) Authority for qualifying states to use certain funds for Medicaid expenditures. -

(1) State option.—

(A) In general.—Notwithstanding any other provision of law subject to paragraph (4), a qualifying State (as defined in paragraph (2)) may elect to use not more than 20

percent of any allotment under section 1397dd of this title for fiscal year 1998, 1999, 2000, 2001, 2004, 2005, 2006, 2007, or 2008 (insofar as it is available under subsections (e) and (g) of such section) for payments under subchapter XIX of this chapter in accordance with subparagraph (B), instead of for expenditures under this subchapter .

(B) Payments to states.—

(i) In In general.—In the case of a qualifying State that has elected the option described in subparagraph (A), subject to the availability of funds under such subparagraph with respect to the State, the Secretary shall pay the State an amount each quarter equal to the additional amount that would have been paid to the State under subchapter XIX of this chapter with respect to expenditures described in clause (ii) if the enhanced FMAP (as determined under subsection (b) of this section) had been substituted for the Federal medical assistance percentage (as defined in section 1396d(b) of this title).

(ii) Expenditures described.—For purposes of this subparagraph, the expenditures described in this clause are expenditures, made after August 15, 2003, and during the period in which funds are available to the qualifying State for use under subparagraph (A), for medical assistance under subchapter XIX of this chapter to individuals who have not attained age 19 and whose family income exceeds 150 percent of the poverty line.

(iii) No impact on determination of budget neutrality for waivers.—In the case of a qualifying State that uses amounts paid under this subsection for expenditures described in clause (ii) that are incurred under a waiver approved for the State, any budget neutrality determinations with respect to such waiver shall be determined without regard to such amounts paid.

(2) Qualifying state.—In this subsection, the term "qualifying State" means a State that, on and after April 15, 1997, has an income eligibility standard that is at least 184 percent of the poverty line with respect to any 1 or more categories of children (other than infants) who are eligible for medical assistance under section 1396a(a)(10)(A) of this title or, in the case of a State that has a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that was first implemented on August 1, 1994, or July 1, 1995, has an income eligibility standard under such waiver for children that is at least 185 percent of the poverty line, or, in the case of a State that has a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that was first implemented on January 1, 1994, has an income eligibility standard under such waiver for children who lack health insurance that is at least 185 percent of the poverty line, or, in the case of a State that had a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that was first implemented on October 1, 1993, had an income eligibility standard under such waiver for children that was at least 185 percent of the poverty line and on and after July 1, 1998, has an income eligibility standard for children under section 1396a(a)(10)(A) of this title or a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX of this chapter that is at least 185 percent of the poverty line.

(3) Construction.—Nothing in paragraphs (1) and (2) shall be construed as modifying the requirements applicable to States implementing State child health plans under this subchapter.
(4) Option for allotments for fiscal years 2009 through 2015.—
(A) Payment of enhanced portion of matching rate for certain expenditures.—In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State's allotment made under section 1397dd of this title for any of fiscal years 2009 through 2015 (insofar as the allotment is available to the State under subsections (e) and (m) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under subchapter XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1396d(b) of this title).
(B) Expenditures described.—For purposes graph (A), the expenditures described in this subparagraph are expenditures made after February 4, 2009, and during the period in which funds are available to the qualifying State for use under subparagraph (A), for the provision of medical assistance to individuals residing in the State who are eligible for medical assistance under the State plan under subchapter XIX or under a waiver of such plan and who have not attained age 19 (or, if a State has so elected under the State plan under subchapter XIX, age 20 or 21), and whose family income equals or exceeds 133 percent of the poverty line but does not exceed the Medicaid applicable income level.

Revised Code of Washington 43.43.837, "Fingerprint-based background checks—Requirements for applicants and service providers—Shared background checks—Fees—Rules to establish financial responsibility," states:

(1) Except as provided in subsection (2) of this section, in order to determine the character, competence, and suitability of any applicant or service provider to have unsupervised access, the secretary may require a fingerprint-based background check through both the Washington state patrol and the federal bureau of investigation at any time, but shall require a fingerprint-based background check when the applicant or service provider has resided in the state less than three consecutive years before application, and:
(a) Is an applicant or service provider providing services to children or people with developmental disabilities under RCW 74.15.030;
(b) Is an individual residing in an applicant or service provider's home, facility, entity, agency, or business or who is authorized by the department to provide services to children or people with developmental disabilities under RCW 74.15.030; or
(c) Is an applicant or service provider providing in-home services funded by:
(i) Medicaid personal care under RCW 74.09.520;
(ii) Community options program entry system waiver services under RCW 74.39A.030;
(iii) Chore services under RCW 74.39A.110; or
(iv) Other home and community long-term care programs, established pursuant to chapters 74.39 and 74.39A RCW, administered by the department.
(2) Long-term care workers, as defined in RCW 74.39A.009, who are hired after January 7, 2012, are subject to background checks under RCW 74.39A.056.

(3) To satisfy the shared background check requirements provided for in RCW 43.215.215 and 43.20A.710, the department of early learning and the department of social and health services shall share federal fingerprint-based background check results as permitted under the law. The purpose of this provision is to allow both departments to fulfill their joint background check responsibility of checking any individual who may have unsupervised access to vulnerable adults, children, or juveniles. Neither department may share the federal background check results with any other state agency or person.

(4) The secretary shall require a fingerprint-based background check through the Washington state patrol identification and criminal history section and the federal bureau of investigation when the department seeks to approve an applicant or service provider for a foster or adoptive placement of children in accordance with federal and state law.

(5) Any secure facility operated by the department under chapter 71.09 RCW shall require applicants and service providers to undergo a fingerprint-based background check through the Washington state patrol identification and criminal history section and the federal bureau of investigation.

(6) Service providers and service provider applicants who are required to complete a fingerprint-based background check may be hired for a one hundred twenty-day provisional period as allowed under law or program rules when:
   (a) A fingerprint-based background check is pending; and
   (b) The applicant or service provider is not disqualified based on the immediate result of the background check.

(7) Fees charged by the Washington state patrol and the federal bureau of investigation for fingerprint-based background checks shall be paid by the department for applicants or service providers providing:
   (a) Services to people with a developmental disability under RCW 74.15.030;
   (b) In-home services funded by medicaid personal care under RCW 74.09.520;
   (c) Community options program entry system waiver services under RCW 74.39A.030;
   (d) Chore services under RCW 74.39A.110;
   (e) Services under other home and community long-term care programs, established pursuant to chapters 74.39 and 74.39A RCW, administered by the department;
   (f) Services in, or to residents of, a secure facility under RCW 71.09.115; and
   (g) Foster care as required under RCW 74.15.030.

(8) Service providers licensed under RCW 74.15.030 must pay fees charged by the Washington state patrol and the federal bureau of investigation for conducting fingerprint-based background checks.

(9) Children's administration service providers licensed under RCW 74.15.030 may not pass on the cost of the background check fees to their applicants unless the individual is determined to be disqualified due to the background information.

(10) The department shall develop rules identifying the financial responsibility of service providers, applicants, and the department for paying the fees charged by law enforcement to roll, print, or scan fingerprints-based for the purpose of a Washington state patrol or federal bureau of investigation fingerprint-based background check.

(11) For purposes of this section, unless the context plainly indicates otherwise:
   (a) Applicant" means a current or prospective department or service provider employee, volunteer, student, intern, researcher, contractor, or any other individual who will or may have unsupervised access because of the nature of the work or services he or she

provides. "Applicant" includes but is not limited to any individual who will or may have unsupervised access and is:

(i) Applying for a license or certification from the department;

(ii) Seeking a contract with the department or a service provider;

(iii) Applying for employment, promotion, reallocation, or transfer;

(iv) An individual that a department client or guardian of a department client chooses to hire or engage to provide services to himself or herself or another vulnerable adult, juvenile, or child and who might be eligible to receive payment from the department for services rendered; or

(v) A department applicant who will or may work in a department-covered position.

(b) Authorized" means the department grants an applicant, home, or facility permission to:

(i) Conduct licensing, certification, or contracting activities;

(ii) Have unsupervised access to vulnerable adults, juveniles, and children;

(iii) Receive payments from a department program; or

(iv) Work or serve in a department-covered position.

(c) Department" means the department of social and health services.

(d) Secretary" means the secretary of the department of social and health services.

(e) Secure facility" has the meaning provided in RCW 71.09.020.

(f) Service provider" means entities, facilities, agencies, businesses, or individuals who are licensed, certified, authorized, or regulated by, receive payment from, or have contracts or agreements with the department to provide services to vulnerable adults, juveniles, or children. "Service provider" includes individuals whom a department client or guardian of a department client may choose to hire or engage to provide services to himself or herself or another vulnerable adult, juvenile, or child and who might be eligible to receive payment from the department for services rendered. "Service provider" does not include those certified under *chapter 70.96A RCW.

Revised Code of Washington 74.15.030, Powers and duties of secretary, states:

The secretary shall have the power and it shall be the secretary's duty:

(1) In consultation with the children's services advisory committee, and with the advice and assistance of persons representative of the various type agencies to be licensed, to designate categories of facilities for which separate or different requirements shall be developed as may be appropriate whether because of variations in the ages, sex and other characteristics of persons served, variations in the purposes and services offered or size or structure of the agencies to be licensed hereunder, or because of any other factor relevant thereto;

(2) In consultation with the children's services advisory committee, and with the advice and assistance of persons representative of the various type agencies to be licensed, to adopt and publish minimum requirements for licensing applicable to each of the various categories of agencies to be licensed.

The minimum requirements shall be limited to:

(a) The size and suitability of a facility and the plan of operation for carrying out the purpose for which an applicant seeks a license;

(b) Obtaining background information and any out-of-state equivalent, to determine whether the applicant or service provider is disqualified and to determine the

character, competence, and suitability of an agency, the agency's employees, volunteers, and other persons associated with an agency;

(c) Conducting background checks for those who will or may have unsupervised access to children, expectant mothers, or individuals with a developmental disability; however, a background check is not required if a caregiver approves an activity pursuant to the prudent parent standard contained in RCW 74.13.710;

(d) Obtaining child protective services information or records maintained in the department case management information system. No unfounded allegation of child abuse or neglect as defined in RCW 26.44.020 may be disclosed to a child-placing agency, private adoption agency, or any other provider licensed under this chapter;

(e) Submitting a fingerprint-based background check through the Washington state patrol under chapter 10.97 RCW and through the federal bureau of investigation for:

(i) Agencies and their staff, volunteers, students, and interns when the agency is seeking license or relicense;

(ii) Foster care and adoption placements; and

(iii) Any adult living in a home where a child may be placed;

(f) If any adult living in the home has not resided in the state of Washington for the preceding five years, the department shall review any child abuse and neglect registries maintained by any state where the adult has resided over the preceding five years;

(g) The cost of fingerprint background check fees will be paid as required in RCW 43.43.837;

(h) National and state background information must be used solely for the purpose of determining eligibility for a license and for determining the character, suitability, and competence of those persons or agencies, excluding parents, not required to be licensed who are authorized to care for children or expectant mothers;

(i) The number of qualified persons required to render the type of care and treatment for which an agency seeks a license;

(j) The safety, cleanliness, and general adequacy of the premises to provide for the comfort, care and well-being of children, expectant mothers or developmentally disabled persons;

(k) The provision of necessary care, including food, clothing, supervision and discipline; physical, mental and social well-being; and educational, recreational and spiritual opportunities for those served;

(l) The financial ability of an agency to comply with minimum requirements established pursuant to chapter 74.15 RCW and RCW 74.13.031; and

(m) The maintenance of records pertaining to the admission, progress, health and discharge of persons served;

(3) To investigate any person, including relatives by blood or marriage except for parents, for character, suitability, and competence in the care and treatment of children, expectant mothers, and developmentally disabled persons prior to authorizing that person to care for children, expectant mothers, and developmentally disabled persons. However, if a child is placed with a relative under RCW 13.34.065 or 13.34.130, and if such relative appears otherwise suitable and competent to provide care and treatment the criminal history background check required by this section need not be completed before placement, but shall be completed as soon as possible after placement;

(4) On reports of alleged child abuse and neglect, to investigate agencies in accordance with chapter 26.44 RCW, including child day-care centers and family day-care homes, to determine whether the alleged abuse or neglect has occurred, and whether child protective services or referral to a law enforcement agency is appropriate;
(5) To issue, revoke, or deny licenses to agencies pursuant to chapter 74.15 RCW and RCW 74.13.031. Licenses shall specify the category of care which an agency is authorized to render and the ages, sex and number of persons to be served;
(6) To prescribe the procedures and the form and contents of reports necessary for the administration of chapter 74.15 RCW and RCW 74.13.031 and to require regular reports from each licensee;
(7) To inspect agencies periodically to determine whether or not there is compliance with chapter 74.15 RCW and RCW 74.13.031 and the requirements adopted hereunder;
(8) To review requirements adopted hereunder at least every two years and to adopt appropriate changes after consultation with affected groups for child day-care requirements and with the children's services advisory committee for requirements for other agencies; and
(9) To consult with public and private agencies in order to help them improve their methods and facilities for the care of children, expectant mothers and developmentally disabled persons.

Washington Administrative Code 388-825-615 – "What is the process for obtaining a background check?" states:

(1) Long-term care workers, including individual providers, undergoing a background check for initial hire or initial contract, after January 7, 2012, will be screened through a state name and date of birth check and a national fingerprint-based background check; except that long-term care workers in community residential service businesses are subject to background checks as described in subsection (1)(a) and (b) in this section. Parents are not exempt from the long-term care background check requirements.
  (a) Prior to January 1, 2016, community residential service businesses as defined above will be screened as follows:
    (i) Individuals who have continuously resided in Washington state for the past three consecutive years will be screened through a state name and date of birth background check.
    (ii) Individuals who have resided outside of Washington state within the past three years will be screened through a state name and date of birth and a national fingerprint-based background check.
  (b) Beginning January 1, 2016, community residential service businesses as defined above will be screened as described in subsection (1) of this section.
(2) For adult family homes refer to chapter 388-76 WAC, Adult family home minimum licensing requirements. For assisted living facilities refer to chapter 388-78A WAC, Assisted living licensing rules.

Washington Administrative Code 388-825-320 – "How does a person become an individual provider?" states:

In order to become an individual provider, a person must:

(1) Be eighteen years of age or older.

(2) Provide the social worker/case manager/designee with:
   (a) Picture identification; and
   (b) A Social Security card.

(3) Complete and submit to the social worker/case manager/designee the department's criminal conviction background inquiry application, unless the provider is also the parent of the adult DDD client and exempted, per chapter 74.15 RCW.
   (a) Preliminary results may require a thumbprint for identification purposes.
   (b) An FBI fingerprint-based background check is required if the person has lived in the state of Washington less than three years.

(4) Provide references as requested.

(5) Complete orientation, if contracting as an individual provider.

(6) Sign a service provider contract to provide services to a DDD client.

(7) Meet additional requirements in WAC 388-825-355.

2017-050 The Department of Social and Health Services, Aging and Long-Term Care Administration and Developmental Disabilities Administration, made improper overtime payments to Medicaid individual providers.

Federal Awarding Agency:	U.S. Department of Health and Human Services	
Pass-Through Entity:	None	
CFDA Number and Title:	93.775	State Medicaid Fraud Control Units
	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778	Medical Assistance Program (Medicaid; Title XIX)
Federal Award Number:	5-1705WA5MAP; 5-1705WA5ADM; 5-1705WAIMPL; 5-1705WAINCT	
Applicable Compliance Component:	Activities Allowed/Unallowed Allowable Costs/Cost Principles	
Known Questioned Cost Amount:	$9,778 ($7,993 – Individual Provider services) ($1,785 – Associated costs)	

Background

Medicaid is a jointly funded State and federal partnership providing coverage for about 1.9 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and accounts for about one-third of the State's federal expenditures. The program spent about $12.3 billion in federal and State funds during fiscal year 2017.

The Aging and Long-Term Care Administration and the Developmental Disabilities Administration within the Department of Social and Health Services (Department) offers personal care, respite and other services to support Medicaid clients in community settings. The Department uses an assessment to evaluate a client's support needs and to calculate the number of personal care hours the client needs to successfully live in the community. Individual providers contract with the Department to provide personal care and respite services to clients. In fiscal year 2017, the state Medicaid program paid about $30 million in overtime expenditures for personal care and respite services.

In January 2015, the U.S. Department of Labor's Domestic Service Rule went into effect, requiring the Department to pay overtime to individual providers. In April 2016, the state Legislature passed a bill to limit the financial effect of this ruling on the State by minimizing overtime costs and directing the Department to establish rules regarding individual provider overtime.

The Department implemented work week limit rules and sent letters to individual providers and their clients to notify them of their authorized overtime work week hours on May 13, 2016. Services included in an individual provider's authorized overtime work week limit include personal care, relief care, skills acquisition training and respite care. For providers who were contracted and working in January 2016,

their authorized overtime work week limits were based on the hours paid to them in January 2016. State statute limits providers who worked 40 hours or less in January 2016, and new providers, from working more than 40 hours per week unless certain criteria are met. The Department may grant temporary approvals to allow providers to work above their authorized overtime work week limits based on individual client need. Providers receive a notice indicating the amount and duration of the approval of a temporary increase.

Description of Condition

We used a statistical sampling method to randomly select and examine 86 out of 67,505 overtime payments paid during fiscal year 2017. We compared the hours providers claimed during a month with their authorized overtime hours and found 20 instances when the Department made unallowable payments to individual providers who claimed payment for more hours than their authorized overtime work week limit.

This condition was not reported in the prior audit.

Cause of Condition

The Fair Labor Standards Act requires providers to be paid for all hours worked. Department staff said the timing of the U.S. Department of Labor's ruling required them to launch a new payment system before it was designed to make overtime payments to providers. Staff did not have sufficient time to train providers about the new overtime rules.

Effect of Condition and Questioned Costs

We determined the Department made $14,274 in unallowable payments to the providers who claimed to work more hours than their authorized overtime work week limit We are questioning $7,993, which is the federal portion of the unallowable payments.

When unallowable payments are identified, federal regulations suggest auditors consider if associated costs, such as benefits, were also paid. The Department pays payroll-related benefits, which are considered associated costs, on behalf of individual providers. Examples of these costs include health insurance, retirement, payroll taxes and training.

For the $14,274 in payments we determined were unallowable, we identified $3,187 in associated costs that we also consider to be unallowable. We are questioning $1,785, which is the federal portion of the unallowable payments.

Including associated costs, the total amount we are questioning is $9,778.

Because a statistical sampling method was used to select individual provider overtime payments, we estimate the amount of improper payments to be $11,204,046. The federal share of this estimate is $6,274,266.

For the $3,187 in questioned associated costs, we estimate the total amount of improper payments to be $2,501,220. The federal share of this estimate is $1,400,683.

The statistical sample used for testing was also used to test compliance with activities allowed and provider eligibility requirements. Because some unallowable payments we examined violated multiple federal compliance requirements, some of the questioned costs reported here might also be reported in finding numbers 2017-045, 2017-046 and 2017-049.

Projection to population personal and respite care	Known questioned costs	Estimated improper payments
Federal expenditures	$9,778	$7,674,949
State expenditures	$7,682	$6,030,317
Total expenditures	**$17,460**	**$13,705,266**

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

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Recommendation

We recommend the Department consult with the U.S. Department of Health and Human Services to determine if the questioned costs identified by the audit should be repaid.

Agency's Response

The Department does not concur with the finding

The Department uses the CMS approved Comprehensive Assessment Reporting Evaluation (CARE) tool to assess for client need and to allocate the number of hours of personal care and respite the client is eligible to receive. These payments were made to qualified providers for services the client was authorized to receive. All hours paid to the individual providers were allowable as no payments were made in excess of the CARE generated allowable hours. The Department's process complies with CMS's directive that any processes developed by States must comply with the Fair Labor Standards Act, as required by Medicaid law, (Department of Health & Human Services, CMCS Informational Bulletin, July 3, 2014). CMS also requires that Department policy protect clients' access to services and supports they are eligible to receive in their person-centered service plan from a provider of their

choice. This CMS guidance also acknowledges that overtime costs paid under the Fair Labors Standards Act can be reimbursed as a reasonable cost related to the delivery of Medicaid services.

The legislature imposed work week limits on individual providers with the passage of Engrossed Second Substitute House Bill 1725 (ESSHB 1725) and directed the Department to adopt rules for when individual providers can work additional hours in a work week. The statute directed the Department not to impose work week limits on individual providers until the Department conducted a review of the plan of care for the clients served by the individual provider. These reviews were not completed until July 29, 2016. Five of the payments deemed by the SAO to be unallowable were made prior to July 29, 2016. The rules adopted as a result of ESSHB 1725, have a mechanism for terminating the individual providers if they repeatedly exceed their work week limit. These statutory limits and the associated rules which restrict the individual provider have no relation to the client's benefit which is reflected as authorized hours.

Regardless of whether the individual provider exceeded their work week limit, payment for all hours worked is required. For instance, RCW 49.46.800 requires the Department to pay individual providers one and one-half times their regular rate for hours worked in excess of forty hours in a given work week. The Department also adhered to the specific actions outlined in WAC 388-114-0120 before stopping the payment to the individual provider who worked more than their work week limit. In all cases, except one, the Department issued a contract action against the provider. The Department cannot prevent the provider from being paid more than their work week limit because labor law requires payment for all hours worked. Providers must therefore be allowed to claim and be paid for hours worked. The Department then uses the post-payment procedure outlined in WAC 388-114-0120 to address claims that exceed a provider's work week limit.

In addition to not concurring with the finding, the Department also notes that the calculation of the questioned costs was erroneously applied. Because the hours in question are within the CARE generated hours, the provision of the hours themselves are not in question, only the payment of overtime for these hours. Since cost of overtime is the difference between the individual provider's base rate of pay and one and a half times that rate of pay, questioned costs would be calculated only on the overtime cost.

Auditor's Concluding Remarks

We agree with the Department that overtime must be paid if a provider exceeds 40 hours in a work week. However, at the direction of the Legislature, the Department implemented rules to limit the State's financial burden of incurring these costs. Included in the Department's rules are limits on the number of overtime hours a provider can work. On May 13, 2016, the Department notified individual providers of their allowable overtime hours. If special situations occur that necessitate additional overtime hours to be worked, providers are notified by the Department about the number of additional hours they may work.

We reviewed overtime payments issued by the Department and found 20 instances when the Department violated its rule and made overtime payments to individual providers who claimed payment above their authorized hours.

In their response, the Department states that five of the payments were made prior to July 29, 2016 and should not have been included in our review because plans of care had not been completed. We met with the Department on multiple occasions and reviewed implementation dates with them. We discussed the May 13, 2016 notification date. Because providers had not been notified of their authorized hours until that date, we did not include payments from service dates prior to June 2016 as exceptions. We specifically asked the Department if there were any other timing issues that we needed to be aware of and representatives from both Administrations said no. Due to the timing of receiving this new information from the Department, we cannot assess what effect, if any, it may have on our audit results.

We reaffirm our finding and will follow-up with the Department in the next audit.

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).
(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

(a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Title 42 U.S. Code of Federal Regulations Part 433, Stat Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers

Section 433.300 Basis.

This subpart implements -

(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.
(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Section 433.316 When discovery of overpayment occurs and its significance.

(a) *General rule.* The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) *Requirements for notification.* Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of - -

(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

(d) *Overpayments resulting from fraud.*

(1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by § 455.15, § 455.21, or § 455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

(e) *Overpayments identified through Federal reviews.* If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS

will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) *Effect of changes in overpayment amount.* Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) *Effect of partial collection by State.* A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

(h) *Effect of administrative or judicial appeals.* Any appeal rights extended to a provider do not extend the date of discovery.

The Revised Code of Washington 74.39A.270 - Collective bargaining—Circumstances in which individual providers are considered public employees—Exceptions—Individual provider pay—Joint legislative-executive overtime oversight task force, states in part:

(5) Except as expressly limited in this section and RCW 74.39A.300, the wages, hours, and working conditions of individual providers are determined solely through collective bargaining as provided in this chapter. Except as described in subsection (9) of this section, no agency or department of the state may establish policies or rules governing the wages or hours of individual providers. This subsection does not modify:

(a) The department's authority to establish a plan of care for each consumer or its core responsibility to manage long-term in-home care services under this chapter, including determination of the level of care that each consumer is eligible to receive. However, at the request of the exclusive bargaining representative, the governor or the governor's designee appointed under chapter 41.80 RCW shall engage in collective bargaining, as defined in RCW 41.56.030(4), with the exclusive bargaining representative over how the department's core responsibility affects hours of work for individual providers. This subsection shall not be interpreted to require collective bargaining over an individual consumer's plan of care;

(b) (i) The requirement that the number of hours the department may pay any single individual provider is limited to:

(A) Sixty hours each workweek if the individual provider was working an average number of hours in excess of forty hours for the workweeks during January 2016, except for fiscal years 2016, 2017, and 2018, the limit is sixty-five hours each workweek; or

(B) Forty hours each workweek if the individual provider was not working an average number of hours in excess of forty hours for the workweeks during January 2016, or had no reported hours for the month of January 2016.

(ii) Additional hours may be authorized under criteria established by rules adopted by the department under subsection (9) of this section.

(iii) Additional hours may be authorized for required training under RCW 74.39A.074, 74.39A.076, and 74.39A.341.

(iv) An individual provider may appeal to the department for qualification for the hour limitation in (b)(i)(A) of this subsection if the average weekly hours the individual provider was working in January 2016 materially underrepresent the average weekly hours worked by the individual provider during the first three months of 2016.

(v) No individual provider is subject to the hour limitations in (b)(i)(A) of this subsection until the department has conducted a review of the plan of care for the consumers served by the individual provider. The department shall review plans of care expeditiously, starting with consumers connected with the most individual provider overtime;

(c) The requirement that the total number of additional hours in excess of forty hours authorized under (b) of this subsection and subsection (9) of this section are limited by the total hours as provided in subsection (10) of this section;

(d) The department's authority to terminate its contracts with individual providers who are not adequately meeting the needs of a particular consumer, or to deny a contract under RCW 74.39A.095(8);

(e) The consumer's right to assign hours to one or more individual providers consistent with the rules adopted under this chapter and his or her plan of care;

(f) The consumer's right to select, hire, terminate, supervise the work of, and determine the conditions of employment for each individual provider providing services to the consumer under this chapter;

(g) The department's obligation to comply with the federal medicaid statute and regulations and the terms of any community-based waiver granted by the federal department of health and human services and to ensure federal financial participation in the provision of the services; and

(h) The legislature's right to make programmatic modifications to the delivery of state services under this title, including standards of eligibility of consumers and individual providers participating in the programs under this title, and the nature of services provided. The governor shall not enter into, extend, or renew any agreement under this chapter that does not expressly reserve the legislative rights described in this subsection (5)(h).

(9) The department may not pay any single individual provider more than the hours listed in subsection (5)(b) of this section unless the department authorizes additional hours under criteria established by rule. The criteria must be limited in scope to reduce the state's exposure to payment of overtime, address travel time from worksite to worksite, and address the following needs of consumers:

(a) Ensuring that consumers are not at increased risk for institutionalization;

(b) When there is a limited number of individual providers within the geographic region of the consumer;

(c) When there is a limited number of individual providers available to support a consumer with complex medical and behavioral needs or specific language needs;
(d) Emergencies that could pose a health and safety risk for consumers; and
(e) Instances where the cost of the allowed hour is less than other alternatives to provide care to a consumer, distinct from any increased risk of institutionalization.
(e) The department is authorized to adopt rules, including emergency rules under RCW 34.05.350, to implement this subsection.

Washington Administrative Code 388-114-0070

May an individual provider work more than his or her permanent work week limit?

An individual provider with a permanent work week limit of:

(1) Forty service hours per week may only exceed the permanent work week limit as described in WAC 388-114-0080;
(2) More than forty service hours has flexibility to work more than his or her permanent work week limit in a given week if:
  (a) Requested by the client to meet a specific need;
  (b) Doing so would not exceed the client's monthly authorized hours;
  (c) The total number of service hours worked over forty for each work week in a calendar month does not exceed the amount of overtime the individual provider would receive if he or she worked his or her permanent work week limit every week of the calendar month; and
  (d) The use of more service hours in a given week will not result in a client going without essential care in other weeks of the month.

Washington Administrative Code 388-114-0080

When may the department temporarily approve a client specific increase to an individual provider's work week limit?

(1) The department may temporarily increase an individual provider's work week limit if it determines the increase is necessary:
  (a) Due to a lack of available providers who are able to adequately meet a client's care needs, as evaluated by the department in its consideration of:
    (i) The overall availability of providers in the geographic region;
    (ii) Whether the client has complex medical or behavioral needs;
    (iii) Whether the client requires a provider with specific language skills; and
    (iv) The client's good faith efforts and cooperation to manage his or her service hours and locate and select additional providers, examples of which may include:
      (A) Making schedule adjustments within the work week limits of current providers who are providing services;
      (B) Seeking a qualified family or friend to contract as an individual provider;
      (C) Utilizing the home care referral registry; and
      (D) Requesting a worker through a home care agency, unless doing so would cost more than paying the individual provider overtime;

(b) To protect a client's health and safety, as evaluated by the department in its consideration of:
  (i) Whether the request is to approve service hours the individual provider spent caring for the client because of an emergent condition;
  (ii) The nature and severity of the emergent condition; and
  (iii) Whether the need could have been postponed until another provider could have arrived;
(c) To prevent an increased risk that the client will be unable to remain in a home or community based setting, except in cases where there are additional qualified providers available to select and the client has chosen not to select them; or
(d) To enable a client to assign to an individual provider the same number of hours in months with thirty days as are assigned in months with thirty-one days, provided that:
  (i) The client is unable to assign the same number of the hours due to the individual provider's permanent work week limit;
  (ii) There is no other qualified provider assigned that can work the hours within his or her permanent work week limit;
  (iii) The increase does not result in a monthly total that exceeds the number of hours assigned to an individual provider in a thirty-one day month; and
  (iv) The increase does not exceed two and one-half hours per week.

(2) When a client specific increase is no longer approved by the department, the individual provider's work week limit will revert back to the permanent work week limit described in WAC 388-11-0030.

(3) The department may only approve a client specific work week limit in excess of eighty service hours per week for an individual provider if the client's circumstances meet the criteria set out in WAC 388-440-0001 (1)(a) through (e) and where the department is unaware of any reason that the individual provider will be unable to appropriately meet the needs of the client.

(4) The department will not approve additional service hours to any individual provider's permanent work week limit that would result in a monthly total that exceeds the client's monthly service hours.

(5) The individual provider is not entitled to an administrative hearing under chapter 34.05 RCW regarding the department's decision on whether to approve or continue a client specific temporary increase to the work week limit.

2017-051 The Department of Social and Health Services charged payroll costs to the Disability Insurance/SSI Cluster that were not adequately supported.

Federal Awarding Agency:	U.S. Social Security Administration
Pass-Through Entity:	None
CFDA Number and Title:	96.001 Social Security – Disability Insurance
	96.006 Supplemental Security Income
Federal Award Number:	15-0404WADI00, 16-0404WADI00, 17-0404WADI00
Applicable Compliance Component:	Activities Allowed or Unallowed
	Allowable Costs/Cost Principles
Known Questioned Cost Amount:	$557,743

Background

The Department of Social and Health Services administers the Disability Insurance and Supplemental Security Income programs. The programs are overseen by Disability Determination Services (DDS), which is part of the Department's Economic Services Administration. DDS adjudicates medical claims for the Social Security Administration to make disability determinations for the state of Washington.

The Department may only use grant funds for costs that are allowable and relate to the grant's purpose. Federal regulations require employee compensation charged to federal grants to be adequately supported. According to Department policy, if employees are expected to work solely on a single federal award or cost objective, charges for their salaries and wages must be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. The certifications are prepared at least semi-annually and are signed by the employee and a supervisory official that has firsthand knowledge of the work performed by the employee to ensure they are accurate.

For the Disability Insurance and Supplemental Security Income programs, a manager sends out the required certifications twice a year to the supervisors. The supervisors are required to complete and return them by the 15th of the second month following the certification period.

In fiscal year 2017, the Department spent $51.8 million in federal funds on the program. Approximately $1.1 million was for payroll expenses related to employees working on a single federal award.

Description of Condition

During the audit period, the Department was to have completed 25 salary certifications – we found 13 of those certifications were not completed.

This condition was not reported in the prior audit.

Cause of Condition

The manager responsible did not send the semi-annual certifications for the period in question to the supervisors, and the supervisors did not ensure the certifications were done as required by policy. Additionally, management did not provide sufficient oversight to ensure compliance with the requirement.

Effect of Condition and Questioned Costs

The Department charged $557,743 in direct payroll and benefits to the Disability Insurance/SSI Cluster that were not adequately supported. Therefore, we are questioning these costs.

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

Recommendations

We recommend the Department follow its own policy to ensure payroll costs charged to a federal grant are supported by required documentation. We also recommend the Department consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid.

Agency's Response

The Department concurs with the audit finding.

The Department acknowledges certifications were not submitted in a timely manner for the period of October 2016 to March 2017 as required in DSHS Administrative Policy No. 19.50.01 A (B). However, the Department does not believe that the payroll charges for $557,743 should be repaid.

While the Department did not obtain the certifications on a timely basis, the Department did obtain certifications for the positions once the Department became aware of the issue. The Department reviewed the certifications against the actual costs incurred to ensure that all the positions were charged accurately to the applicable federal programs. This review showed that no adjusting entries were required and federal monies were expended appropriately. Given that the Department did obtain supporting documentation and reconciled that information, the costs incurred are allowable and there is no repayment to discuss with the U.S. Social Security Administration.

The Department immediately established a process to ensure payroll costs charged to the Disability Insurance/SSI Cluster are adequately supported, and done so in a timely manner in accordance with state and federal laws and regulations.

Auditor's Concluding Remarks

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

Applicable Laws and Regulations

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes reporting requirements for audit findings.

Section 200.53 Improper Payments states:

(a) *Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

(b) *Improper payment* includes any payment to an ineligible party, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), any payment that does not account for credit for applicable discounts, and any payment where insufficient or lack of documentation prevents a reviewer from discerning whether a payment was proper.

Section 200.403 Factors affecting Allowability of costs.

Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards.

(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles.

(b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items.

(c) Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.

(d) 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 sample purpose in like circumstances has been allocated to the Federal award as an indirect cost.

(e) Be determined in accordance with generally accepted accounting principles (GAAP), except, for state and local governments and Indian tribes only, as otherwise provided for in this part.

(f) Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period. See also §200.306 Cost sharing or matching paragraph (b).

(g) Be adequately documented. See also §§200.300 Statutory and national policy requirements through 200.309 Period of performance of this part.

Section 200.410 Collection of unallowable costs.

Payments made for costs determined to be unallowable by either the Federal awarding agency, cognizant agency for indirect costs, or pass-through entity, either as direct or indirect costs, must be refunded (including interest) to the Federal Government in accordance with instructions from the Federal agency that determined the costs are unallowable unless Federal statute or regulation directs otherwise. See also Subpart D—Post Federal Award Requirements of this part, §§200.300 Statutory and national policy requirements through 200.309 Period of performance.

Section 200.516 Audit findings, states in part:

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

(3) Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor must also report known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program. In reporting questioned costs, the auditor must include information to provide proper perspective for judging the prevalence and consequences of the questioned costs.

Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*

Section 200.430 Compensation – personal services, states in part:

(i) *Standards for Documentation of Personnel Expenses* (1) Charges to Federal awards for salaries and wages must be based on records that accurately reflect the work performed.

DSHS Administrative Policy No. 19.50.01A states, in part:

A. Programs must support charges for the salaries and wages of employees who work solely on a single federal award by completing periodic certifications. The allocation of staff time that is directly charged to federal awards must be identified in the DSHS written cost allocation plan and approved by the granting federal authority.
B. Programs must complete semi-annual certifications for all employees that work solely on and are coded directly to a single federal award.
C. Certifications must be completed in the second month following certification period…
D. Program staff must validate the employee's payroll coding at the time of the certification and make any necessary changes.
E. The employee and their supervisor must sign the semi-annual certification…
F. The program must retain all required documentation in accordance with the applicable retention schedule.

2017-052 The Washington Military Department did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of Disaster Grants-Public Assistance received required audits.

Federal Awarding Agency:	Department of Homeland Security
Pass-Through Entity:	None
CFDA Number and Title:	97.036 Disaster Grants-Public Assistance
Federal Award Number:	FEMA-1671-DR; FEMA-1734-DR; FEMA-1817-DR; FEMA-1825-DR; FEMA-1963-DR; FEMA-4056-DR; FEMA-4083-DR; FEMA-4168-DR; FEMA-4188-DR; FEMA-4242-DR; FEMA-4243-DR; FEMA-4249-DR; FEMA-4253-DR
Applicable Compliance Component:	Subrecipient Monitoring
Known Questioned Cost Amount:	None

Background

The Disaster Grants-Public Assistance (PA) program helps state, tribal and local governments pay for responding to and recovering from disasters. Following a presidential declaration of a major disaster or an emergency, the Federal Emergency Management Agency (FEMA) provides supplemental federal disaster grants assistance for debris removal, emergency protective measures and the restoration of disaster-damaged facilities owned by states, municipalities, tribes and certain private nonprofit organizations. In Washington, the PA program agency is the Military Department (Department).

In state fiscal year 2017, the Department spent almost $30 million in federal PA funds.

Federal regulations require the Department to monitor award subrecipients' activities. This includes ensuring its subrecipients that spend $750,000 or more in federal grant money during a fiscal year obtain a single audit. The Department must also follow up on any audit findings a subrecipient receives that might affect the federal program, and must issue a management decision within six months of the audit report's acceptance by the Federal Audit Clearinghouse. The management decision must clearly state whether the audit finding is sustained, the reasons for the decision, and whether the auditee is expected to repay disallowed costs, make financial adjustments or take other action. These requirements help ensure grant money is used for purposes that are authorized and within the provisions of contracts or grant agreements.

Description of Condition

We found the Department did not have adequate internal controls in place to verify:

- Subrecipients received required audits
- Findings were followed up on and management decisions were issued promptly

Although the Department did have policies specifying this monitoring is required and how to perform it, no monitoring was performed during the audit period. We determined the Department provided subrecipient funding to 163 entities during fiscal years 2015 and 2016 that may have required monitoring during the audit period.

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

This condition was not reported in the prior audit.

Cause of Condition

Although the Department had established policies to monitor and verify if subrecipients obtained required audits, staff turnover led to these duties not being performed. Additionally, management did not monitor to ensure these requirements were met.

Effect of Condition

Without establishing adequate internal controls, the Department cannot ensure all subrecipients that met the threshold for an audit complied with federal grant requirements, and thus that it has met federal monitoring requirements.

Recommendations

To improve its monitoring of subrecipients, we recommend the Department:

- Verify all required audits occurred
- Follow up on all subrecipient audit findings related to the program and issue a management decision promptly
- Ensure management effectively monitors to ensure it meets federal grant requirements

Agency's Response

The Military Department concurs with the statements/finding, "The Washington Military Department did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of Disaster Grants-Public Assistance received required audits", as well as, "Department did not appropriately implement their financial policy and did not comply with federal requirements to ensure subrecipients of Disaster Grants-Public Assistance received required audits". However, the Department believes these statements are not completely accurate.

The Military Department concurs with the statements/finding, "these internal control weaknesses constitute a material weakness". We have initiated actions to address this internal controls weakness.

Currently within the Department, the Single Audit Act Sub-recipient monitoring responsibility is divided between various offices of the Department. The WMD Audit Tracker – Single Audit Act certification maintained by the Finance Division cohesively monitors across all Department Sub-

recipients (federal pass-through funds) to monitor Sub-recipient audits and to alert Program managers of audit irregularities or potential non-compliance with Single Audit Act requirements.
Through calendar year (CY) 2015 (local jurisdictions), the WMD Audit Tracker process remained in place and was operational. The WMD Audit Tracker process, stopped because of extensive staff turnover in the Finance Division beginning in July 2016. The process stoppage was not briefed to management.

The 163 entities during fiscal years 2015 and 2016 (calendar years, school years, and federal years) were spaced across two fiscal years with a significant amount of activities completed because of five new disasters (Oct 2015-April 2017). As such, many elements of the WMD Audit Tracker were being accomplished which was completed and documented; however, not documented in the WMD Audit Tracker.

Once notified of the audit finding, the PA Program completed an exhaustive review of all open Sub-recipients using existing Single Audit Act certification dates (certified by Sub-recipient CFOs), 2 CFR 200 Sub-recipient risk assessment review dates, and WMD Audit Tracker reviews (prior to July 2016) to determine if any Sub-recipient audit findings related to the program and/or Management Decision Letters were needed. The PA Program used WA SAO/Federal Clearinghouse databases to research each open Sub-recipient's latest three financial, financial/federal, accountability, and/or assessment audits (some dating back to CY 2011) to determine no Sub-recipient audit findings related to CFDA 97.036 (PA Program) and/or Management Decision Letters were needed.

The Department has initiated actions to address this internal controls weakness. We have set a meeting to review the existing Department policy and to update the policy to include the following:

(1) use/frequency of the Department Contracts Office certification form – 2 CFR Part 200 Subpart F Audit Certification Form,
(2) other changes mandated by the implementation of 2 CFR 200 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, and
(3) delineation of responsibilities between Department divisions and grants programs.

Once the updated policy is agreed upon, the WMD Audit Tracker will be updated from CY 2015 (for SFY 2016 certification) to present to re-establish cohesive Single Audit Act Sub-recipient monitoring.

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 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) establishes the following applicable requirements:

Section 200.303 Internal controls, states in part:
The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).
(b) Comply with Federal statutes, regulations, and the terms and conditions of the Federal awards.
(d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

Section 200.516 Audit findings, states in part:

(a) *Audit findings reported*. The auditor must report the following as audit findings in a schedule of findings and questioned costs:
  (1) Significant deficiencies and material weaknesses in internal control over major programs and significant instances of abuse relating to major programs. The auditor's determination of whether a deficiency in internal control is a significant deficiency or material weakness for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the Compliance Supplement.
  (2) Material noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards related to a major program. The auditor's determination of whether a noncompliance with the provisions of Federal statutes, regulations, or the terms and conditions of Federal awards is material for the purpose of reporting an audit finding is in relation to a type of compliance requirement for a major program identified in the compliance supplement.

Section 200.331 Requirements for pass-through entities, states in part:

(d) Monitor the activities of the subrecipient as necessary to ensure that the subaward is used for authorized purposes, in compliance with Federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved. Pass-through entity monitoring of the subrecipient must include:
  (3) Issuing a management decision for audit findings pertaining to the Federal award provided to the subrecipient from the pass-through entity as required by §200.521 Management decision.
(f) Verify that every subrecipient is audited as required by Subpart F—Audit Requirements of this part when it is expected that the subrecipient's Federal awards expended during the respective fiscal year equaled or exceeded the threshold set forth in §200.501 Audit requirements.

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

> .11 For purposes of adapting GAAS to a compliance audit, the following terms have the meanings attributed as follows: …
>
> **Deficiency in internal control over compliance.** A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when a properly designed control does not operate as designed or the person performing the control does not possess the necessary authority or competence to perform the control effectively.
>
> **Material weakness in internal control over compliance.** A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:
>
> **Reasonably possible**. The chance of the future event or events occurring is more than remote but less than likely.
>
> **Probable**. The future event or events are likely to occur.
>
> **Significant deficiency in internal control over compliance.** A deficiency, or a combination of deficiencies, in internal control over compliance that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.
>
> **Material noncompliance**. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.